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**Medical and Professional
Homoeopathy in the UK:
a study of tensions in a
heterodox healthcare
profession.**

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Submitted in fulfilment of the Degree of Doctor of Philosophy

City University

Department of Sociology

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"All perfection in this life is accompanied by a measure of imperfection, and all our knowledge contains an element of obscurity."

Thomas À Kempis

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DECLARATION

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ABSTRACT

Homoeopathic practitioners in the United Kingdom can be divided into two groups, those with medical qualifications and those without, professional homoeopaths. This study examines these two groups to discover how they practise homoeopathy and why. Also examined are any tensions that may exist, both between the two groups and within the groups.

Collecting qualitative and quantitative data using questionnaires and interviews, a randomly selected sample of homoeopaths was studied. All subjects were members of either the Faculty of Homoeopathy or the Society of Homoeopaths.

The study starts by examining the development of homoeopathy over its almost 200 year history. Following this section data regarding the practice of homoeopathy and the opinions of homoeopaths on this practice are discussed. The homoeopath's opinions regarding their opposite numbers are also discussed, that is professional homoeopath's opinions of medically qualified homoeopaths and vice versa.

The data highlighted a number of tensions that exist between medically qualified homoeopaths and professional homoeopaths. Medically qualified homoeopaths questioned the wisdom of allowing non-medically qualified people to practice homoeopathy and the professional homoeopaths questioned the validity of the homoeopathic methods used by medically qualified homoeopaths.

Tensions within professional homoeopathy were also identified between pro and anti professionalisation and registration subgroups. Another tension identified was between those professional homoeopaths who claim to use the original, 'classical' formulation of homoeopathy and those using a more eclectic therapeutic regime with changes to the original method incorporated into their practices.

Finally, the utility of the concept of heresy when describing both medically qualified homoeopaths and professional homoeopaths in the United Kingdom was addressed. Although the labelling of heretics is properly reserved for those members of the orthodoxy, not for researchers, a small number of homoeopaths were identified as holding potentially heretical ideas. On the whole the medically qualified homoeopaths and the majority of professional homoeopaths could not be regarded as heretics or dissenters in any way.

In the light of the tensions that were identified, and the policies being promoted by the professional bodies, the conclusion examines the possible future of homoeopathy in the United Kingdom in the first years of the new millenium. A thoroughly modernist medicine in a possibly postmodern era.

1 AN INTRODUCTION TO HOMOEOPATHY

1.1 General introduction

Homoeopathy has been in existence since 1796 when Samuel Hahnemann first started to experiment with a new form of medicine that he had devised. Over two hundred years later homoeopathy is still being practised around the world alongside the modern, high technology forms of medicine that have been devised in the twentieth century.

Who are the practitioners that still use this dated method of prescribing based upon an ancient law of similars, why are they using it and how ? Has homoeopathy changed since Hahnemann's use of it, or are practitioners rigidly adhering to his methods, rules and regulations ? These are the questions that are addressed in this work.

A further set of questions addresses the possible tensions that may exist within homoeopathy in the United Kingdom (UK) due to the existence of two different groups of practitioners, the medically qualified homoeopaths and the non-medically qualified homoeopaths. What conflicts exist between these groups ? Is there any co-operation between these two groups as they both pursue their own strategies to enhance the status of homoeopathy as a medical practice and as a profession ?

In addition to these questions is another enquiry into the nature of homoeopathic practitioners. This enquiry is to determine if these practitioners should be regarded as heretics or dissenters by the medical orthodoxy that they work alongside and also if there are homoeopaths whose practice is regarded as heretical by their fellow homoeopathic practitioners.

The work divides into three sections. The first section draws upon secondary sources to outline the history of homoeopathic practice in the UK and in the USA. It also examines the current status of homoeopathy as a heterodox therapy that is gaining popularity with the public and whose practitioners are embarking on strategies of professionalisation.

The second section describes the process of the collection of data from homoeopaths and then proceeds to describe the data. Finally, in the third section

the data from secondary and primary sources are analysed together to piece together the current picture of the practice of homoeopathy in the UK and the tensions that exist within this professional community.

Questionnaires and interviews with homoeopaths were the main methods of data collection used. Extensive use was also made of documentary sources of data from both the Society of Homoeopaths and the Faculty of Homoeopathy, these being the largest organisations representing both medically qualified homoeopaths and professional homoeopaths in the UK.

1.1.1 Terminology

One of the major dilemmas facing writers in the field of homoeopathy is that of terminology relating to the therapy. Is homoeopathy an alternative or a complementary technique? The decision of which is the appropriate term to use is one that is often made by practitioners, users and commentators in a value laden way. Some homoeopaths insist that they are complementary practitioners while others argue that their practice is alternative. In order to avoid the possible confusion that this may cause the term 'heterodox' will be used to denote any form of health care other than the orthodox medicine of the western culture in which the research was based.

Alternative and complementary will only be used either in direct quotes or where there is intended to be a distinction between alternative and complementary.

Similarly the term 'orthodox medicine' could be used in a value laden way and this is not intended in this text. Where the term orthodox is used it is to distinguish from a heterodox practice rather than to denote that there is a higher value placed upon the orthodox.

Homoeopaths who have followed a full course in medicine and have qualified as orthodox medical practitioners prior to using homoeopathy are referred to as medically qualified homoeopaths.

Homoeopaths who have not followed a course in medicine and are therefore not qualified as doctors of medicine are often referred to as 'lay' practitioners. However many such practitioners object to this term as it may give the mistaken

impression that they have not attended any training and have no qualifications. The non medically qualified homoeopaths in this study all appear in the Register of the Society of Homoeopaths and as such have all attended a training course to achieve a qualification in homoeopathy. These practitioners will be referred to in the text as 'professional homoeopaths'.

1.1.2 Literature

Work has been carried out investigating a mixture of complementary practitioners in the UK (Sharma 1992) but no major work has been carried out investigating homoeopaths in the UK. Studies of practitioners of particular complementary therapies have been carried out, for example White and Skipper (1971) researched the career contingencies of chiropractors in the United States of America (USA) and Baer (1984) investigated professionalisation in British osteopathy.

The concept of heresy in the medical sciences has been defined and discussed by Wolpe (1994) and Gillett (1994) and Stambolovic (1996) have extended the use of the concept in medical sciences. However there has been no previous investigation of homoeopaths as heretics or dissenters.

1.1.3 Current status

The current status of homoeopathy in the UK is somewhat unusual. The majority of homoeopathic practitioners in the UK are not medically qualified. These 'professional homoeopaths' follow a three or four year course to qualify in homoeopathy. There are also a smaller number of medically qualified homoeopaths who use homoeopathy either as an adjunct to their conventional medical practice or as the main therapeutic method in their practice.

The National Health Service (NHS) also makes provision for homoeopathic treatment and has done so since its outset in 1948. Homoeopathy was the only heterodox health care practice to be included in the NHS until December 1991 when the Parliamentary Secretary for Health, Stephen Dorrell, confirmed in a Department of Health press release that general practitioners were able to employ complementary therapists to offer NHS treatment within their practices (Society of Homoeopaths 1992).

1.2 What is homoeopathy ?

1.2.1 Homoeopathy

Homoeopathy is a 200 year old system of medicine based on an ancient law of cure, the Law of Similars. The scope of this work cannot include all of the theories of how homoeopathy works however a short version will be useful.

The law of similars, as used in homoeopathy, states that any substance that could produce a symptom picture when administered to a healthy individual, will cure a person whose illness has produced a similar symptom picture. The role of the homoeopath is, therefore, to determine the patient's symptom picture in as much detail as possible and then find the homoeopathic remedy that possesses the most similar symptom picture in order to cure the patient.

1.2.2 Classical or 'Hahnemannian' prescribing

There are a number of differing styles within homoeopathy all resulting in slightly different methods of selecting and prescribing remedies. The method described here relates most closely to that which is usually referred to as the 'Classical' or 'Hahnemannian' method. The method of determining the patient's symptom picture is a lengthy interview that will gain information for the homoeopath about all aspects of the patient, not only the presenting symptoms. In keeping with its holistic stance homoeopathy utilises information regarding all manner of personal details about the patient's likes and dislikes, fears and dreams and mental and emotional dispositions. All of this information is grist to the homoeopath's mill, and all will be used to select the most appropriate remedy, that is, the one with a symptom picture which is most similar to that of the patient. The homoeopathic interview can therefore be a lengthy one, especially the initial interview, with many homoeopaths spending in excess of an hour and a half gaining a thorough picture of their patient.

1.2.3 The diagnosis

In homoeopathy the term 'diagnosis' is not used in the same way as it is in orthodox medical practice. In orthodox medicine the diagnosis refers to the labelling of the patient's disease or syndrome and this will then lead on to a currently acceptable therapeutic regime for that diagnosis.

Many homoeopaths will not use the word diagnosis and will point out that homoeopaths do not make a diagnosis in the conventional sense. Instead they individualise each patient in order to prescribe for them their own 'tailor-made' remedy.

Diagnosis, in the homoeopathic sense, therefore amounts to selecting a remedy rather than the labelling of symptoms. Many homoeopaths will not provide a diagnosis, in the conventional sense, for their patient but will often tell them what remedy they have selected to treat them.

1.2.4 Remedy selection

How is the remedy selected with the aid of the large and complex mass of data that has arisen from the homoeopathic interview ? Many homoeopaths rely on databases of homoeopathic knowledge which they call repertories. In the past repertories have always been produced in book form with the most commonly used one being *Kent's Repertory of the Homoeopathic Materia Medica* written by James Tyler Kent in 1887. In the past ten years or so these repertories have increasingly appeared in computer format allowing more and more rapid cross referencing of data to take place.

The repertory lists, under a series of headings relating to body parts such as extremities, skin and head, a multitude of symptoms that might afflict each of these parts and systems, often in minute detail, for example;

HEAD, Pain, shooting, temples, bending head backwards aggravates.

(Kent 1990: 203)

EXTREMITIES, Coldness, foot, left, daytime, during menses.

(Kent 1990: 962)

Next to each of these symptoms is a list of remedies that can cause this symptom, and therefore may cure it, often graded according to how often the symptom has occurred while the remedy was being given to healthy individuals testing the remedy. Sometimes there will be only one or two remedies listed and in other examples there will be several hundreds.

The homoeopath will analyse this data often using either a points system or a process of elimination. This will enable the homoeopath to calculate which remedy from the homoeopathic materia medica is most strongly indicated by the symptom picture given by the patient (Wright-Hubbard 1988). Often the homoeopath will double check the most strongly indicated remedies by referring to printed materia medica that list all of the known symptoms produced by the remedies, using the same anatomical subheadings used in the repertories.

1.2.5 Potentised remedies

When the most similar remedy has been selected it will be given to the patient in a 'potentised' form. Homoeopathic potentisation involves two processes. The first process is the serial dilution of the original substance; usually remedies are diluted 1:100 with a mixture of alcohol and water. This process of serial dilution may occur many, many times in the production of the remedy and the number of such dilutions will be indicated using the suffix 'c', representing centissimal, that is 1:100 dilution. For example a remedy made from *Arnica montana* that has been diluted 1:100 thirty times will be referred to as *Arnica 30c*. Classical homoeopaths might start treatment using 30c remedies but may go up in potency to 200c and 1000c, usually referred to as 1M. Many homoeopaths use dilutions up to 50M or even CM, that is 100,000, dilutions of 1:100. The more dilute the substance is made, then the more powerful, or potentised, the remedy is thought to be (Vithoulkas 1979).

The second process in potentisation involves the vigorous shaking of the remedy following each serial dilution. In homoeopathy this vibration of the remedy is referred to as 'succussion'. Hahnemann is known to have succussed his remedies by hitting them against his family Bible. Thus a potentised remedy is one that has been serially diluted and repeatedly succussed.

In classical homoeopathic prescribing there should be only one remedy that is the 'similimum', or most similar to the patient's symptom picture, and therefore only one remedy should be taken at any one time. It is the classical practice to prescribe just one dose of the similimum, usually just one tablet, and then to await any reaction to this dose before repeating it, or prescribing a different remedy, according to the reaction that has been observed to the first dose of remedy.

This picture of the typical classical homoeopath's practice cannot be thought of as a universal representation of homoeopathic practice in Britain. Many homoeopaths make little, or no, reference to repertories or '*materias medica*' because they prefer to rely on their own knowledge of the remedies and their actions that has often been painstakingly gained. This form of practice is rare however and increasingly the computer repertories are easing the work of the homoeopaths by almost instantaneously producing a list of the top ten remedies for any patient's symptom picture.

1.2.6 'Not Just Classical'

As has been stated above the form of homoeopathy described here is the 'Classical' or 'Hahnemannian' form. However, there are many other styles of homoeopathy, all differing in some, usually small, ways from the Classical form, and from each other. Many practitioners describe themselves as 'Kentians' or 'Eizayagans' depending on whose writings they base their practice upon.

When it sought to re-write the description of the principles of homoeopathy, the Society of Homoeopaths in Britain recently discovered that it was not as easy as it had originally supposed to describe the practice of homoeopathy by its members. This description of the principles of homoeopathy is printed in the register of members sent out to members of the public enquiring about the location of their nearest registered homoeopath (Carlyon 1996). The 'Letters' page of the Society of Homoeopaths quarterly 'Newsletter' carried correspondence from the membership, both for and against the Society's re-writes, for several issues throughout 1996-7 (See for example, The Society of Homoeopaths Newsletters, September 1996, December 1996 and March 1997).

The differences in style are usually minor and certainly the concept of the Law of Similars is universally accepted. Differences in posology, the science of dose regimes, account for most of the differences observed in practice. Differences in how many remedies are used, how often they are given and the choice of starting potency account for much debate between the different 'sects' amongst homoeopaths.

There is also some dispute regarding what substances should be used as remedies and some practitioners will potentise their patient's own body fluids to be

used as a remedy. Classical homoeopaths regard this as something other than homoeopathy. For example, they argue that using an AIDS sufferer's own blood, homoeopathically potentised, to treat his/her AIDS symptoms is the practice of isopathy, that is 'identical to the disease', rather than homoeopathy which is 'similar to the disease'.

Hahnemann was very specific in his description of how homoeopathy should be used. He described in detail the preparation of remedies, how to 'take the case', that is how to conduct the interview, and how to use the remedies. He detailed when to repeat the dose and when to leave well alone, when to change the remedies and when to continue with the original choice. All of this Hahnemann published in his *Organon of the Art of Healing* (Hahnemann 1988) and these instructions are strictly adhered to by the classical homoeopaths.

Homoeopathy as a form of therapy has many adherents who still practise in the way that Hahnemann prescribed almost two hundred years ago. It claims to produce good therapeutic results to stand alongside those of conventional medicine. Some practitioners argue that the environment in which we live has changed so much in the last two centuries that homoeopathy needs to change with it and this is used as a justification for the changes that they have brought to this practice. This is countered by the classical homoeopaths who claim that good results can only be obtained if homoeopathy is practised in the true classical way which Hahnemann used to such good effect.

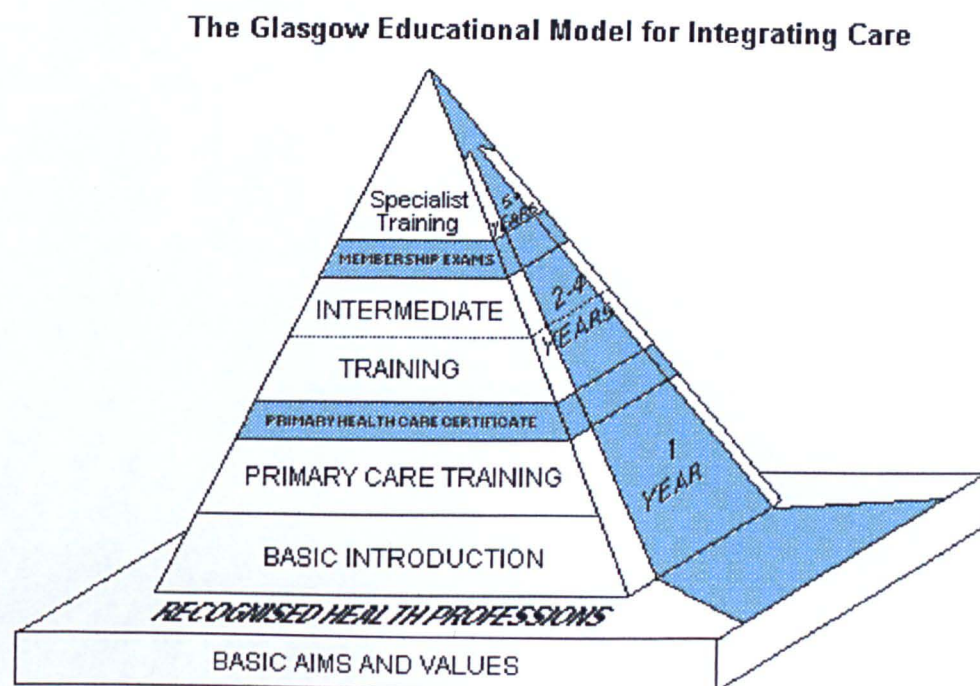
1.3 The present status of medically qualified homoeopathy.

1.3.1 The Faculty of Homoeopathy

The Faculty of Homoeopathy is the organisation responsible for the registration and education of medically qualified homoeopaths in the UK. Recently a one year basic introductory course leading to a Primary Health Care Certificate in Basic Homoeopathy has been added to their portfolio. This certificate is open only to statutorily registered health professionals, other than doctors, for example nurses, midwives or physiotherapists. Obtaining the certificate does not, however, lead to membership of the Faculty of Homoeopathy (MFHom). Veterinarians and doctors who attend the Faculty's courses may seek MFHom status. Dental surgeons who attend the Faculty courses may apply to be an Associate of the Faculty of

Homoeopathy. In November 1995 there were 180 doctors with MFHom status registered with the Faculty, practising in mainland Britain (Faculty of Homoeopathy 1995).

1.3.2 Educational courses.



Integrating Complementary and Orthodox Care Using The Generalist-Specialist Split

A model developed by AdHom - The Academic Departments of Homoeopathic Medicine, Glasgow Homoeopathic Hospital.

Figure 1.1The Glasgow Educational Model for Integrating Care

Probably the most popular courses for doctors are those run by the Academic Departments of Homoeopathic Medicine, Glasgow Homoeopathic Hospital (AdHom). In 1997 AdHom published figures (AdHom 1997) to show how the numbers of doctors and other health care professionals undertaking training in homoeopathy had increased over the decade between 1984 and 1994 from just under 40 students in 1984 to just over 250 in 1994. The largest proportion of these students were attending the Basic Introductory programme, just over 100 students in 1994. Of the 250 attendees in 1994 around seventy were attending the Primary Health Care module for health professionals other than doctors. The number of doctors attending is therefore closer to 180 rather than 250. Of these

180 doctors only around 40 were attending the second year intermediate course and slightly less were on the third year intermediate course leading to the Faculty's membership examinations and MFHom status.

1.3.3 The AdHom Membership course

The AdHom course in Glasgow leading to membership of the Faculty of Homoeopathy is a three or four year course of study following a modular design. The course is run on a part time basis with most of the work being undertaken outside of the Academic Department as guided home study.

Year one culminates in the Primary Health Care Certificate in Basic Homoeopathy examination. Topics learned in the first year include;

- The scope and limits of homoeopathy
- The similimum
- Individualisation of the patient
- Potentisation of the remedy
- Selection and repetition of potencies
- Four different prescribing strategies - pathological
 - keynote
 - totality
 - essence

In the first year there are five 1 day seminars held, with lectures, video and live case presentations, role play, basic repertorising and clinical prescribing. The majority of the learning is accomplished through guided self study and home reading. Continuous assessment is through self marked multiple choice questions.

Doctors who pass the examination at the end of the year are awarded the status of Licensed Associates of the Faculty of Homoeopathy and may progress on to intermediate training in years two and three. The course in years two and three teaches the taking of chronic cases and the analysis of complex cases. Repertorisation of cases is also taught as is analysing reactions after a prescription and then making a second prescription in a chronic case.

Years 2 and 3 each include five 1 day seminars where students can present their own cases either on paper or on video. Home study is more intense in the

intermediate course and there are essays and repertory questions to complete for marking. By the end of year three students are expected to have gained an in depth knowledge of the 177 different homoeopathic remedies on the Faculty's 'A list' and know the key features of the 77 remedies on the Faculty's 'B list'.

After intermediate training the student must submit ten detailed case studies to the examiners. If these are judged to be satisfactory then the student may sit the 6 hours of written papers for Membership. If these are passed then the student is invited to one of three national examination centres for a clinical examination with four examiners, one of whom is the Dean of the Faculty of Homoeopathy. The clinical examination consists of a one hour 'long case' with a patient followed by 30 minutes of questioning from the examiners. This is followed by a number of 30 minute 'short cases' which are taken with the examiners present. Finally a viva voce examination with all four examiners is conducted. If the candidate successfully passes all of the components of the clinical examination they are awarded Membership of the Faculty of Homoeopathy (see Figure 1.2)

Reilly and Taylor (1993) carried out a two year follow up study of students on the Glasgow MFHom course and found that two years after completing the course 78% of the doctors who had attended were still using homoeopathy, integrated into their other health care practices. Comments from doctors who had completed the course were collected by Reilly and Taylor (1993) and these included;

- I listen more
- I re-learned history taking
- I'm more aware of natural healing
- I'm more broad minded
- I now see patients as a whole and not at a cellular biochemical level.

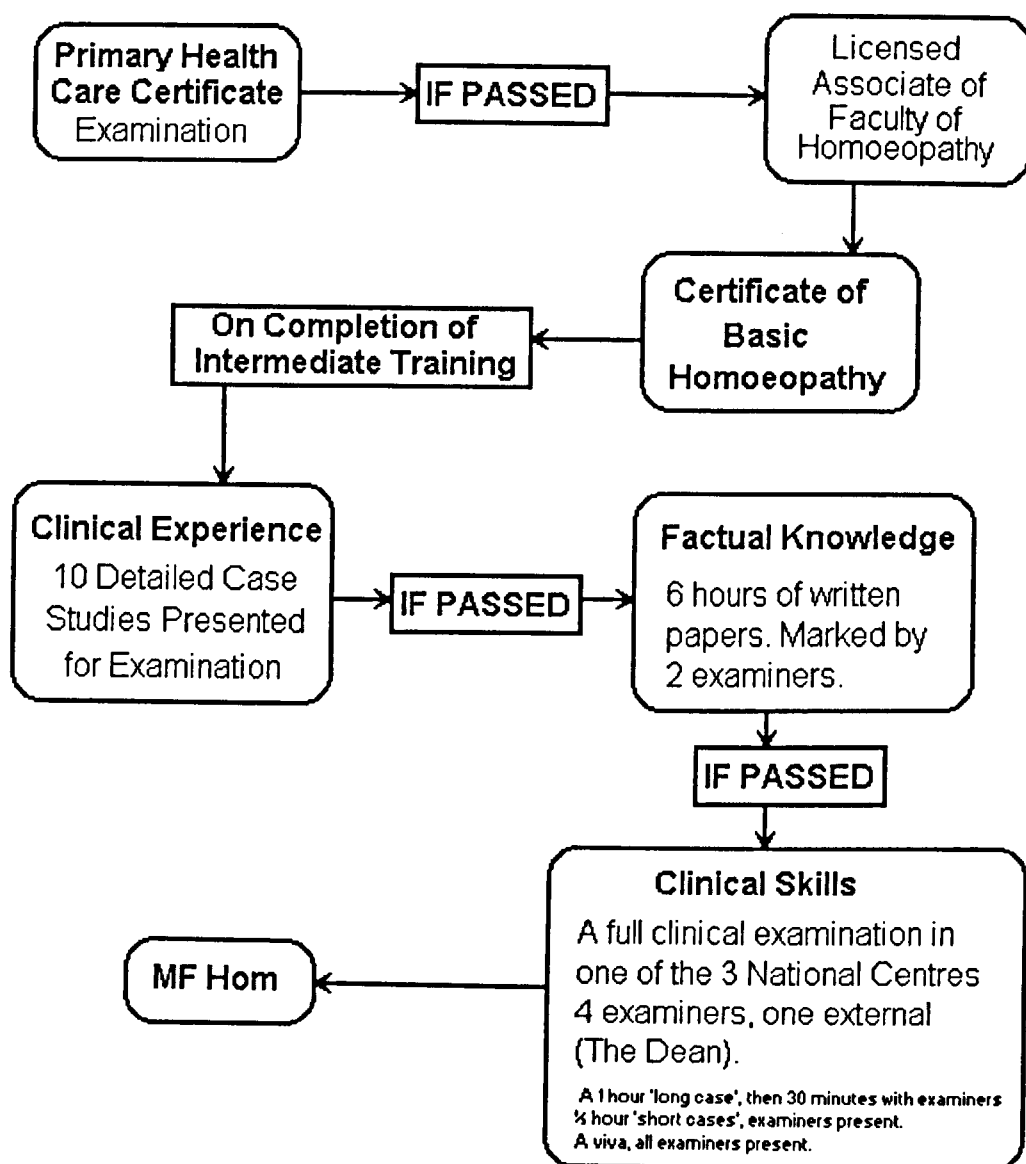


Figure 1.2 The Route to Membership of the Faculty of Homoeopathy

1.4 The present status of professional homoeopathy in the UK

1.4.1 Professional organisations

There are presently a number of organisations registering professional homoeopaths. Some of these organisations also play a role in setting educational and practice standards, and codes of practice and ethics. The largest organisation

in the UK that fulfils all of these roles is the Society of Homoeopaths (SoH). There are other organisations whose main role is registration. These organisations are the United Kingdom Homoeopathic Medicine Association (UKHMA), the General Council and Register of Consultant Herbalists, Homoeopaths Register (GCRH), and the Association of Natural Medicines (ANM).

Representatives of all of these groups have been working with the National Association of Homoeopathic Groups (NAHG), a collection of autonomous local groups of patients with a nationally elected committee, towards producing a single register of UK professional homoeopaths (Society of Homoeopaths 1997).

All four organisations produce their own registers of homoeopaths. Registration is the only role of the UKHMA, aside from providing insurance cover for the practitioners that they register. The UKHMA is not involved in educational policy and as yet has not attempted to influence the curricula of any homoeopathic college to allow its graduates to join the UKHMA register. There were 320 homoeopaths on the UKHMA register in September 1997 (Society of Homoeopaths 1997) although as the UKHMA also allows medically qualified homoeopaths to join the register it is not possible to know for certain how many of these are professional homoeopaths.

The ANM is a training body that runs a four year, part time course in partnership with Anglia University. The ANM registers its own students and will also admit other homoeopaths following a written examination and case study. The ANM also produces a code of ethics for practitioners on its register. In September 1997 there were 150 homoeopaths on the ANM register (Society of Homoeopaths 1997).

The GCRH is one school running a four year home study course which they are currently developing as a degree equivalent course. There were 200 homoeopaths on the GCRH register in September 1997 (Society of Homoeopaths 1997).

The SoH had 500 registered members in September 1997 and 613 licensed members en route to full registration (Society of Homoeopaths 1997). The SoH has an educational policy with fifteen recognised college courses whose students may take advantage of a college route to registration. This is a route in which the colleges internal assessment scheme is deemed sufficient to allow access onto the

register after one year of clinical supervision, submission of ten case studies and a site visit to the homeopath's practice premises. The SoH also has a code of practice and a continuing professional development policy.

As the largest of the registering bodies the SoH will be the subject of most discussion here.

1.4.2 A typical course

An SoH recognised course runs over 3 years full time or 4 years part time. A typical four year, part time course is as follows.

There are eleven 2 day seminars per year in the first three years and six 2 day seminars in the fourth year.

In the first year the seminars include lectures and case presentations on video. Students are expected to spend 8 - 10 hours per week on home study. This pattern is repeated in the second and third years with clinical observation of qualified homoeopaths taking place on seminar weekends and outside the college. Throughout the entire course the student must attend a minimum of 100 hours of clinical observation.

In the second year the students are granted 'first level supervision'. This allows the student to arrange consultations to take the cases of people outside of the college. The case is sent to the supervisor for agreement prior to any prescription being made. Only if the supervisor agrees with the analysis of the case and the remedy chosen can the prescription be given to the patient. After a minimum of ten 'well managed' cases the student may progress to 'second level supervision'. At this stage of supervision the student may prescribe a remedy for the patient before they contact their supervisor.

In the fourth year a 5-7,000 word research project must be completed along with a minimum of ten, second level supervised cases. These cases are then passed to an independent assessor who will examine them on behalf of the SoH. Written and viva voce examinations are set at the end of each of the first three years of the course.

1.5 A comparison of medically qualified homoeopathy and professional homoeopathy courses.

It is possible to detect many similarities that exist between the educational systems of the medically qualified homoeopaths and the professional homoeopaths. The duration of the courses that lead to full registration with either the Faculty of Homoeopathy or the Society of Homoeopaths is usually 4 years of part time study, although the Faculty of Homoeopathy allows those studying for 3 years part time to become registered providing they satisfy all of the entry requirements.

The courses are run in similar styles with weekend seminars being the preferred method. The professional homoeopaths will, however, attend on around 20-25 days per year whereas the medically qualified homoeopaths usually attend for 5 days per year on the AdHom course held in Glasgow. One reason for the extended attendance for professional homoeopaths may be the inclusion of anatomy and physiology as well as 'medical sciences' in these courses, this being necessary as many of the students will not possess such knowledge. The students on the medically qualified homoeopathy course should possess this knowledge and there is therefore no necessity to include it in the course curriculum.

In order to supplement the learning that takes place during the weekend seminars, students are expected to complete some home study. This is expected of both the medically qualified homoeopaths and the professional homoeopaths. Courses in professional homoeopathy usually advocate that around eight to ten hours per week should be allocated to home study.

The teaching methods used on these seminar weekends appear to be very similar, with both professional and medically qualified homoeopaths using live and video cases and the presentation of paper cases by the students.

Professional homoeopathy courses differ slightly from medically qualified homoeopathy courses in their use of observation of qualified homoeopaths at work, with most courses insisting on attendance at a minimum of 100 hours of such observation. It is possible that as this technique is used to teach professional homoeopaths the skills of taking a medical history, the medically qualified

homoeopaths may feel that this is not necessary as all students would be qualified medical practitioners with abundant case taking practice.

Assessments are based on a mixture of written examinations and the presentation of a minimum of ten supervised cases for both the professional and medically qualified homoeopaths. However differences in assessment are also apparent with the medically qualified homoeopaths undertaking a clinical examination with viva voce, while the professional homoeopaths must complete a research project and submit to a site visit to their practice premises. The site visit would seem to be undertaken to ensure that practices are run professionally and the research project has been introduced in order to encourage further research into homoeopathy by professional homoeopaths.

The structures of the courses do bear comparison well, the content of the courses differs by necessity as medically qualified homoeopaths should already possess some of the skills and knowledge that the professional homoeopaths must learn in order to be proficient homoeopathic practitioners.

One other difference seems to exist also, this is the teaching of four different prescribing strategies on the course for medically qualified homoeopaths, pathological, keynote, totality and essence. Only one of these would be recognised by a college for professional homoeopaths that was teaching 'classical' homoeopathy, that would be totality prescribing. Essence prescribing is also sometimes used by, and taught to, professional homoeopaths. Pathological prescribing is not usually taught and its use would usually be severely criticised in professional homoeopathy colleges as a peculiarly 'allopathic' method of prescribing.

1.6 Who practices homoeopathy and why ?

There have been few studies of heterodox practitioners that have determined who practices heterodox medicine and why. Sharma's (1992) is perhaps the most notable study of such practitioners in the UK, however even she does not study specifically any one form of heterodox therapy, preferring to investigate 'complementary practitioners' as a group.

Studies of practitioners of specific therapies have been undertaken, for example White and Skipper (1971) studied chiropractors and Baer (1981 and 1984) looked at osteopaths and their drive for professionalisation. Specific studies of homoeopaths have been undertaken, Moore and Stephenson (1962) compared the motivations of homoeopaths in the USA and the UK, however this study is now rather dated, much has changed in the intervening three and a half decades and the study only included the views of medically qualified homoeopaths. However, as a snapshot of heterodox physicians in the early 1960s it is of some merit. Cant and Sharma (1996) studied professional homoeopaths in the UK but with a view to investigating the strategies of professionalisation that they were utilising rather than how or why they practised.

Possibly the best source of data available for providing information on who is practising homoeopathy in the UK in the late 1990s, and why, is Sharma's work on 'complementary practitioners' (Sharma 1992). Sharma interviewed 34 heterodox practitioners who were in full time or part time paid practice. The interviewees were working within one, or more, of the therapies that Sharma described as conforming to a 'medical system'. Homoeopaths were included in this group along with chiropractors, osteopaths, acupuncturists, reflexologists, herbalists and hypnotherapists. Of the 34 interviewees, four were homoeopaths. Orthodox general practitioners who also practised heterodox therapies were not included and so this is a study of 'lay' practitioners only.

Sharma (1992) showed that the mean age of those interviewed was 42 years and that most had been in practice for less than 10 years, therefore many of these practitioners were probably aged in their mid to late thirties before they had started in heterodox health care. Many of these practitioners had been in other professional roles prior to their heterodox practice, ten of the 34 had previously been working within the National Health Service in a health care role and 6 had previously been working as teachers or counsellors.

The motivators which enable an individual to leave one career and start another are probably no different for potential heterodox therapists than for any other individual who decides upon a change of career, disaffection with the current

career is often implicated in a future career change. What is it that initiates an interest in a career in heterodox medicine ?

Sharma (1992) showed that for those working in the National Health Service there may have been a disaffection with orthodox medicine, they witness it at work everyday and become disillusioned when it does not always work, or causes unwanted side effects or other iatrogenic illnesses (Sharma 1992). An acupuncturist who had previously worked as a nurse expressed this well;

"I was concerned the way things were going, too technical and too many drugs, getting away from the natural" (Female Acupuncturist).

(Sharma 1992)

Sharma (1992) suggested however, that often a training in heterodox medicine was not seen as an escape route from National Health Service employment. The choice of training was often made from a genuine interest in the subject often with a view to utilising the heterodox therapy alongside their orthodox, and usually nursing, practice within the National Health Service.

Almost one in three of the practitioners interviewed by Sharma (1992) mentioned a personal illness experience as having influenced them, and this observation is confirmed by other studies of the motivators to study or practice heterodox medicine (White and Skipper 1971; Moore and Stephenson 1962). Some practitioners described their experiences of inappropriate orthodox treatment and stated that this had prompted them to formulate their own ideas about modern medicine's inability to possess all of the answers. Sharma likened this to a cult of affliction, individuals acquire the capacity to heal from having suffered and undergone treatment themselves. Turner (1968) used the idea of a cult of affliction to describe the curative practices of certain African cultures and Sharma suggested that this idea could certainly be applied to spiritualist healers in the UK who find that receiving such healing is a normal prelude to discovering their own healing abilities. Sharma (1992) further suggested that these illness experiences did not constitute a deciding factor but rather a relevant experience. The positive experience of heterodox therapy seemed, she suggested, to make the individual more open to the idea of studying it later in their lives than they might otherwise have been.

Sharma (1992) found that there were two strong motivational influences which were often reported by the practitioners she interviewed. The first of these was the desire to work with people, to heal and to help. This, as Sharma states, is quite unsurprising. Allied to this motivator was an interest in people, in psychology and human interaction.

The second major motivating influence was the desire to work independently, or at least to be free from the bureaucratic restraints such as those found while working within the National Health Service. Sharma (1992) suggested that although this did not necessarily mean that heterodox practitioners were unwilling to co-operate and work with other therapists, it did suggest a dislike of hierarchy and organisational formality. Sharma called this 'a kind of occupational individualism', founded on the practitioners dislike of organisational constraints. Indeed several of the practitioners interviewed by Sharma attributed the negative characteristics of orthodox medicine to such organisational constraints rather than the basic tenets upon which the practice was based. This view was most strongly expressed in the way that many heterodox practitioners deplored the pressures on general practitioner's time due to excessive patient loads that led to an inadequate time to allow the doctor to have a 'healing' encounter (Sharma 1992).

2 HISTORY OF HOMOEOPATHY

2.1 First steps

In 1810 a book was published in the small German town of Torgaou. The book was entitled 'Organon of the Art of Healing' and its author Samuel Christian Freidrich Hahnemann was a prominent physician and medical author and, as such, the appearance of another book written by him was greeted with much interest. When the book had been read, the medical communities of Germany, and then much of Europe, were thrown into a state of confusion, anger and uproar by its claims. This sensation was caused by the introduction, through the book, of a completely novel, and radically different, system of medicine that was entirely opposed to the traditional medicine of its time.

Hahnemann had introduced the world to his new system of medicine, homoeopathy, a system that he had been working on for twenty years. In these years he had initially carried out experiments upon himself and then also on his family. Finally he had been joined by a small band of converts seeking a new form of medicine and they too had tested the new system on themselves and each other.

More than two hundred years after his initial experiments on himself, which led to his formulation of the system of homoeopathy, this system is still practised by homoeopaths around the world - during this time homoeopathy has climbed to lofty peaks of acceptance and sunk into deep troughs of indifference. Interest in all complementary forms of medicine is currently high, both amongst doctors (Reilly 1983, Ernst *et al* 1995), and members of the general public (Sharma 1992), and consequently homoeopathy is at a peak of acceptance.

The publication of 'The Organon' almost two hundred years ago had a huge impact on the practice of medicine and the ripples of that shock wave are still being felt in the medical world today. Homoeopathy still has the power to shock and disturb today, just as it did at the beginning of the nineteenth century.

2.2 Samuel Hahnemann

Dr. Samuel Christian Hahnemann was born in 1755 at Meissen in Germany, the son of a china painter. He was an accomplished linguist from an early age and,

when he wished to go to University, he paid for his studies of chemistry and medicine by translating English text books into German.

Hahnemann qualified as a physician from the University of Leipzig in 1779 and was soon publishing works on both chemistry and medicine. In 1791 his work in chemistry resulted in his election to the Academy of Science in Mayence. He published *The Apothecary's Lexicon* around this time and this became a standard textbook for the apothecaries of the day. At this time Hahnemann was also given the task of standardising the German Pharmacopoeia.

Against this background, however, it appears that Hahnemann was not an entirely happy man. He had quickly become disillusioned with the 'heroic' medical practices of the late eighteenth century such as bleeding, purging and vomiting, using powerful concoctions made to secret recipes containing dozens of ingredients. In 1796 the apothecaries of Leipzig mounted an attack on Hahnemann following his denunciation of such polypharmacy - Hahnemann had criticised the use of Venetian Treacle, a popular 'cure all' with dozens of ingredients. This criticism was seen as a threat to the livelihoods of the apothecaries who were responsible for the production of Venetian Treacle and many other complex medicines.

Hahnemann married and started a family and then gave up his, quite lucrative, medical practices and made a living translating medical textbooks. It was whilst translating one such book that Hahnemann's questioning mind was unleashed on the formulation of his new system of medicine. In 1790 Hahnemann was translating 'Lectures on the Materia Medica' by the renowned Scottish physician William Cullen (1710 - 1790) who was then a professor at the University of London. Cullen had devoted no less than twenty pages to the study of 'Peruvian Bark', the bark of the Cinchona tree. A decoction of this bark that was usually referred to as 'china' was described by Cullen as being useful in 'intermittent fever', a condition now referred to as malaria. The bark of the Cinchona tree is a source of quinine. What attracted Hahnemann's interest was Cullen's explanation for the efficacy of china in treating intermittent fever. Cullen had ascribed its usefulness to the extremely bitter and astringent qualities of the remedy that helped to restore 'tone' to the stomach. Hahnemann argued that if this was the case then other, equally astringent and bitter substances should be equally effective in the treatment of

intermittent fever. From his medical studies Hahnemann knew that this was not the case.

2.3 Initial experiments with homoeopathy

Hahnemann was so dissatisfied with Cullen's explanation that he performed an experiment upon himself; he took a series of doses of Peruvian Bark and recorded his experiences. It is not known what prompted Hahnemann to this act of self experimentation, but in the light of the importance of this act to the development of homoeopathy it is worth quoting Hahnemann's full account of this experiment as published in 'The Lesser Writings of Samuel Hahnemann'.

"I took by way of an experiment, twice a day, four drachms of good China. My feet, finger ends, etc., at first became cold; I grew languid and drowsy; then my heart began to palpitate, and my pulse grew hard and small; intolerable anxiety, trembling, prostration throughout all my limbs; then pulsation in my head, redness of my cheeks, thirst, and, in short, all these symptoms, which are ordinarily characteristic of intermittent fever, made their appearance, one after the other, yet without the peculiar chilly, shivering rigor.

Briefly, even those symptoms which are of regular occurrence and especially characteristic - as the stupidity of mind, the kind of rigidity in all the limbs, but, above all the numb, disagreeable sensation, which seems to have its seat in the periosteum, over every bone in the body - all these make their appearance. This paroxysm lasted two or three hours each time, and recurred if I repeated this dose, not otherwise; I discontinued it and was in good health."

(Hahnemann 1987)

It is difficult to imagine the effect that this result must have had on Hahnemann. It was certainly sufficient to bring about a dramatic shift in his ideas regarding the treatment of disease. The accepted orthodoxy stated that if the body produced a symptom, then a treatment must be given to oppose, and therefore relieve, that symptom. This idea was so deeply ingrained in medical practice that it had almost become an automatic reflex in the minds of both the doctor and the patient alike. In his experiment however, Hahnemann had found empirically, with first hand experience, that a substance efficacious in intermittent fever was capable, not only

of removing the symptoms of those stricken with the fever, but also of producing the symptoms in those who were healthy and not stricken with the fever.

Hahnemann dismissed ideas that this was an exception to the rule. The observation itself was important to Hahnemann, and he set about making further experiments with other substances. These experiments led Hahnemann to formulate his own law of cure.

A substance which produces symptoms in a healthy person will cure those symptoms in a sick person.

2.4 Initial publication of the theory of homoeopathy

Following this discovery Hahnemann attracted interest from a small number of like minded physicians who also carried out such experiments. Hahnemann and his colleagues continued in this experimentation for six years, scrupulously recording the symptoms produced by each drug taken. This process was called 'prufrung', a German verb meaning to test. This term has been corrupted in the anglicised jargon to 'proving'.

In addition to the self experimentation, Hahnemann, who was fluent in Latin, Greek, Arabic, French and English in addition to his native German tongue, compiled a list of accidental poisonings recorded by doctors in many countries through centuries of medical history. The symptoms of these poisonings and of the experiments upon himself and his colleagues were then all gathered together in detailed volumes.

Hahnemann and his colleagues recognised in these collected symptom pictures the symptomatologies of many diseases for which they had previously sought cures. These 'homoeopathic' substances were then tried on patients with similar symptoms - often achieving, it was claimed, remarkable cures.

From these experiences, Hahnemann articulated, in 1796, his own formulation of an ancient theory of cure, the Law of Similars, '*Similia similibus curentur*', 'Let Likes be Cured by Likes'. Although Hahnemann had formulated his own version of this fundamental law he did not profess to have discovered it, but acknowledged its

ancient origins in the writings of Hippocrates, in the works of Boulduc on the use of rhubarb to cure diarrhoea and Bethardings' use of senna to treat colic. Hahnemann quoted a contemporary of his, Stahl, who stated that;

"The rule accepted in medicine to cure by contraries is entirely wrong; on the contrary diseases vanish and are cured by means of medicines capable of producing a similar affection."

(Hahnemann 1988)

It is possible to find even more ancient references to the use of similars than Hippocrates. In the Mekhilta, a rabbinic commentary on the chapter Exodus in the ancient Hebrew Bible, written in the second century by Rabbi Ishmael ben Elisha, we read that God heals with similars;

"Come and see, the healing of the Holy One, blessed be He, is not like the healing of Man. Man does not heal with the same thing that he wounds, but he wounds with a knife and heals with a plaster. The Holy One, blessed be He, however is not so, but He heals with the very same thing with which he smites."

(Rabbi Ishmael, second century)

Although the principle was by no means novel, Hahnemann alone reasoned that it should be possible to identify the curative properties of a substance by 'proving' them using healthy individuals. This was Hahnemann's unique contribution to 18th and 19th century medicine.

It is noteworthy that in the same year, 1796, the English physician Edward Jenner was also experimenting with a new principle that utilised the concept of similars. Jenner had theorised some years earlier that cow pox could act as a defence against the similar, but far more serious, disease smallpox. In May, 1796 Jenner finally put his theory to the test when he inoculated an eight year old boy, James Phipps, with cowpox. The boy did not contract smallpox even after he was administered a dose of the smallpox virus by Jenner.

Jenner was unsuccessful in his first attempt to publish his findings in 1797 and his *Inquiry into the cause and effect of the Varicolae Vaccine* was eventually published

privately in 1798, two years after Hahnemann had first published his own interpretation of the Law of Similars.

Although Jenner's cowpox vaccination was a preventative measure and Hahnemann's homoeopathy was a curative medicine, Hahnemann hailed Jenner's work in a footnote to paragraph 46 of the sixth edition of his *Organon of Medicine*, written in 1841-2, stating that the homoeopathic law of similars was responsible for

"... the remarkable, salutary result of the widespread use of Jenner's cow-pox vaccination. The smallpox has not since then appeared among us with such widespread virulence."

(Hahnemann 1983)

Although both were working simultaneously on theories that utilise similar, 'artificial', diseases to attenuate the effects of naturally occurring disease, it is unlikely that either was aware of the others work as no publication was made until Hahnemann's paper in 1796, just after Jenner's inoculation of master Phipps.

Although Hahnemann first articulated his formulation of the Law of Similars and his method of 'proving' medicines in 1796, it was a further five years before he once again entered medical practice - but this time as a homoeopath. It was then a further nine years before he published his '*Organon of Medicine*' in 1810, although in 1805 he had published '*Medicine of Experience*' in which many of the ideas later published in *The Organon* were first suggested.

2.5 Hahnemann as a homoeopath

From 1801 to 1835 Hahnemann practised as a homoeopath in Germany. In 1830 his wife died and in October 1834 he met Melanie d'Hervilly-Gohier, a well born and, by all accounts, beautiful thirty-four year old woman who had travelled from France to Coethen in Germany to see him for treatment. Within three months they were married and on 7th June 1835 Samuel and Melanie Hahnemann left Coethen

for Paris. Hahnemann continued practising homoeopathy in Paris from 1835 until his death eight years later, at the age of 88¹.

In October 1839, only four years before his death, Hahnemann opened the Institut de la Medecine Homoeopathique at 93, Rue de la Harpe, in the centre of old Paris with a Dr. Croserio as the director. By July 1840 a further college had been opened in Rue Git-le-Coeur on the south bank of the Seine.

Hahnemann attracted many influential and wealthy patients to his house in the Rue de Milan, where in 1843 he was to meet his death. These included a group of Englishmen who eventually were to establish homoeopathy in Britain. The Rev. Thomas Everest and Mr. William Leaf, a wealthy silk merchant, had both been patients of Hahnemann's, and Drs. Paul Curie and F.F.H. Quin had gone to Paris to study under him.

2.6 The beginning of British homoeopathy

The first mention of homoeopathy in the British medical journals occurred in *The Lancet* of 1826-7, in a report of a meeting of the London Medical Society. On the evening of 24th September 1826 the President of the Society, Dr Clutterbuck, informed the audience of an,

... account of a new medical doctrine which had sprung up in the German Universities, and which appeared to be extensively diffused throughout Germany and some of the neighbouring countries. It originated with a Dr HALNEMANN (sic) and was called HOMOŒPATHIA (sic).

(The Lancet 1826)

¹ Hahnemann's death in 1843 was not the final chapter in his story. He was buried on 11th July in that year in the Cimetiere du Montmartre in grave number 8. When Melanie died 35 years later in 1878, she was buried in grave number 9. Twenty years later however, on the insistence of a number of wealthy American homoeopaths, both graves were opened so that the bodies could be re-interred in the more prestigious Cimetiere Pere Lachaise, where their grand tomb can still be seen today. Haehl (1922) gives a graphic account of the disinterment of the bodies and their carriage across Paris before their final re-interment in the grave at the Cimetiere Pere Lachaise.

Dr Clutterbuck had little to add regarding the new doctrine other than that,
there was much ingenuity, and probably some truth [in it].

(The Lancet 1826)

Four years later the first serious discussion of homoeopathy appeared in print in Britain. Writing in *The Edinburgh Review* of January 1830, Sir Daniel Sandford, Professor of Greek at the University of Glasgow, and a medical layperson therefore, called for the doctrine of homoeopathy to,

Be made known to the British public, and submitted to the keen and sagacious criticism of our own medical school.

(The Edinburgh Review 1830)

The four individuals already identified as the original importers of homoeopathy into Britain could be neatly divided into two camps. In one camp Dr. F.F.H. Quin (1799-1878) and Dr. Paul Curie (1799-1853), the grandfather of the physicist Pierre Curie, were both qualified physicians prior to visiting Hahnemann in Paris. Their visit to see Hahnemann in Paris was made in order to study homoeopathy with a view to including its methods into their medical practices.

In the other camp, Mr. William Leaf (1790-1853) and the Rev. Thomas Rapoul Everest (1801-55) were not medically qualified and both contacted Hahnemann initially in order to avail themselves of homoeopathic treatment. They both became interested in the practice of homoeopathy and along with Drs. Quin and Curie became part of the 'inner sanctum' of Hahnemann's protégés. All became close confidantes of Hahnemann during the last 15 years of his life (Haehl 1922).

All four protégés established practices in the UK in the 1830s and, later, free dispensaries for the poor. Quin distanced himself from what he saw as the over zealous excesses of Curie and the two lay practitioners, all of whom were equally enthusiastic in their teaching of homoeopathy to lay persons. Quin instead concentrated his efforts on converting his medically qualified colleagues to the practice of homoeopathy (Nicholls 1988). By 1848 it was reported that there were

73 homoeopathic practitioners in England and Scotland, of whom 51 were doctors and 22 were lay practitioners (Rosenstein 1849).

2.7 The rise and decline of British homoeopathy

In the 1860s the London School of Homoeopathy was established as the first teaching centre in Britain. By the late 1870s it had merged with the London Homoeopathic Hospital, after Quin's death in 1878. The school was managed by Dr. William Bayes, among others. Around this time two other teaching centres were opened in Liverpool along with dispensaries for the poor. Later the two doctors responsible for these schools, Drs Drysdale and Berridge, were to establish the Liverpool Homoeopathic Hospital.

By the late 1860s and early 1870s there were 62 homoeopathic dispensaries in operation in Britain. This was to prove to be the high point for British homoeopathy - by the 1890s these dispensaries had declined to 40 in number and by 1909 there were just 31. British homoeopathy appeared to be rapidly heading for extinction (Morrell 1995).

Much of the initial expansion of British homoeopathy was only possible through the offices of wealthy patrons. Quin was the son of the Duchess of Devonshire (c1765 - 1824), and his homoeopathic practice in London attracted other members of the nobility. Royalty, too, patronised the new form of medicine, becoming generous financiers of the homoeopathic hospitals and dispensaries (Inglis 1964).

The use of homoeopathy spread rapidly through the rich and powerful of Britain, fuelled by the patronage of HRH the Duchess of Teck, and the Lord Mayor of London, Sir George Wyatt Truscott, and dozens of other such patrons around the turn of the century. It is little wonder then that homoeopathy came to be known as the 'rich man's therapy' (Morrell 1995).

Considerable resistance to homoeopathy's message was also apparent. In 1833 the Royal College of Physicians wrote to Quin stating that as he did not possess the credentials necessary to practice physic in the City of London he should cease from doing so until he had been duly examined and licensed. Quin ignored the letter and received a second some four weeks later. He acknowledged receipt of

the second letter and left it at that. The College decided not to proceed with the matter, well aware of his powerful connections with royalty (Nicholls 1988).

Most doctors were not unduly impressed by the homoeopathic information booklets and pamphlets published, from the mid 1830s in Britain, by homoeopathic doctors. Many of these were aimed at the public in an attempt to convert them to using homoeopathy, and many doctors thought this smacked of advertising, as well as revealing disunity in the medical profession. When lay enthusiasts such as Rev. Everest also started publishing such material the regular doctors felt that this added insult to injury (Nicholls 1988).

The orthodox medical press responded with hostile reviews, those published in *The Lancet* were often quite derisive. A review of a homoeopathic text from 1836 sets the tone nicely. For those who practise homoeopathy, or consent to be treated by the system,

‘... there is nothing left for it, but to laugh the parties out of their self-conceits or if the matter be of graver tendency, to charitably shut them up in a madhouse’.

(Anonymous 1836)

In 1844 *The Lancet* published its first, and last, case history of successful homoeopathy when it printed a case study of the treatment of haematemesis by John Epps (Epps 1844). There was an immediate rebuttal of the success of homoeopathy in this case, it was argued that the recovery had been due to previous allopathic treatment (Mackin 1844).

Homoeopathy’s threat to the incomes of many orthodox doctors led to hostilities. Even the British Royal family were not above ridicule as was shown when *The Lancet* discussed the ‘Queen’s confidence in this absurd system’ in tones of despair (Nicholls 1988).

It was becoming obvious to the regular medical profession that patients were likely to prefer the gentle, mild treatments of the homoeopaths, to the violent reactions sought through their own ‘heroic’ practises. One consequence was that many doctors modified their own practice methods by reducing drug dosages and even utilising some of the homoeopathic remedies, albeit in an allopathic fashion, to

produce a gentler form of practice that would not frighten off their patients. Many of the homoeopathic doctors were also using a mixture of homoeopathy and the latest techniques of regular medicine to achieve their results whilst distancing themselves from Hahnemann's idea of a 'spiritual power' that resided in the medicines. In this way the threat of homoeopathy was diminished as it became increasingly difficult to distinguish homoeopaths from the regular doctors. It was only in the hands of the lay homoeopathic practitioners that Hahnemann's ideas and doctrines were still flourishing.

2.8 The orthodoxy's attack on homoeopathy

This 'bastardising' of medical homoeopathy did not prevent the medical profession from continuing to attack homoeopathic doctors as 'Hahnemannian fundamentalists'. The attacks helped to justify the professional ostracism that followed in an attempt to prevent any further homoeopathic defections by their patients. The regular doctor's campaign had started in 1851. At its nineteenth annual meeting on 13th and 14th August 1851, the Provincial Medical and Surgical Association (which became the British Medical Association five years later in 1856) decided to act against the irregular practitioners. A series of resolutions were all adopted on the 14th August, amongst these were the following,

- that homoeopathy was absurd and no reputable medical practitioner should have anything to do with it.
- that homoeopaths were guilty of heaping abuse on the regular profession.
- that no member of the Provincial Medical and Surgical Association (PMSA) should have professional contact with homoeopaths.
- that membership of the PMSA would be withdrawn from any homoeopaths or those who consulted with them.

The following year rules were drawn up stating that any applicant for membership of the PMSA must provide a written statement that they were not practising homoeopathy and that they were not intending to in the future. In 1858 these measures were incorporated by the British Medical Association, which had been formed from the PMSA two years earlier.

Throughout the 1860s, 1870s and 1880s numerous steps were taken to discredit homoeopathy and its practitioners. Punishments for consultation with a homoeopath were savagely administered by the BMA and local medical societies (Nicholls 1988) and on a number of occasions, at least one of which was successful, doctors attempted to get homoeopaths tried for manslaughter following the deaths of their patients. Numerous articles discrediting the theoretical basis of homoeopathy were written in the medical journals. The popular press echoed these themes publicising the failures of homoeopathic treatment and attacking the moral and ethical character of homoeopaths.

The increasingly beleaguered homoeopaths regrouped around London, which became a regular meeting place for several homoeopathic doctors, between 1880 and 1900, where they could share experiences and compare case notes. This group came to be known as the 'Cooper Club' after one of its founder members, Dr. Robert Cooper. The core group consisted of Cooper and Drs. Skinner and Compton-Burnett, later being joined by Dr. John Henry Clarke, a younger homoeopath.

2.9 Twentieth century British homoeopathy

By the start of the twentieth century, with many of the original British homoeopaths getting older, and few new recruits to the fold, homoeopathy gradually became in danger of extinction. In the years between 1890 and 1906 seven of the most important figures in medical homoeopathy died, including all three original core members of the Cooper Club. The movement for medical homoeopathy had started to fall into a decline that it would take more than seventy years to recover from (Morrell 1995).

In 1913 Dr. McClelland regretted the 'halting progress of homoeopathy' (Burford 1913) and in 1926 the President of the British Homoeopathic Society remarked that their roll had not increased (Weir 1926). Four years later the then President spoke of a serious crisis that had to be faced, namely the decline of homoeopaths in the provinces (Hall-Smith 1931). For the first half of the twentieth century the numbers of homoeopaths registered with the British Homoeopathic Society hovered around the 200 mark (Nicholls 1988).

This decline in medical homoeopathy predated a decline in lay homoeopathic practice by around forty years. Lay homoeopathic practice was encouraged, at the expense of medical homoeopathy, following the defection of Clarke from his medical colleagues to the teaching of lay homoeopaths. Clarke had become disgusted at the hostile reaction that homoeopathy was receiving from the orthodox medical establishment. Embittered by the decline of homoeopathy in the medical world, he started publishing works aimed at the lay practitioner. In 1900 he resigned from the British Homoeopathic Society in disgust and never returned despite many attempts from its members to draw him back (British Homoeopathic Journal 1932).

Some of the lay persons originally taught by Clarke were to become important practitioners and teachers in their own right. The Rev. Upcher, Noel Puddephatt and J. Ellis Barker were three notable lay students of Clarke's.

J. Ellis Barker was a close confidant of Clarke's who was born in Cologne, the son of a doctor, and emigrated to Britain in 1920. When Clarke died in 1932 Barker took over Clarke's editorship of *The Homoeopathic World* and renamed it *Heal Thyself*. Barker then used the pages of this journal to launch a series of vitriolic attacks on orthodox medicine and on the British Homoeopathic Society for its apathy, blaming both of them for the lack of expansion of homoeopathy in Britain. *Heal Thyself* reached a peak of popularity in 1937. Barker incited homoeopaths to take homoeopathy to the masses and was, arguably, responsible for the first, brief lived, mass movement for alternative medicine in Britain.

Barker died in 1948 after which both the journal, and lay homoeopathy, collapsed into a decline in the UK. The journal changed hands several times and finally folded in 1967. Lay homoeopathy slumped in popularity and became what Peter Morrell has called,

“a quiet and quaint backwater of UK medical practice”

(Morrell 1995).

Orthodox medicine had successfully marginalised homoeopathic practice and homoeopathy rapidly became thought of as the domain of 'cranks'. Noel Puddephatt emerges throughout the 1950s and 1960s and could be seen trying to kick start back to life the mass movement that Barker had started in the 1930s. These efforts were to no great avail, though Puddephatt can be regarded as a

teacher of great importance to those few dedicatees of homoeopathy who had little effect, however, on popular awareness of homoeopathy. In 1963 Puddephatt emigrated to South Africa and died there in 1978. The 1950s were still, to all intents and purposes, a 'quiet and quaint backwater'.

A change occurred in the mid 1960s when two major teaching forces emerged on the scene in London. Although both had been practising and teaching, on an informal basis, for some years, it was the decade between 1965 and 1975 that saw John Da Monte and Thomas Maughan become important influences on the London homoeopathy scene. Both men taught a growing band of lay students until their deaths in the space of one year (1975-6). Their students came together in 1977 to form The Society of Homoeopaths. They opened a register, started a journal and, in 1978, inaugurated The London College of Homoeopathy, the first of around 14 learning centres to be opened over the next fifteen years for the education of lay homoeopaths.

Medical homoeopathy also saw a resurgence in the late 1970s and it was during this decade that the numbers of medically qualified homoeopaths started to grow, the roll of the Faculty of Homoeopathy for 1975-6 shows 306 members, this had grown to 540 by 1981-2 and 633 by 1982-3 (British Homoeopathic Journal 1982 & 1983). This growth in homoeopathy has continued to the present day. The growth in the number of colleges offering homoeopathy courses to lay persons has led to such an increase in the numbers of lay practitioners that they now easily outnumber the medical homoeopaths (Morrell 1995). The training programmes offered by the lay colleges are also widely recognised as being considerably superior to those offered to medical homoeopaths by the Faculty of Homoeopathy (Morrell 1995).

Successive governments in Britain have adopted a laissez-faire attitude towards the practice of lay homoeopathy and there has been a distinct lack of interest in legislation on lay homoeopathic practice, either to outlaw it or to introduce statutory regulation of its practitioners - this is generally true of most complementary medicine.

The history of homoeopathy in Britain has been one of a continuing willingness to pass down knowledge along various lines, which include those aimed at educating

lay persons as well as doctors, and this has led to a flourishing lay homoeopathic profession alongside a medical homoeopathic profession. This history differs from those of other countries where lay practice has been discouraged or banned altogether. An example of such a history, leading to the discouraging of lay practice, can be followed if the history of homoeopathy in the United States of America is studied.

2.10 Homoeopathy in America

During the early part of the nineteenth century American physicians were beginning to lose their political power and their privileged position as legally sanctioned healers. By the time that homoeopathy had entered America in 1825, public opinion demanded that anyone who wished to work as a healer should be allowed to do so (Coulter 1982).

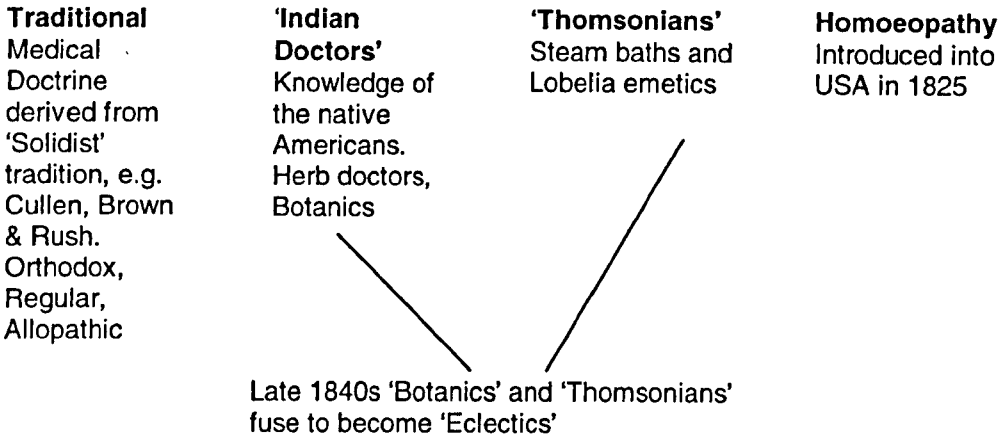
Medicine in America was a three or four way conflict between differing schools of thought for most of the nineteenth century. The 'traditional' medical doctrine - derived from the 'Solidist' tradition of Cullen and Brown, both Scotsmen, and Benjamin Rush, an American - was the therapeutic persuasion held by the licensed practitioners of the day. These practitioners were known as 'Regulars'.

The regulars were not alone in the field of medical practice. A second system of medical practice was that of the 'Indian Doctors'. These were practitioners who obtained their healing knowledge from the Native Americans. The majority of these 'herb doctors', as they were also called, had obtained no regular medical training and quite openly opposed the therapies of the regulars. In the early part of the century a few orthodox trained doctors espoused some of the techniques of the native Americans and these doctors were often referred to as 'Botanics'.

A third system of medicine was that derived from the work of Samuel Thomson (1796-1843) and his followers. This system was devised as a reaction against the perceived complexity of the regular medicine of the day. Thomson's method was a simple system of copious steam baths and the use of a native American emetic made from the root of the lobelia plant (*Lobelia inflata*). In the late 1840s, following the death of Thomson, the Botanics and the Thomsonians merged to form a group calling themselves 'Eclectics'.

The fourth system was homoeopathy, introduced into America in 1825 by Dr. Hans Gram, who moved to New York from Germany and opened the first homoeopathic practice in America.

These four opposing camps can be summarised thus:



Homoeopathy differed from the other two opponents of regular medical practice in two ways. Firstly it possessed a far more integrated doctrinal basis for its therapeutic practices. Secondly, and perhaps more importantly, homoeopathy recruited most of its practitioners from the ranks of the regular doctors, rather than from the lay population as was the case with the 'Indian Doctors' and the 'Thomsonians' (Coulter 1982).

2.11 The attack on American homoeopathy

In the first half of the century the Botanics, Thomsonians and Indian Doctors had represented the main opposition to the regulars. Around 1845 this role was taken over by the homoeopaths (Coulter 1982). The doctrinal differences between homoeopathy and the regular practice covered even the fundamental concepts of symptom interpretation, classification of diseases, the role of surgery and even the appropriate drugs for a given kind of disease.

This brief description of homoeopathy's beginnings in America demonstrates an initial difference between Britain and America. In Britain there were a large number of lay homoeopathic practitioners in addition to the medical homoeopaths. In America lay opposition to orthodox medicine came from the Indian Doctors and Thomsonians who were from among the ranks of the non medically qualified

practitioners. Homoeopathy in America recruited most of its adherents as converts from regular medicine rather than from the lay population. In 1845 the American Institute of Homoeopathy passed a resolution that only allowed homoeopaths who had originally qualified from a regular medical school to become members.

Because the homoeopaths were originally regular doctors who had deserted their original doctrine to join a new and radical therapeutic system they were seen as the major threat to orthodox practice from 1845 onwards (Coulter 1982). The regulars' opposition to the Indian Doctors and the Thomsonians had been relatively easy because these groups could be discredited as unlearned 'quacks' who had no medical training. This criticism could not be aimed at the homoeopaths quite as easily as many of them had graduated from the same prestigious medical schools as the regulars themselves. Starr (1982) argues that, due to its simultaneous experimental approach and philosophical attitude, homoeopathy was seen by the public as being more scientific than orthodox medicine.

As homoeopathy gained popular support in America, so the orthodox medical practitioners had to make a stand against it. Kaufman (1971) reports that one orthodox physician summed up the regular's reaction to homoeopathy at a meeting of the American Medical Association as follows,

"We never fought the homoeopath on matters of principle, we fought him because he came into the community and took the business."

Homoeopathy was opposed on financial grounds rather than on philosophical grounds or on grounds of principle. Homoeopathy's gentle approach was seen by the public as preferable to the heroic practices of bleeding, purging and applying leeches, which were carried out by the regular doctors. Homoeopaths were seen to be taking patients from the regular doctors and with the patients went the regular doctor's income. It soon became apparent to the regulars that in order to make a reasonable living as a doctor you had to attract the patients with homoeopathy. As more regulars took up homoeopathy to earn an income the practice of homoeopathy in America became almost entirely dominated by qualified medical practitioners from the regular schools of medicine.

2.12 The formation of the American Medical Association

Those regular physicians left remaining feared that homoeopathy might triumph over their practice and so launched a counter-attack on homoeopathy and homoeopaths (Coulter 1982). One strand in this strategy was the formation of a national professional organisation. In 1844 Dr. Nathan Davis was agitating for a national medical association and the American Medical Association was duly set up with a number of aims. Firstly the Association was to improve the education of orthodox doctors by setting high standards in medical education to enable the public to distinguish educated doctors from 'quacks' and thus ensure the public's return to using regular medicine. In reality the American Medical Association did little to improve medical education until well into the twentieth century.

The second aim of the Association was to educate the public in matters medical in order to help them to make 'correct' decisions when choosing health care. To this end a number of popular journals, pamphlets and periodicals were published.

The third aim of the American Medical Association was to re-educate the homoeopathic physicians to help them see the error of their ways and bring them back to orthodox practice. One method of bringing homoeopathic doctors back to the fold was the adoption, in May 1847, of the so called 'consultation clause' in the Code of Ethics of the American Medical Association. This clause prohibited members of the Association from consulting with 'those whose practice is based upon an exclusive dogma'. Homoeopaths were judged to base their practices upon just such an exclusive 'dogma'. This effectively prevented referrals from orthodox doctors to homoeopaths and vice versa. The clause was rigidly upheld leading to frankly ludicrous situations such as the case of Dr. Moses B. Pardee, a Norwalk physician who was expelled from the Fairfield County Medical Society for consulting with a homoeopath - Dr. Emily V.D. Pardee who was his wife (Kaufman 1971). This clause remained in the Code of Ethics from 1847 until 1900 and it prevented the affiliation of local medical societies to the American Medical Association unless they had first 'purged' themselves of any homoeopaths among their membership.

2.13 The 'Golden Age' of American homoeopathy

Despite these strictures it appeared that homoeopathy was still flourishing into a 'golden age'. In 1903 the rules of the American Medical Association were amended to allow homoeopaths to join the Association provided that they did not practice or proselytise homoeopathy. This offer of membership of the Association to homoeopaths was taken up by many of the remaining homoeopaths who were practising in America and homoeopathy finally was on the road to becoming a very quiet backwater in American Medicine.

The theory that homoeopathy experienced a 'golden age' in America between 1850 and 1900 has been proposed by many writers (see for example Coulter 1982 and Ullman 1991). Statistics published in the New England Medical Gazette in 1869 show that the number of homoeopaths in New York doubled every five years between 1829 and 1869. The Cincinnati cholera epidemic of 1849 is often thought to be a significant event in establishing American homoeopathy. Bradford (1900) stated that the death rate amongst those treated homoeopathically was 3% whilst between 48% and 60 % of those receiving orthodox treatment died. Similarly in 1878 the Yellow Fever epidemic throughout the Southern States provided evidence to the population of the south that homoeopathy had better rates of recovery than orthodox medicine (Coulter 1982).

In 1886 Henry James' novel 'The Bostonians' was published. The novel, set in the mid 1870s, relates the following conversation that takes place between two of the main characters, Miss Birdseye and Basil Ransom. Basil Ransom has just poured out a dose of Miss Birdseye's medicine which she proceeds to drink when James relates the following,

" 'It's homoeopathic,' she remarked, in a moment.

' Oh, I have no doubt of that; I presume you wouldn't take anything else.'

' Well, it's generally admitted now to be the true system.' "

(James 1984)

By 1892 there were 22 homoeopathic medical schools, 110 homoeopathic hospitals, 62 orphan asylums and old people's homes, over 30 nursing homes and sanatoria and more than 1,000 homoeopathic pharmacies in America.

Although America had no royalty or aristocracy to provide support for homoeopathy, as had occurred in the UK, it nevertheless gained strong support from many respected members of society, including William James, Henry Wadsworth Longfellow, Harriet Beecher Stowe, Loisa May Alcott and John D. Rockefeller (Ullman 1991).

This theory of the 'golden age' has been questioned recently by two American writers, Daniel Cook and Alain Naudé. Cook and Naudé (1997) argue that the golden age did not exist as the proponents of homoeopathy during this period were actually using orthodox techniques as often as, if not more often than, homoeopathic therapy. They cite in evidence the syllabuses of the homoeopathic medical schools to show that homoeopathy was a very minor element of their medical education, often tagged on as an afterthought.

Cook and Naudé have referred to the practice of the graduates from these homoeopathic medical schools as 'pseudo-homoeopathy',

"An era of pseudo-homoeopathy came and went in the second half of the nineteenth century. It did not continue because it was not real. The passing of paradise was the passing of a mirage."

(Cook and Naudé 1997)

Cook and Naudé (1997) claim that homoeopathy was seen as a bandwagon and a 'gravy train', and was used as such by a large number of practitioners who lacked integrity. From its beginnings in genuine Hahnemannian practice American homoeopathy was subsumed into orthodox medical practice even before the start of the 'golden age' in 1850, and most homoeopaths were practising an eclectic mixture of therapies that were all deemed to be efficacious for the patient.

If Cook and Naudé's sources are accurate, and there is no reason to believe that they are not, then homoeopathy, as originally described by Hahnemann, never really flourished in America except during a short period after its arrival in 1825.

2.14 The decline of American homoeopathy

With many homoeopaths joining the American Medical Association after 1903, homoeopathy started to head into the wilderness in the twentieth century. In 1935 the American Medical Association resolved that as from July 1938 they would no longer approve schools with 'sectarian titles'. The term 'homoeopathy' was removed from college titles and homoeopathy courses were made an optional part of the medical courses offered, before they were finally eliminated.

The American Institute of Homoeopaths, encouraged by Dr. Lucy Herzog, did join forces with the American Medical Association in order to campaign against 'New Deal' legislation that would lead to a regimented state medicine. Encouraged by this co-operation the homoeopaths tried, on a number of occasions, to have the American Medical Association recognise homoeopathy as a specialism in internal medicine thus securing a more formal recognition of homoeopathy. Despite the more radical International Hahnemannian Association being disbanded, they voted themselves out of existence after 80 years, the American Medical Association still would not recognise homoeopathy and requests to be listed as a specialty were all refused.

By the 1960s American homoeopathy was at a very low ebb (Nicholls 1988). Many of its practitioners were advanced in age and new recruits were few in number, probably due to the perceived difficulty in gaining expertise, the time needed for consultations and the fact that conventional medicine controlled the medical education establishments.

2.15 The current picture

Homoeopathy is currently experiencing a minor renaissance in America. In the early 1970s there were less than one hundred homoeopathic doctors in America, and yet by the mid 1980s there were around 1,000 physicians specialising in homoeopathy (Ullman 1991). Between 1980 and 1982 the number of homoeopaths in America doubled (Chase 1983). There were also calculated to be over 1,000 other health care professionals using homoeopathy in America, these included dentists, veterinarians, naturopaths, chiropractors, acupuncturists and nurses. The American public also seemed to rediscover homoeopathy and the

Food and Drug Administration in America reported a 1000% increase in sales of homoeopathic medicines from the late 1970s to the early 1980s (F.D.A. Consumer 1985).

The reasons for this rise in popularity may be similar to those that led to the initial wave of popular demand for homoeopathy in the nineteenth century. There is an increasing intolerance of iatrogenic damage among the public and also a recognition that regular medicine is often quite limited in its ability to treat some of the major diseases currently affecting people in developed countries. Homoeopathy is seen as a safe form of medicine with no side effects that might be utilised in the treatment of those diseases for which regular medicine holds no solution.

2.16 America and Britain compared

The differences between the American and British experiences of homoeopathy are plain. In Britain medical homoeopaths encouraged the teaching of lay homoeopaths and, after setting up their own colleges, this group now represents the largest number of homoeopaths in Britain. In America homoeopathy was mainly practised by converts from orthodox medicine who made moves to stop lay practice in 1845 and were then subsumed within orthodox American medicine.

It may be possible to explain the different levels of acceptance of homoeopathy by the medical profession in the USA and the UK by reference to different cultural traits.

Lynn Payer (1988) investigated differences in twentieth century medical practices in the UK, USA, France and Germany, all western, developed countries with similar mortality rates from similar diseases.

The concept of *terrain* which is of such importance to the French and the Germans can be useful in explaining the initial discovery and subsequent development of homoeopathy in Germany and then France. Homoeopathy is a system of medicine that aims to improve the overall constitution of the person in order to help them 'fight off' disease symptoms. The concept of improving the *terrain* was

therefore not alien to Hahnemann and his subsequent followers in Paris. As Payer states,

“Many diseases result from a combination of some type of outside insult and the body’s reaction to that insult. While English and American doctors tend to focus on the insult the French and Germans focus on the reaction and are more likely to try to find ways to modify the reaction as well as fight off the disease.”

(Payer 1988)

The unpopularity of homoeopathy with the medical profession in nineteenth century America could be explained by Payer’s assertion that the Americans favour aggressive medicine. The Americans, Payer (1988) claims, are a nation of ‘doers’ rather than thinkers, and the doing tends to be more aggressive in America than elsewhere. This aggressive therapy is epitomised by the heroic practices of Benjamin Rush and his followers with their violent purgings and bleedings, and their denial of the existence of the *vis medicatrix naturae*. The American medical profession’s desire to do something, rather than nothing, and their preference for aggressive interventions (Payer 1988) could have made it difficult for homoeopathy to make an impact on the qualified medical practitioners of the 19th century. It has been argued that even those who did call themselves homoeopaths did not stick to the gentle techniques of homoeopathy but used conventional techniques instead (Cook and Naudé 1997).

In the UK the system of patronage would appear to have helped homoeopathy to establish a small but enduring foothold in the medical establishment of the 19th century, which has managed to remain intact to the present day. The British emphasis on outside factors rather than on the *terrain* (Payer 1988) may have dictated the manner in which homoeopathy is still practised by doctors in the UK, with specific remedies for specific diseases rather than the classical homoeopathic manner of strengthening the constitution to enable the body to heal itself.

The theory of the ‘golden age’ of American medical homoeopathy is seriously threatened by Cook and Naudé’s challenge to its veracity. It would seem to be the case that in both Britain and America the growth of medical homoeopathy in the

late nineteenth and early twentieth centuries was in fact what Nicholls has referred to as 'Bastard Homoeopathy' (Nicholls 1988).

3 HETERODOX, ORTHODOX, ALTERNATIVE OR COMPLEMENTARY

3.1 Heterodox medicine

Heterodox medicine, as the term implies, is a form of medicine that is other than orthodox medicine. Orthodox medicine, here, will refer to that form of medicine conventionally practised in the United Kingdom within the National Health Service (NHS).

The question of terminology is a difficult one within heterodox health care practice. The major difficulty is that posed by the use of the terms 'complementary' and 'alternative'. Sharma (1992) addressed this difficulty at length, illustrating the potential minefield that exists. She began by defining what constitutes complementary medicine, for this is her preferred term. For Sharma 'medicine' indicates certain properties or characteristics of any practice that uses the word 'medicine' to describe itself. For Sharma to accept a therapy as a form of medicine it must closely approximate that which is generally understood in western societies as being medicine (Sharma 1992). Desirable characteristics should include:

- a claim to be curative. That is it claims to cure actual illness rather than simply encourage a general well-being.
- a body of knowledge or theory of both the human body and the aetiology of disease.
- a technical intervention from an expert practitioner. Examples given include the administration of substances as happens in homoeopathy, herbalism and orthodox medicine or manipulation of the body as in osteopathy, chiropractic and reflexology.

(Sharma 1992)

Sharma is, however, the first to admit that such strict definitions are not wholly satisfactory as some forms of therapy do not easily fit this model and yet may be referred to as complementary medicine by the public and medical professionals

alike. Examples are given of these techniques which exist in this terminological 'limbo'. One such example is Alexander Technique, where there is a form of technical intervention, touch and small manipulations are made, but where no claim to be curative is made. The claim made by Alexander Technique teachers is to re-educate people into using their bodies more efficiently. Another example given is spiritual healing in which there is a claim to be curative and various interventions are made (laying on of hands and prayer are some examples) but Sharma (1992) stated that in her experience many spiritual healers have no systematised theory of the body and how they heal it.

Although Sharma (1992) stated that the model she proposed was not wholly acceptable it can be seen to be useful in the context of homoeopathy as the three characteristics given apply well. Homoeopathy certainly claims to be curative, indeed Hahnemann clearly states this in the first aphorism of his *Organon of Medicine*;

"The physicians high and *only* mission is to restore the sick to health, to cure, as it is termed."

(Hahnemann 1988)

Homoeopathy also has a body of knowledge regarding causation and treatment of ill health, based upon the original work of Hahnemann published in the *Organon of Medicine* (Hahnemann 1988). The administration of 'potentised' remedies in homoeopathy fulfils the third of Sharma's categories, the technical intervention.

3.2 Heterodox practitioners

Fulder and Munro (1985) found that throughout the United Kingdom there were 12.1 complementary practitioners per 100,000 population, this was equivalent to 26.8% of orthodox general practitioners at the time of their study. Their figures showed a wide variation around the UK with complementary practitioners equivalent to 11% of general practitioners in Cardiff and 91% of general practitioners in Cambridge. When the count was restricted to those practising 'complete systems of medicine', as defined by Pietroni (1986), there were 6.1 practitioners per 100,000 population, equivalent to 14% of general practitioners.

Using data collected in 1980 Fulder and Munro (1985) found that 49% of heterodox practitioners worked full time and that the average length of time that heterodox practitioners had been in practice was 7.5 years. Of the practitioners in their sample, half had attended a college for a part-time or full-time course. The practitioners in Fulder and Munro's sample held, on average, 40 consultations per week compared to the average general practitioners work load of 105 consultations per week. Fulder and Munro found that on average the first consultation lasted 51 minutes with follow-up consultations taking on average 36 minutes, these times showed that complementary practitioners held consultations on average 6 times longer than those held by orthodox general practitioners. Complementary practitioners also saw their patients for more consultations in a course of treatment than orthodox practitioners, the complementary therapists seeing patients for an average of 9.7 consultations for a course of treatment (Fulder and Munro 1985).

3.3 Differences within heterodox practices

The therapies that are often grouped together as 'complementary medicine' are many and diverse. The origins and philosophies of this multitude of therapeutic techniques vary widely. Acupuncture is thousands of years old, having its origins in Traditional Chinese Medicine. Homoeopathy originated in Germany in the late 18th century and osteopathy and chiropractic were first developed in the late 19th century and early 20th century respectively.

Heterodox practitioners vary widely in their attitudes to science and to orthodox medicine, in the extent of their training and in their desire for professional recognition (Vincent and Furnham 1997; Fulder and Munro 1985; Cant and Sharma 1995). The range of treatments used is also wide, from the insertion of needles to physical manipulation of the spine, from the high doses of 'mega-vitamin' supplements to the minuscule doses of highly diluted homoeopathic remedies.

Canter and Nanke (1991) described the enormous diversity within complementary medicine in this way;

"Iridologists with their arcane diagnostic system have virtually nothing in common with osteopaths who spend a number of years in

training studying human anatomy in great detail. The bizarre, pseudo-scientific explanations of gem therapy bear no relationship to the carefully articulated but virtually science free accounts of homoeopathy. The use of plants and infusions by naturopaths make some pharmacological sense but is antithetical to the very small, virtually non existent, doses of homoeopathy. The list is endless as to the forms of treatment and associated diagnosis that are used by complementary practitioners and the variety of ways in which they contradict each other.”

Vincent and Furnham (1997) however, suggested that within this diversity there were some common themes in the philosophies of the major systems of heterodox medicine. Homoeopathy, acupuncture, herbalism and naturopathy all subscribe to the idea that the physical, mental, emotional and spiritual being are maintained in a state of health by an underlying, ubiquitous energy, ‘dynamis’ or ‘vital force’, the *vis medicatrix naturae*. Disease is therefore explained by all of these heterodox systems in terms of an imbalance within this energy or force (Vincent and Furnham 1997).

This belief in a ‘vital force’ is then associated with the notion that the body is self-healing and that the practitioners task is therefore to aid the body in its self-healing process, to enable the functions of the *vis medicatrix naturae* (Vincent and Furnham 1997) to proceed unhindered. Vincent and Furnham further suggested that this belief had a psychologically important effect upon the relationship that existed between the practitioner and the client. Because the client’s body was healing itself, rather than being acted upon by some external intervention, it became necessary for the client to do everything possible to help themselves in this process of self-healing. The client is often encouraged to discover why they have become ill, why their vital force has become imbalanced, and to then work their way back to health. This can often develop into the idea that there is a ‘journey’ back to health and to self discovery, along which the practitioner accompanies the client (Fulder 1988).

Lastly, Vincent and Furnham (1997) suggested that many heterodox practitioners were similar in their use of an all encompassing theory of disease. They suggested that specific symptoms were used, not as clues to specific diseases, but as a

manifestation of a general imbalance affecting the entire system. Disease was therefore seen to be caused by these general imbalances and specific symptoms were the result of these general imbalances.

3.4 Differences between heterodox and orthodox therapies.

Having established the variety that exists within heterodox medicine it is worth attempting to contrast heterodox and orthodox practices in some respects. Vincent and Furnham (1997) suggested that there were differences between orthodox and heterodox therapies in the diagnosis made and in the form that the consultation took. The diagnosis started with a careful history taking in both orthodox and heterodox medicine. However, this was usually followed in orthodox medicine by a series of tests to confirm, or disconfirm, the tentative diagnosis that was often made. Such tests often included blood tests, x-rays, scans or even the taking of a biopsy. These tests were often invasive and could be painful or distressing and were often the object of any suspicions of 'high tech' medicine that the patient had.

Vincent and Furnham (1997) contrasted this experience with that of heterodox diagnosis where the initial history taking might seek information of a more personal, psychological nature, often not obviously relevant to the patient's presenting complaint. Touch and careful observation of the patient are also used by many heterodox practitioners to aid in diagnosis. The initial history taking consultation was also of a considerably longer duration in heterodox practice than in orthodox general practice;

“Few private patients in orthodox medicine, who always get more time and attention than National Health Service patients, would be given the time that most complementary patients receive at a fraction of the cost.”

(Vincent and Furnham 1997)

Differences were also apparent between heterodox and orthodox therapies in the way treatments were managed. Patients of heterodox practitioners appeared to be treated more as partners in the treatment process and were encouraged to take a more active part in their treatment wherever possible (Aakster 1989). Many

patients may be attracted to heterodox therapies by this greater involvement in the treatment process than is present in orthodox medical practice, and the involvement and sense of responsibility may be beneficial in itself (Vincent and Furnham 1997).

	Orthodox	Heterodox	'Classical' Homoeopathy	Medical Homoeopathy
Health	Regarded as deviation from illness	Illness regarded as deviation from health - more directed towards maintaining health	An unattainable perfection of balance. Model states all humans are tainted with 'psora' therefore perfect health is impossible	Illness regarded as deviation from health
Disease	No general theory of disease	There may be a general theory of disease	An imbalance of the 'vital force' often linked to miasmatic susceptibilities	No general theory: some acceptance of theories regarding immune suppression
Diagnosis	No treatment without diagnosis: diagnosis is morphological	Diagnosis not so important: type of diagnosis is 'functional'	'Diagnosis' takes the form of determining the required remedy rather than the disease. Homoeopaths do not diagnose	Diagnosis made and often used to make homoeopathic prescriptions based upon pathological principles
Therapy	Combating destructive forces	Strengthening constructive forces	Rebalancing the 'vital force' thus enabling the body to restore itself to vital functioning	Strengthening the bodies immune and repair systems often to supplement orthodox therapy
Patient	Passive recipient of external solutions	Active participant in regaining health	Extremely active participant in relating symptoms and then using own 'vital force' to restore health	A recipient of solutions but with some active involvement in shared decision making
Symptoms	Untoward signs of disease that must be countered	Guides to imbalances and idiosyncrasies	Bodies method of alerting the homoeopath to imbalances in the 'vital force'. A guide to the direction of cure.	Signs of disease whose eradication is utilised to audit the success of therapy

Figure 3.1 Concepts in conventional and alternative medicine to include professional homoeopaths and medically qualified homoeopaths (with acknowledgements to Aakster 1989)

Aakster (1989) used a table to demonstrate the differences in several concepts used by both orthodox and alternative medicines. Using Aakster's original table as a basis it was possible to extend the idea to include both 'Classical' professional homoeopaths and medically qualified homoeopaths into the table to differentiate these from each other and from orthodox medicine (see Figure 3.1).

Fulder (1988) gave some good examples of the variety present within the heterodox therapies, and their relationship with orthodox medicine;

The philosophies of radionics or healing are utterly at odds with conventional medical principles, but the bases of osteopathy or herbalism are quasi-scientific and could be incorporated into conventional medicine without stretching its scientific model to breaking point.

(Fulder 1988)

In an attempt to organise this variety into a classificatory scheme Pietroni (1986) grouped heterodox therapies into four categories;

1. **Psychological approaches and self help exercises**, such as breathing and relaxation, meditation, exercise regimes and visualisation.
2. **Specific therapeutic methods**, such as massage, reflexology, aromatherapy and spiritual healing.
3. **Diagnostic methods**, such as iridology, kinesiology, radionics and Kirlian photography.
4. **Complete systems of healing**, such as acupuncture, herbalism, osteopathy, chiropractic, homoeopathy and naturopathy.

Pietroni (1986) suggested that those techniques in group 2, the specific therapeutic methods, were indeed forms of heterodox medicine but that they lacked the development of a theoretical system that underlies the complete systems included in group 4. Complete systems are characterised by their association with a coherent and systematic theory of the functioning of the body and the mode of action of the therapeutic method used, although as Vincent and Furnham (1997) pointed out, this is not to say that such theories are correct or have been subjected to empirical testing.

3.5 Differences in client / practitioner interactions

Hewer (1983) reviewed ten studies of client / heterodox practitioner encounters carried out between 1954 and 1980 in Australia, America, Germany and The Netherlands. The practitioners who were studied practised a variety of heterodox therapies, however a number of common themes did emerge. Consultations with heterodox practitioners were of a longer duration than those with general practitioners and, although the quality of diagnosis and treatment from the general practitioner did not necessarily suffer as a result of these time constraints, the patient's experience did suffer. Patients reported feeling less rushed, less stressed and more able to give and receive full explanations of their problems during consultations with heterodox practitioners. Tate (1983) suggested that the higher client satisfaction gained from these consultations with fewer time constraints often resulted in better client compliance with treatment.

Hewer (1983) suggested that the relationship between heterodox practitioners and their clients tended to be more patient-oriented, with better explanations of illness, and more egalitarian. King et al (1985) suggested that orthodox practitioners tended to be more formal in their dress, their style and their behaviour than many heterodox practitioners. This might lead to the patients perceiving orthodox practitioners as more authoritarian, which may then result in a less egalitarian relationship, with the practitioner in the dominant role.

Furnham et al (1995) found that patients of heterodox practitioners perceived the practitioner as being more sympathetic than a general practitioner and as having more time to listen. Heterodox practitioners were also thought to be better at explaining why the patient was ill and how the treatment given might work and why it was given.

Vincent and Furnham (1997) pointed out that another consideration in the relationship was the payment of a fee. Paying for a heterodox consultation when it is possible to obtain an orthodox consultation within the NHS without payment of a fee could result in the client valuing the treatment more highly, they also suggest that the fee might encourage extra attentiveness on the part of the practitioner.

3.6 Heterodox medicine as a form of private medicine

Wiles and Higgins (1996) suggested that one of the factors that led to patients deciding to take up privately funded orthodox health care was the appreciation of the length of time doctors spent with them in the unhurried atmosphere of the private hospital. This extra time allowed for more information to be given to the patient and doctors were more willing to discuss the patient's condition and treatment with them.

Is the duration of the heterodox consultation linked to the fact that it is almost always a privately funded consultation ? Is the higher level of egalitarianism linked to the fact that the patient is paying a fee ?

Wiles and Higgins (1996) certainly found that private patients of orthodox doctors reported much lower levels of paternalistic relationships with their doctors, the private patients that they interviewed felt less paternalism was present in the private consultation than in consultations that they had experienced within the National Health Service. Private patients also felt that the doctor / patient relationship in private medicine was characterised by elements of both mutuality, for example shared decision-making and 'friendly chats', and consumerism, for example getting appointments at times that suited them rather than the hospital and getting results earlier.

It is important to note, however, that Wiles and Higgins (1996) concluded that the relationship remained unequal, the private patient still had insufficient expert knowledge and the doctor had intimate knowledge of the patient, the patient was still seen as vulnerable due to their dependence on the doctor for a cure or alleviation of their condition.

Wiles and Higgins (1996) summed up by suggesting that paying for private health care did not lead to the level of consumerist behaviour that might be expected. Even in the private health care sector doctors continue to possess the power to develop doctor-patient relationships that meet the doctors needs rather than those of the patient, albeit within the constraints of market forces that demand that some,

rather superficial, changes be made. Wiles and Higgins (1996) did not include patients paying for heterodox health care in their study, all of the patients were paying for orthodox private health care.

Sharma (1992), taking a view that she admitted was perhaps too cynical, suggested that the high patient-centredness of heterodox therapy could be nothing to do with 'holism, New Age ideologies of personal development or psycho-social theories of disease'. She suggested that it might be a simple consequence of the market relationship that exists between the practitioner and the patient. Using Freidson's (1960 and 1975) concepts of client control and professional control Sharma (1992) argued that as largely independent practitioners most heterodox therapists are not subject to professional control as they are not wholly reliant on professional referrals from other practitioners. Heterodox practitioners are however subject to client control, they need to attract fee paying clients and then convince them to continue in their treatment, and in their payments. Patients will not be strongly motivated to stay in treatment if they are not getting what they want. Sharma (1992) suggested that surely the best way to ensure that the patient gets what they want, and therefore continues in their treatment, is to individually tailor the treatment to each patient.

As Sharma readily admits, this may be too cynical a view to take, especially in the light of other evidence that she produces from her interviews with heterodox practitioners which demonstrate their high levels of altruism, their discomfort at requesting payment and their distrust of the credentials and motives of practitioners who seem to be more interested in making money than in curing their patients, the 'cowboys' as they are called by the practitioners that Sharma interviewed (Sharma 1992).

3.7 Gender differences in the consultation

Sharma (1992) has pointed out the 'substantial presence of women' as practitioners of heterodox medicine, 63% of her sample were female. Bearing this in mind, is there any correlation between the predominance of women and the interactional styles used by heterodox therapists ?

Hall et. al. (1994) found that female orthodox physicians conducted longer visits and nodded and smiled more than their male counterparts. They also found that

female doctors asked more questions and made more partnership statements than male doctors. Other studies have shown that female physicians professed to like their patients more than male physicians did (Hall et. al. 1993) and that female physicians are less egotistical and more humanistic, sensitive and altruistic than male physicians (Day et. al. 1989; Scadron et. al. 1982). Eagly and Johnson (1990) for example, showed that women tend to downplay status differences in interpersonal relations, in contrast to men's tendency to assert such differences. When all of these attributes are taken together it is probable that patients of heterodox practitioners may be benefiting from the interaction style that female physicians have been shown to display.

One further issue regarding gender is also of interest. Mechanic (1978) suggested that the kind of student that is recruited into medical school tends to display a number of attributes that are normally associated with maleness, such as task orientation, single mindedness, quantitative skills and narrow focus. Klass (1987) suggested that the attitudes that are then inculcated into the medical student have also traditionally been masculine. Klass described medicine as glorifying machismo, with the effect of turning both male and female medical students into macho doctors. Heterodox practitioners who are not medically qualified have not been subjected to these selection and socialising procedures and may therefore have escaped the pressures for maleness in their interactional strategies. For patients wishing a more egalitarian relationship with their health care practitioner the abundance of females in heterodox health care may therefore be an attractive feature.

3.8 Is heterodox different ?

Sharma (1992) stated that the heterodox practitioners that she interviewed saw their practice as being somehow holistic, dealing with the psychological and social dimensions of the client's problem as well as the physical. Patients were not seen as a machine that was somehow faulty and therefore required servicing. She suggested that this often meant that the practitioner was engaged in counselling their clients in some form. Sharma (1992) suggested that this holism, however it is interpreted, implies a highly patient-centred approach in which the treatment is individually 'tailored' to suit each patient.

Taylor (1984) whilst recognising the differences between the various heterodox therapies, and the fact that they have no common epistemological basis, argues that they are distinguishable from orthodox medicine because of their emphasis on the patient's subjective experience and the insistence that the practitioner focus on the whole person, not merely the disease.

This patient centredness is, for Taylor (1984), one of the most important differences between orthodox and heterodox health care. As she argued, the consumer movement, the women's movement and the more general demands for more accountability from the professions have brought about pressures for change in the interaction between doctor and patient. These pressures, she suggested, have been resisted by the medical profession, and what is more, there has been a deterioration in the medical encounter due to the caution engendered in doctors by the threat of malpractice litigation and the move away from generalists towards specialists, thus making the forging of long-term doctor patient relationships much less likely.

For Taylor (1984) medicine is a relationship, and this relationship is becoming increasingly fragile. The causes of this fragility are varied, medicine is seen as powerful and influential, the demand for medicine has never been higher and yet increasing costs and rationing have, she suggested, led to a perception of withdrawing services from the consumer.

Taylor (1984) explained the popularity of heterodox medicine by suggesting that it appeared in the right place at the right time. Just as the fragile relationship between doctor and patient in orthodox medicine was declining further a large number of heterodox practitioners appeared on the scene. The attraction of heterodox medicine, Taylor (1984) suggested, was determined more by the ability of the practitioner to deliver a satisfactory medical encounter, than by the efficacy of its treatment methods. When a patient has a chronic illness for which there is no orthodox cure, or even relief, then the aspect of their health care that assumes primary importance is often the quality of the relationship that they have with their doctor.

Kelner and Wellman (1997a) suggested that although some previous studies showed that patients often chose heterodox medicine for the pragmatic reason of being pushed into it by negative experiences with orthodox health care, rather than pulled into it by their belief in heterodox medicine (Fulder 1988; Furnham and Smith 1988) other studies have shown that some users of heterodox medicine are drawn to what Pawluch et. al. (1994) call an 'alternative therapy ideology' that contains the following components;

- a definition of illness as a chronic condition;
- a commitment to a proactive and preventative role in one's health care;
- a holistic understanding of health as physical, mental, emotional and spiritual well-being;
- an openness to the full range of available therapies;
- an emphasis on individual and personal responsibility for all health care decisions.

(Pawluch et. al. 1994)

It was also noted that the use of heterodox therapies did not preclude the simultaneous use of orthodox therapies. This would suggest that, in some clients, the holistic nature of the encounter and the emphasis on personal responsibility for decision making is equally as important as the use of all therapies available, both heterodox and orthodox .

Ditto et.al. (1995) suggested a simple dichotomy in the style that patients expect their doctors to adopt. Either an authoritarian style is adopted, where the doctor assumes the role of expert and primary decision maker who gives clear cut answers, or alternatively the doctor may adopt the egalitarian style, in which the doctor suggests options and discusses these with the patient in order to allow them to take part in the decision making process. Vincent and Furnham (1997) suggested that patients who prefer their doctors to assume the egalitarian style may be drawn closer to using practitioners of heterodox medicine.

Few studies have investigated the doctor patient relationship from the practitioner's point of view, what do the practitioners feel is important, what do they want ? Choi and Tweed (1996) surveyed both orthodox general practitioners and a range of heterodox practitioners to determine if, given the greater importance placed on the

holistic approach by practitioners of heterodox medicine, heterodox therapists would place a greater importance on the practitioner-patient relationship than general practitioners would. Their findings did indeed suggest that heterodox practitioners placed greater emphasis on the practitioner-patient relationship than general practitioners. Patient variables were more important to the orthodox practitioners while practitioner consultation variables were more important for the heterodox practitioners. Choi and Tweed (1996) pointed out that differences in the two study groups must be taken into consideration and could account for these differences, for example heterodox consultations were, on average, 51 minutes long while orthodox consultations averaged 9.4 minutes in duration. Also the orthodox practitioners were older and had been in practice, on average, twice as long as the heterodox practitioners and were thus more experienced.

Although Choi and Tweed found that orthodox practitioners did not rate practitioner consultation variables as highly as the heterodox practitioners, they did still rate them higher than patient variables indicating that they did feel that the consultation characteristics were very important, highlighting a conflict felt by many orthodox practitioners, wanting a satisfactory consultation for them and their patients and yet having to work within strict time constraints within the National Health Service where the average consultation with a general practitioner lasts for less than ten minutes.

3.9 Alternative or complementary?

As Sharma (1992) stated, the use of the term alternative in relation to medicine is consistent with its use when referring to aspects of culture or lifestyle which are regarded as unconventional and more in harmony with nature. Not all practitioners or users of heterodox health care espouse alternative lifestyles however (Sharma 1992). Nor is it often the case that such therapies are used by the clients in isolation from orthodox therapies. In other words these therapies are often used alongside orthodox medicine in a complementary way rather than as an alternative to orthodox therapy (Sharma 1992; Thomas *et.al.* 1991).

Homoeopathy is an interesting example of a heterodox medicine when the question of alternative versus complementary is raised. Hahnemann coined the term homoeopathy to describe his system of medicine because the remedies, he

claimed, produced a 'similar disease' (homoeo-pathy) to that evident in the patient. Hahnemann also coined the term allopathy to describe the conventional, orthodox medical practices of the late 18th and early 19th centuries in western societies. This term referred to the use of remedies that opposed the disease (allo-pathy). Hahnemann devised these terms in order to distance himself and his homoeopathic practice from the allopaths and to show that his work was an alternative to the orthodox medical practice of his day.

As Sharma (1992) stated, a minority of the practitioners that she interviewed described their practice as 'alternative' to convey the idea of a different, independent system of medicine, albeit working in a parallel fashion to orthodox medicine. Most practitioners preferred 'complementary medicine' as this conveyed the idea of co-operation with orthodox medicine. Sharma also stated that she preferred this term as it better reflected the patient's behaviour and the practitioner's views (Sharma 1992).

The term alternative medicine can also be seen to be a pejorative term when used by some individuals and organisations. In the first report from the British Medical Association's Board of Science and Education (British Medical Association 1986) heterodox medicine is termed 'alternative' and the members of the Board of Science and Education clearly state their position in the report:

"These [alternative medical] systems are incompatible with the corpus of scientific knowledge, and must be rejected by anyone who accepts the general validity of the latter."

(British Medical Association 1986)

Here the term alternative was being used by an organisation representing the orthodox medical practitioners in order to distance themselves from what they saw as unscientific practices.

The term alternative medicine was used, in what can only be described as a diatribe against heterodox therapies published in an editorial in the British Medical Journal under the title "The flight from science", to distinguish such questionable practices from orthodox medicine (British Medical Journal 1980). Especially under attack was chiropractic:

“For treating conditions other than bone and joint abnormalities chiropractic, for example ought to be as extinct as divination of the future by examination of a bird’s entrails.”

(British Medical Journal 1980)

In 1993 the British Medical Association’s Board of Science and Education published a second report on heterodox therapies, however this was entitled “Complementary Medicine: New Approaches to Good Practice” (British Medical Association 1993) and the report used the term ‘non-conventional therapies’. In this report a distinction was made between those therapies that were seen as complementary, that is those that worked alongside and in conjunction with orthodox medical treatment, and those that were seen as alternative, that is those that are given in place of orthodox medical treatment and aim to replace it (British Medical Association 1993). This report therefore acknowledged that some ‘non-conventional therapies’ could work alongside orthodox medicine in a beneficial way. They did, however, acknowledge that there was still a threat from alternative therapies that aimed to replace orthodox medicine.

Orthodox and non-orthodox are terms which can also be used and Sharma (1992) stated that they have their merits in not implying anything about the content of the systems of medicine to which they refer. However non-orthodox is a negative term as it implies only deviation from an official norm, the orthodox. Sharma (1992) questioned the defensibility of defining a system purely in relation to the form of medicine recognised by the state.

Other terms sometimes used to refer to heterodox therapies include holistic and natural. The claim to be holistic, that is to treat the whole person rather than malfunctioning organs, systems or tissues, is made by many heterodox therapists and the term holistic medicine is sometimes used as synonymous with non-orthodox medicine (Stalker and Glymour 1989). Although Sharma (1992) stated that many heterodox practitioners did indeed work in a holistic fashion, she added that many orthodox practitioners also claimed to work in a holistic fashion. Holism does not serve to distinguish the heterodox from the orthodox medical practitioners and is therefore of questionable use in this situation.

Natural medicine also has problems. As Sharma stated:

“It seems to me that there is nothing inherently more natural about sticking needles into a person’s body (like acupuncturists) than administering steroid drugs or transplanting organs (like orthodox doctors).

(Sharma 1992)

What is ‘natural’ lies in the eye of the beholder and the term is open to considerable manipulation (Coward 1989).

3.10A summary of heterodox therapies

Heterodox practitioners can therefore be seen as an eclectic mix of therapists practising a range of therapies, from the esoteric spiritual healers and gem therapists, to the more scientifically minded osteopaths and chiropractors. Within this mix are those therapists that might also be described as pseudo-scientific by the conventional medical scientists such as the acupuncturists and the homoeopaths. Finally there are those therapies which can be incorporated into conventional medical wisdom in some way, acupuncture is one such therapy provided that theories of Yin and Yang are replaced by neuroimmunological explanations.

Despite the obvious variety within heterodox practice, it has also been shown that in some ways these practitioners share some characteristics. On the whole they are seen to be less rushed, offer longer consultations and fuller explanations and generally treat their clients in a more egalitarian manner, sometimes accompanying them on their ‘journey back to health and fulfilment’.

In one respect however heterodox practitioners are often at odds with each other, even within the same therapy as well as between therapies. This is their use, or not, of scientific or ‘pseudo-scientific’ theories to explain their therapies. Some practitioners appear to find such explanations desirable, even necessary, others do not. Some are happy to offer esoteric or ‘New Age’ explanations involving energy fields or chakras, while others prefer to speak of boosting the clients immune system to enable the body to heal itself.

From this eclectic mix of practitioners it is necessary to focus on one group, the homoeopaths. There has, unfortunately, been little published work that has been specific to homoeopaths, many authors preferring the broader spectrum of complementary medical practitioners to the focus upon one particular group.

3.11 Medically qualified homoeopaths and professional homoeopaths

Aside from the innumerable books published for students and practitioners of homoeopathy describing how homoeopathy can be practised there is not a great deal of published work describing just how homoeopathy is practised in the UK, or any other country.

In their first report on alternative therapy published in 1986 the British Medical Association's Board of Science and Education (British Medical Association 1986) offered no description of homoeopathy other than to conclude that there was no rational basis for the explanations of homeopathy's mode of action and that two distinct placebo effects may operate, the faith of the practitioner and the unique dosage regimen of the medicine.

A difference was also noted in the report between the way that 'lay practitioners' and doctors practice homoeopathy. The metaphysical theories of vitalism and the mysticism of the potency theory were reported as persisting as 'the core of homoeopathic lay practice' (British Medical Association 1986), whereas the medically qualified homoeopaths were reported to be developing what was described as a 'neo-Hughian movement' with its strict adherence to scientific principles (British Medical Association 1986). Campbell (1984) is quoted in the report as suggesting that the 'potency dogma' be either rejected or modified using scientific evidence, and that the 'similars principle' should not be regarded as a 'law of nature' but rather as a 'rule of thumb'.

In 1981 the Ministry of Health and Environmental Protection in The Netherlands commissioned a report on alternative medicine in The Netherlands. In the section of the report on homoeopathy the Commission for Alternative Systems of Medicine

(1981) stated that homoeopathy is regarded either as a supplementary pharmacotherapeutic method, the view held by the medically qualified homoeopaths, or as a genuinely alternative system of medicine, the view of many practitioners who were not doctors.

These sources suggested, therefore, that there were different systems of homoeopathy being used. If the evidence of practice in The Netherlands can be applied to the UK, and there is no reason to suggest that it cannot, then a picture emerges of two groups of homoeopaths with differing claims for homoeopathy.

The 'lay' or professional homoeopaths, it was suggested, still adhered to Hahnemann's original thesis of vitalism or dynamism, had faith in the potency theory and the theory of the 'law of similars' and regarded homoeopathy as a genuine alternative to orthodox medicine. Doctor homoeopaths however, did not hold with ideas of vitalism and potency unless they could be proven with 'scientific' evidence and therefore tended to use homoeopathy to support any other therapeutic intervention that might be deemed necessary.

The British Medical Association's Board of Science and Education, in response to criticism of their 1986 report, published a second report only seven years later (British Medical Association 1993). The tone of the 1993 report had shifted slightly, even the title 'Complementary Medicine' denoted this shift. The distinctions between alternative and complementary practices were still evident but perhaps the heterodox practitioners were no longer all 'tarred with the same brush'. Many heterodox therapies were referred to in the 1993 report as complementary therapies, herbalism was singled out as representing those therapies that were still regarded as alternative practices. Homoeopathy did not appear in the discussion of alternative or complementary therapies and it is therefore difficult to place it, within the context of the report, as one or the other. However, homeopathy's non inclusion as an alternative therapy may have denoted a shift in the perception of the Board of Science and Education with respect to homoeopathy. Could professional homoeopaths perhaps be considered as a mixture of complementary practitioners and alternative practitioners, depending on whether they sought to replace orthodox medicine or not ?

3.12 Homoeopathy and orthodox medicine

If homoeopathy is compared to orthodox medical practice then the greatest difference that a patient would notice about the way homoeopathy is practised is the depth of the interview necessary in order to make a decision about the treatment to be used. Vithoulkas (1979) gave a useful description of the homoeopathic interview, he stated that the consultation would be considerably longer than one with a conventional doctor, and it would be 'painstakingly individualised'. The unique sensation of consulting a homoeopathy was conveyed well by the following quote from Vithoulkas;

"During the interview, you might feel slightly self-conscious. It may seem that the homoeopath is gently scrutinising your every mannerism. But you quickly realise that this is not a process of passing judgement, but merely of interested observation. You soon get the idea he or she is as much or more interested in *you* as in your ailment".

(Vithoulkas 1979 [original emphasis])

Vithoulkas also pointed out other differences, the homoeopath's constant referral to books (twenty years after Vithoulkas wrote this these books are often replaced by a computer), and the patient's common experience of leaving the homoeopath's consulting rooms without a prescription or a remedy as the homoeopath must spend some time, often hours even with the introduction of specialised computer software, analysing the information and selecting the most similar remedy.

The time frame used by homoeopaths is apparently much longer than that used by conventional practitioners. The consultation is longer, the time taken to analyse the case and prescribe is also longer and finally, the time taken to effect a cure may be considerably longer. Vithoulkas (1979) quotes a rough rule of thumb that states that for every year that a patient has possessed a condition or a symptom, it will take a month of homoeopathy to treat it. So, for example, a patient who has had rheumatoid arthritis for eight years will require eight months of homoeopathic treatment, a thirty year old patient who has had psoriasis since infancy will require two or three years of treatment in order to effect a lasting result.

Vithoukas was describing the manner of working that a non medically qualified homoeopath might have used in the late 1970s and early 1980s, however, with the exception of the introduction of increasingly more powerful computerised systems to aid in the selection of the remedy, the mode of work is very similar almost twenty years later. Vithoukas does not, however, suggest whether the homoeopathic doctors of the time were working in the same way or not. The report of the British Medical Association (British Medical Association 1986) suggests that many homoeopathic doctors were using a neo-Hughian approach, a strictly scientific method of utilising homoeopathy as a supplementary process used alongside orthodox medicine rather than the holistic, almost mystical, approach described by Vithoukas (1979).

4 PROFESSIONAL ORGANISATION

4.1 Registration of heterodox practitioners

Inglis (1985) suggested that there was a need for statutory registration of heterodox practitioners and also for formal courses to teach and assess such practitioners. He reported that the British chiropractors had put themselves forward for registration with the Council for Professions Supplementary to Medicine but had been rebuffed. Inglis (1985) stated that the chiropractors had claimed to have been informed that the reason behind their refused application for admission was their claim to be able to treat asthma, indigestion and other complaints in addition to spinal problems. These claims represented a truly alternative theory of disease causation to that of orthodox medicine and, it has been suggested that, a clash with orthodox medicine is more likely if the heterodox theory is presenting an alternative point of view (Burton 1990).

In the US, in the 1930s, there was a concerted effort from the American Medical Association to eliminate the chiropractic profession due to their alternative stance, but by 1974 the chiropractors had succeeded in obtaining licensure in every state in the US. Two years later the chiropractors instigated a lawsuit against the American Medical Association alleging a criminal conspiracy to prevent doctors from associating with chiropractors or accepting referrals from chiropractors (Wardwell 1994). In 1990, after 16 years, 2 court trials, 2 appeals, and 2 petitions to the US Supreme Court, the American Medical Association was found guilty of criminal conspiracy and forced to change its policy, inform all of its members of this change, and pay legal expenses and damages to the chiropractors. The chiropractors were finally not only registered in every state but had won a moral, and legal, victory over their right to practice alongside, and in co-operation with, orthodox medicine.

In the UK the osteopaths finally achieved statutory registration after 60 years of trying (Warden 1993). Seven attempts were made before a bill was passed through parliament, this bill made it into the statute book in July 1993 and created a register and a General Osteopathic Council along similar lines to the General Medical Council but with wider powers to investigate incompetent practitioners than the conventional doctors have.

There is no direct regulation of non-medically qualified heterodox practitioners in the UK other than osteopaths and chiropractors, they are mostly allowed to practice freely. Many other European countries restrict the practice of heterodox medicine to those in possession of orthodox medical qualifications. In Belgium, France, Spain, Italy and Greece the practice of any form of medicine by those not statutorily recognised as health professionals is forbidden. In The Netherlands the situation is the same, however the prosecution of non-medically qualified practitioners is not often undertaken unless malpractice has been alleged. In Denmark non-medically qualified practitioners of heterodox medicine may legally practice, however the scope of their practice is limited by the law. Germany is in a unique position with its system of Heilpraktikers (health practitioners). This system was introduced in 1939 and licenses heterodox practitioners who are not recognised health care professionals to practice heterodox therapies provided they pass a basic medical knowledge examination and are then licensed as Heilpraktikers (Fisher and Ward 1994).

4.2 Registration issues.

The UK currently has no mandatory registration for many heterodox medical practitioners. The exceptions to this lack of registration are the chiropractors and the osteopaths. The passing of the Osteopaths Bill in 1993 introduced a legally binding form of registration for this profession, with protection of title making it illegal to practice as an osteopath without the correct qualifications.

There is, as yet, no such registration for homoeopaths in the UK. Registration does exist for homoeopaths but this is not mandatory and currently there are three registering bodies for professional homoeopaths, one for medically qualified homoeopaths and one further body that accepts both professional homoeopaths and medically qualified homoeopaths.

Following the success of the osteopaths in advancing a bill through parliament many of the other heterodox professions began to work towards similar legislation. In the opening years of the 1990s many professional organisations felt that an 'umbrella organisation' was the best way forward towards statutory registration. A small number of such organisations attempted to represent all heterodox health care practitioners but this was a difficult task. The Institute for Complementary

Medicine (ICM) and the Council for Complementary and Alternative Medicine (CCAM) were the two major players undertaking the role of umbrella organisations.

The road to bringing about this co-operative venture was not a smooth one however. Although the ICM registered homoeopaths, the Society of Homoeopaths favoured working with CCAM rather than the ICM (Logan 1992). Factions formed and umbrella organisations lost favour with the heterodox health care organisations when the osteopaths decided to work alone, without the ICM or the CCAM, towards the adoption of a Bill which would statutorily register osteopaths. In December 1991 a Private Members Bill was presented to the House of Lords but this attempt failed due to an intervening General Election. However in June 1992 a Private Members Bill started the ball rolling and by January 1993 the osteopath's bill had received its second reading in the House of Commons.

4.3 Statutory registration for homoeopaths

The Society of Homoeopaths has been engaged in talks with other bodies that register homoeopaths, including the Faculty of Homoeopathy representing the medically qualified homoeopaths, in order to produce a single register of professional homoeopaths (Society of Homoeopaths 1997). There is much debate among the members of the Society of Homoeopaths regarding whether this should be a form of statutory registration, similar to that gained by the osteopaths.

Debates were held at the 1995 Annual Conference of the Society of Homoeopaths, some of these debates were quite heated with protagonists both for and against statutory registration putting forward their own forceful arguments (Gordon 1995; Stone 1995).

As a whole the board of directors of the Society of Homoeopaths have been pro single register and mainly pro statutory registration (Gordon 1994a). It is many of the 'grass-roots' members of the Society who are sceptical regarding statutory registration.

Many professional homoeopaths feared that statutory registration would lead to a loss of professional autonomy and unnecessary bureaucracy (Ryan 1994). Doubts were also expressed regarding the qualifications required for entry onto the

register. Many of the homoeopaths who had been in practice for twenty years or more had no formal qualifications from homoeopathic colleges but, with so many years of clinical experience, they were often highly regarded practitioners. Fears were expressed that such practitioners might be excluded from the register (Gordon 1994b). Another fear that was expressed by members was that the practice of homoeopathy would have to change before it would be accepted as an effective therapy worthy of statutory registration. It was felt that homoeopathic practice might be “watered-down” in order to curry favour with the British Medical Association (Estoda 1995).

The primary motivation for some form of regulation of homoeopaths would appear to be protection. This protection is multi-faceted, firstly there is the protection of title, only those appearing on the register may call themselves a homoeopath. This brings with it effective disciplinary procedures as the ultimate sanction of being struck off of the register would then actually carry some weight. This can be seen to be protecting clients or patients, and the profession, from those who may not practice in a responsible way or in a way recognised by the registering body as being ineffective or unsafe (Stone 1995).

4.4 Orthodox medicine’s view

The British Medical Association have also shown an interest in the registration of heterodox health care professionals for the same reason of protection, however their main interest has been protection of the client;

“The maintenance of a single register of suitably qualified practitioners, which is accessible to the public, provides the greatest safeguard against possible harm to the individual.”

(British Medical Association 1993)

Whether this registration of practitioners should be statutory or voluntary depends upon the nature of the practice;

“Those therapies in which the diagnostic process is integral to the application of the therapy, or whose practice involves invasive or

potentially harmful techniques, should be subject to a *statutory* register of members”

(British Medical Association 1993) (original emphasis)

Homoeopathy, with its use of ingested remedies, would be classed as invasive and the BMA would therefore recommend statutory registration for homoeopaths.

4.5 Anti-registration arguments

Stone (1995) drew attention to other perceived advantages of statutory regulation. These included;

- protection from medical colonisation
- higher status for homoeopaths
- uniformly high standards of education and practice
- facilitation of greater NHS integration

Stone (1995) then argued that many of these perceived advantages were illusory. She cited the example of acupuncture to show that upon higher acceptance of heterodox practices the medical profession were more likely to colonise by ‘picking-off’ parts of therapies and applying them within a biomedical framework.

She argued that the power brought by a higher status may distort the homoeopath/client relationship. Using the increasing number of complaints made against the medical profession Stone (1995) argued that statutory regulation was not a foolproof guarantee of high standards.

Finally Stone (1995) pointed out that there were disadvantages to statutory regulation. Firstly statutory regulation will be expensive to set up and maintain and this could lead to a considerable increase in member’s subscription fees. Secondly unity between all homoeopaths, professional and medically qualified, will be a prerequisite for statutory regulation. This will not be achieved easily, she claimed. Thirdly ‘scientific’ proof of efficacy will also be a necessary prerequisite. This proof could be difficult to obtain, especially as the most widely accepted form of such proof, the double blind trial, does not lend itself to the investigation of homoeopathy with its highly individualised treatment regimes. Fourthly the bureaucracy involved

tends to lead to ossification of the profession and, lastly, statutorily regulated bodies are answerable to government who may well insist on governmental and medical representation on the statutory committees.

In 1993 the Shadow Health Minister, Dawn Primarolo, wrote a consultation document for the Labour Party on complementary therapies in the NHS. In this document Primarolo (1993) stated that as complementary therapies are not statutorily regulated there was no protection for the consumer. For this reason she stated that;

“The main complementary professions must be regularised in this way”

(Primarolo 1993)

Registration of practitioners is a highly contentious issue among homoeopaths with many aware of the advantages that are available but also of the pitfalls that lie in wait.

4.6 Professionalisation of complementary medicine

There is currently a strong pressure to professionalise from many of the practitioners of complementary medicine (Cant and Sharma 1995) and there are many strategies being used by the different organisations that represent the different therapies. The medically qualified homoeopaths, although members of the medical profession, need to perform a fine balancing act whereby they are seen to be sufficiently different from their orthodox colleagues to warrant a separate homoeopathic ‘sub group’ within the medical profession, without being so different that their behaviour is regarded by their medical peers as unacceptable for a registered medical practitioner (Cant and Sharma 1996).

The professional homoeopaths are also working towards professionalisation. Both the Faculty of Homoeopathy and the Society of Homoeopaths are committed to obtaining state recognition and to this end have ‘toned down’ many of their original claims and represent homoeopathy as a complementary, rather than an alternative, practice (Cant and Sharma 1995). Both organisations have made moves to limit access to the profession, introduce science into their training and to gain external credentials for their courses. Despite these strategies of social closure and

credentialism there is still a sizeable minority of the members who see this professionalisation as dangerous. Many of these homoeopaths still regard their practice as an alternative to conventional medicine that should not 'sell-out' to the orthodoxy for an 'elite professional status' (Cant and Sharma 1995). Cant and Sharma have therefore concluded that the professional development amongst professional homoeopaths can be defined as 'reluctant professionalisation' (Cant and Sharma 1995).

4.7 Homoeopathy as a modernist tradition in a (possibly) post-modern society

What has been the motivation for this move towards registration and professionalisation? The Society of Homoeopaths could be reacting to changes that may be occurring in society at large. The move from modernism to post-modernism is often used to explain these changes in society. Homoeopaths may be reacting to changes that are occurring in their client base, changes brought about by a post modern shift.

Homoeopathy was devised by Hahnemann in the last years of the eighteenth century as an opposing force to the medical practices of the day. Within a few months of the publication of Hahnemann's discoveries Jenner had published details of his use of cowpox serum to vaccinate against smallpox. These two men were both, unknowingly, heralding the modernist era in medical therapeutics. The grand theory of biomedicine, the germ theory, was being investigated and propounded, medicine was moving away from the haphazard methods of the heroic medicine of Rush and Cullen towards a modernist concept of germ theory, a theory that, seemingly, explained everything. This was a grand theory which could form a basis for a rational form of modern therapeutics.

At the same time as Jenner was upholding germ theory, Hahnemann was developing his own grand theory of disease causation and treatment. This theory of homoeopathy was based upon notions of imbalance in the internal 'vital force' that required re-balancing by the use of substances prescribed solely on the patient's symptoms. The symptoms were important as they were seen to be the 'language' that the vital force used to communicate its needs to the practitioner.

The birth of homoeopathy and the birth of biomedicine both occurred within a short time span and both were solidly within the modernist tradition of the early nineteenth century. As models of modernist thought it is interesting to speculate on their futures in a post modern society. As Saks (1998) stated, post-modernism negates the idea of the grand theory, and it is upon such grand theories that both biomedicine and homoeopathy are based.

The increasing numbers of individuals seeking relief of symptoms through the use of heterodox sources is surely evidence of a counter-culture that has developed from the mid 1960s. The patients that make up this counter-culture have rejected the rationalist, reductionist and mechanistic nature of the increasingly technology driven biomedical therapy. These patients seek an encounter with their physician that is based upon the concept of the patient as an informed and interested consumer, rather than as a passive recipient of health care.

Post-modernity, as seen by Thompson (1992), is a condition based upon diversity, indeterminacy, multiplicity, fragmentation and flexible specialisation, in contrast to the totalising themes of modernity. The post-modern world is therefore seen as being more tolerant of minorities in a pluralistic society. A further characteristic of post-modernity is its abandonment of the search for absolute truths based on rational scientific knowledge (Nettleton 1995), this is replaced by the acceptance of multiple realities and co-existing narratives.

With these characteristics being typical of post-modernity it is possible to argue that the development of complementary medicine in the United Kingdom is evidence of a post modern shift. Bakx (1991) argued that the decline in the cultural authority of biomedicine, brought about by counter-culture disillusionment with modernism, had opened the way for the co-existence of such diverse perspectives as the orthodox and heterodox in health care. Rising consumer interest in the wide range of heterodox therapies had fuelled this change.

The post-modernist encouragement of pluralism and increased choice, of acceptance of minorities and its negation of the cultural authority of such grand theories as biomedicine, seem to provide a fertile soil for complementary medicine to grow in. The less openly monopolistic, more intimate style of practitioner - client

relationships in heterodox medicine is a post modern phenomenon that has also encouraged growth.

How can homoeopathy, as a distinctly modernist phenomenon, exist in such a milieu ? It is possible that many of the changes currently occurring in homoeopathy, with regard to registration and other professionalisation strategies, are being encouraged as a result of this shift from modernism to post (or late) modernism. The increased acceptance of multiple realities could explain the way in which patients can be eclectic in their simultaneous use of both orthodox and heterodox therapies. This acceptance could also explain the growth in the different forms of homoeopathy that are currently being practised alongside 'classical' or 'Hahnemannian' homoeopathy.

The drive for professionalisation could be seen as an attempt to bring to the public's attention the existence of homoeopathy as one of many realities that co-exist within the field of current health care interventions. Professionalisation also brings with it assurances of the ways in which practitioners will practice, with the best interests of the patient at the core of their professional code. This may be a method of encouraging new patients to try homoeopathy in an increasingly consumerist society. Professionalisation strategies bring the profession to the attention of the public as a choice in healthcare and also promote it as a 'safe' choice as the therapists are all professional, registered practitioners.

Alongside these advantages of professionalisation comes a possible disadvantage. There is the possibility that if homoeopathy was to become a highly professionalised healthcare option it could become too strongly equated with biomedicine and would then lose the attraction that it has for those patients who are part of the post-modern counter-culture, with their search for healthcare answers outside of biomedicine.

4.8 Heterodox medicine as a threat to orthodox medicine.

The possibility of a post modern shift away from biomedicine could be interpreted as evidence of a decline in biomedicine at the expense of heterodox medicine. Is this post modern shift therefore a possible threat to orthodox medicine ?

Mike Saks (1994) proposed the idea that heterodox medicine might be considered a threat to orthodox medicine in the UK. The threat, according to Saks, stems from consumer-based demand for heterodox medicine, in the place of, or in addition to, orthodox medicine. He posed the question:

“How much can consumer-based demand in an increasingly market oriented society diminish established patterns of professional dominance ?”

(Saks 1994)

There has undoubtedly been a huge rise in the popularity of heterodox medicine over the last 25 years in Britain. Saks (1994) showed that in 1993 one in seven of the population of Britain was going to alternative practitioners for treatment. This growth in popularity he attributed to a number of factors:-

- growing awareness of the technical deficiencies of orthodox medicine.
- development of a broader political culture of self-determination.
- the search for relationships with health practitioners in which the consumer is the engaged subject rather than simply the object of health care (Bakx 1991).

These factors could be interpreted as evidence of a movement towards post modern thinking.

This increased popularity of heterodox medicine could pose a threat to orthodox medicine. Heterodox medicine's negation of the orthodox profession's mechanistic view of the body (Stacey 1988) is one form that this threat takes. This threat is embodied in the holistic approach of alternative practitioners. Increasingly, however, orthodox practitioners are also claiming to work holistically (Sharma 1992), and this may be in response to this perceived threat to orthodox medicine from consumer demand for holism.

However, Saks (1994) argued that for all its force, this consumer-led challenge had not yet subverted the foundation of professional dominance of British medicine. This could be seen by the monopoly within the NHS of orthodox doctors while the heterodox practitioners have been predominantly restricted to the private sector.

This situation places the heterodox practitioner in a highly disadvantageous competitive position. This was not always so, in the 18th and 19th centuries an open market existed in Britain. However, following the 1858 Medical Registration Act a unified, self-regulating and exclusionary (and therefore orthodox) medical profession was established, differentiating it from its irregular competitors. This legislation marginalised the heterodox practitioners and labelled them, for the first time, as alternative.

Saks (1994) suggested that this outsider status was underlined in areas such as research funding, which is minimal in heterodox medicine. The elite of the medical establishment has for many years mounted strong campaigns against its 'heterodox competitors in the medical journals as well as in other public and professional forums. This campaigning stance was very evident in the Report of the British Medical Association (British Medical Association 1986) on alternative medicine, which extolled the scientific aspects of modern biomedicine whilst depicting alternative medicine as superstitious dogma. This places heterodox medicine in a double bind situation - criticised by orthodox medicine for not producing enough scientific evidence to support their case, while at the same time suffering from heavy restrictions upon funding for medical research and these funds being allocated almost exclusively to conventional health care activity (Aldridge 1991).

The threat posed to orthodox medicine cannot therefore be perceived as a serious one. Consumer led demands for holism can be met, with varying degrees of success, by orthodox medicine and the position of biomedicine as the accepted orthodoxy is still very strong. The orthodox medical elite are still in a powerful position and the heterodox therapies still require their approval if they are to proceed much further with their professionalisation strategies.

The grassroots of the medical profession are, however, changing their attitude to heterodox medicine despite the stance taken by the medical elite. There have always been those in orthodox health care who were open to heterodox medicine, as witnessed by the small number of medical homoeopaths still operating within the NHS. General practitioners have always shown the most favourable attitude to alternative medicine and, in some cases, have taken up heterodox practices themselves (Reilly 1983; Wharton and Lewith 1986). Even the latest report of the British Medical Association (1993) held back from outright condemnation acknowledging the popularity of heterodox therapies and avoiding direct comment on their validity.

Saks (1994) stated that it is tempting to see this interest within the orthodox medical profession as pointing to a progressive erosion of professional dominance due to the expanding consumer demand and the profession legitimating the operation of its competitors. However, he suggested that it is more plausible that this interest is seen from within a neo-Weberian approach, as an interest-based occupational strategy that has served to defuse the threat to orthodox medicine and maintained the privileged standing of the profession. Incorporation of heterodox practices into orthodox medicine has been limited and always on the orthodox professions terms. Thus acupuncture has been employed by the medical profession in Britain for analgesia, underpinned by orthodox neurophysiological explanations. This strategy has opened up a new territory for the medical profession whilst discouraging the use of non-medically qualified acupuncturists with their, from the orthodox medical profession's point of view, more problematic theories of Yin and Yang. Paralleling these incorporationist tendencies of the medical profession has been the dilution of radical ideas by the alternative practitioners, for example the chiropractors dropping their claims to cure problems other than those of the spine and joints. Thus even the recent growth in the orthodox practitioner's interest in heterodox therapies was not seen by Saks as a threat to orthodox medicine. It was explained by reference to the incorporationist strategy that the medical profession has been successfully using for some time.

The power of the elite of the medical profession still appears to be the major stumbling block to ending the marginalisation of heterodox therapies in Britain, despite the current growth in consumer interest. Marxist authors deny the neo-Weberian professional dominance thesis in medicine as it underplays the influence of finance and industrial capital in capitalist societies (see for example McKinlay 1985 or Navarro 1986). In the Marxist thesis the marginality of alternative medicine could be attributed to the interests of multinational pharmaceutical corporations which are seen to be threatened by the impact that the growth of alternative medicine could have on their profits. This would be an example of history repeating itself with regard to the apothecaries in Leipzig objecting to Hahnemann's homoeopathic practice (see section 2.2). Although it would be unwise to ignore the role of such huge multinational drug corporations as Ciba-Geigy and Glaxo-Wellcome, their negative influence on alternative medicine should not be overestimated. The diversification of the product range of such corporations into the

heterodox health care sector would not be impossible and they could enhance the status of heterodox therapies by association.

It is the elite of the medical profession that the government of Britain has always turned to for scientifically based opinions on the safety and efficacy of heterodox medicines. As such the medical profession is seen as playing a key role in the marginalisation of heterodox therapies and in sustaining a state supported health care system which has not reflected the growing public interest in the alternatives to orthodox medicine.

It would seem that despite a possibly post modern, consumer led demand for holistic, less mechanistic and technological medicine the heterodox therapies are currently posing no significant threat to the orthodox medical establishment in the UK.

5 HOMOEOPATHY AND HERESY

5.1 Heresy in medicine

Heterodox forms of medicine are, by definition, not orthodox medicine, but does this also make them heretical practices ? It has been shown above that some heterodox therapies have sought recognition from conventional medicine and have achieved state registration, the chiropractors and osteopaths are examples of the practitioners of such therapies. These therapies are seen by conventional medicine as complementary medicines (British Medical Association 1994) and they are not therefore perceived as posing a threat to orthodox conventional medicine. In the light of this acceptance it is difficult for the orthodoxy to label these therapies as 'heretical'. What though of other therapies, those that are perceived as mounting an 'alternative' challenge to conventional medicine, those who do not wish to be a complementary therapy but a true alternative to the orthodox, such that they could replace it ? Could these therapies be labelled by the orthodox medical profession as 'heretical practices' ?

Is homoeopathy an alternative to conventional medicine or is it a complementary therapy ? Does homoeopathy pose a threat to the orthodoxy and could it therefore be properly thought of as a heretical practice ?

Although medical and other scientific heresies have been studied by others (Gillett 1994, Gürsoy 1996, Stambolovic 1996, Wolpe 1994) there have been, thus far, no studies of either medically qualified homoeopaths or professional homoeopaths to determine their status as challengers to the medical orthodoxy, and therefore as potential candidates for the category of medical heretics.

It is proposed here that homoeopaths are, in fact, an eclectic group and the terms 'heresy', 'challenge' and 'dissent' apply to different degrees to different practitioners. However, a model will be proposed in this work that will suggest that a number of identifiable sub groups do exist within the homoeopathic community and this model may then aid in making possible some predictions for the future progress of homoeopathic practice in the UK.

5.2 Orthodoxy and heresy defined

Heresy describes a practice or philosophy that is not only different to the accepted orthodoxy, but also mounts a challenge to the orthodoxy (Gillett 1994, Gürsoy 1996, Stambolovic 1996, Wolpe 1994). Originally a term used to describe those mounting an attack upon a religious orthodoxy, Wolpe (1994) suggested that the term 'heresy' be rehabilitated to describe challenges to ideology in a profession, arguing that it is a more robust term than 'dissent' or 'attack' for describing such challenges.

In order to decide whether homoeopathy, as an idea, is a heresy, or whether individual homoeopaths, as practitioners, are heretical, it is first necessary to determine under what circumstances a challenge that is mounted can be defined as truly heretical. How useful is the concept of heresy when describing the relationship that exists between homoeopathy and orthodox biomedicine ?

The usefulness of the concept of 'heresy' becomes apparent if one adopts the perspective of viewing biomedicine as a discourse. Zito (1983) defined a discourse as "any collective activity that orders its concerns through language". From this position he argued that an ideology is a discourse seeking to monopolise ways of speaking about the world. When this ideology becomes institutionalised, Zito suggested, it is then regarded as an orthodoxy (Zito 1983). It could, therefore, be argued that biomedicine is an orthodoxy in that it has sought to institutionalise a set of ideologies regarding the way health and illness are described and therapeutic interventions are made.

Heresy may be said to occur when a subgroup within a discourse community attacks the orthodoxy by challenging its ideology (Wolpe 1994). Heresy can only exist in relation to an orthodoxy, and it is only that orthodoxy that may label any such attack as heretical. Heresy must also contain an element of defiance in order to distinguish it from mere ignorance or error. It is often in the challengers interests to be labelled as heretics, but, as only the orthodoxy can bestow this label on the challengers, the orthodoxy often withhold such labelling in their own best interests.

Wolpe (1994) suggested that three conditions must be met if the concept of 'heresy' is to be invoked in order to describe a challenge:

- The challenge must be internal so that the heretic emerges from within the ranks of the orthodoxy. Following the religious metaphor a challenger from outside of the orthodoxy would be more accurately described as an 'infidel'.
- The challenge must come from those who do not possess the power to determine ideological orthodoxy within the discourse. When the elite of the orthodoxy make claims against the ideology it should correctly be described as revelation, not heresy.
- The heretic must use the language of the discourse to mount the attack. The introduction of overtly alien ideas is dangerous to the heretic unless they are spoken of in the language of the orthodoxy, i.e. in biomedical terms for medical heretics.

(Wolpe 1994)

It is possible that a practitioner might hold heterodox beliefs without wishing to challenge the orthodoxy. If no challenge to the orthodoxy is mounted then the concept of 'heretic' is no longer useful and Wolpe (1994) suggested that 'dissenter' might be a more suitable description of an individual in this position.

As stated earlier there are two professional groups practising homoeopathy in the UK, one whose members hold medical qualifications and one whose members do not, the professional homoeopaths. From Wolpe's conditions it is plain that the term heretic should not be applied properly to professional homoeopaths as heretics must come from within the orthodoxy, and professional homoeopaths are not members of the medical profession, the orthodoxy, they are outsiders. As such, if we follow the religious metaphor to its logical conclusion, the question to be answered should no longer be 'Are homoeopaths heretics?'. The question becomes more complex as we should be asking 'Are professional homoeopaths infidels and medically qualified homoeopaths heretics?'.

5.3 Heretics, infidels and dissenters

The question of whether homoeopaths are infidels or heretics, depending on their status with regards to the orthodoxy, can only be answered if it can be shown

whether or not there is a challenge to the orthodoxy being mounted. If professional homoeopaths can be shown to be mounting a challenge then they could be referred to as infidels. If the professional homoeopaths are not mounting such a challenge then even the term 'dissenters' cannot properly be applied as they are not from within the biomedical orthodoxy.

Medically qualified homoeopaths, however, could possibly be properly labelled as heretics or dissenters depending on whether they wish to mount a challenge to the medical orthodoxy or not.

So then, what of the professional homoeopaths who are not mounting a challenge to the orthodoxy ? This group cannot properly be termed as heretics, infidels or dissenters. If they are attempting to co-operate with the orthodoxy in order to gain recognition and state registration, as it might be suggested that some are (Gordon 1994a) then these professional homoeopaths might be more properly labelled as 'co-operators' or 'professionalisers'. Strategies of professionalisation are being developed by a number of professional homoeopaths in the United Kingdom. After investigating the activities of both the members of the Society of Homoeopaths and its Board of Directors, Cant and Sharma (1995) labelled the professional homoeopaths as 'reluctant professionalisers', slowly coming to terms with a move towards regulation and co-operation with medically qualified homoeopaths. The question could now be reasonably asked that if some of the professional homoeopaths are taking a collaborationist stance with some members of the orthodox medical profession, is it a case of 'if you can't beat them, then join them' ?

The question of heresy has now become further complicated. The medically qualified homoeopaths could now be properly thought of as potential heretics or dissenters as before. However the professional homoeopaths could now be properly classified as either potential infidels or as professionalisers, those homoeopaths interested in further co-operation with the medically qualified homoeopaths and the medical profession as a whole.

This co-operation with the medically qualified homoeopaths now raises the possibility of the existence of a further group in this already complex situation. Does there exist a group of professional homoeopaths who have mounted a challenge to biomedical orthodoxy, and who could therefore be thought of as

infidels, who could also be seen to be challenging a group within their own profession, the professionalisers ? Further, if these professionalisers could claim to represent the professional homoeopathic orthodoxy, and in the light of section 4.3 it could be suggested that they do (Gordon 1994a), then perhaps it could also be argued that some of the infidels, who are also challenging the professionalisers, are thereby also challenging their own homoeopathic orthodoxy and, as homoeopathic insiders, they might also be properly distinguished as heretics within their own group of professional homoeopaths, homoeopathic heretics.

If these homoeopathic heretics exist they would be mounting challenges not only to biomedicine's ideologies but also to the continuing professionalisation and regulation of professional homoeopathy. Cook and Naudé (1997) used the term 'lovers of homoeopathy' to describe professional homoeopaths who seek a revival of homoeopathy not through legislation and regulation, as the professionalisers are seeking to do, but through the good practice of homoeopathic prescribing. In keeping with the religious metaphors being used it is intended that these 'lovers of homoeopathy' be referred to as 'defenders of the faith' in any further discussion. Using this terminology should the enquiry be refined further to 'are there sub-groups of homoeopaths who could be properly described as either heretics, dissenters, infidels, professionalisers or defenders of the faith ?'

5.4 Measuring dissent and challenge

Data were collected and analysed in order to propose a model that would explain the divisions that might exist within homoeopathy. In order to distinguish those homoeopaths, both medically qualified and professional, who possessed attitudes about homoeopathy and medicine that could be interpreted as challenging the orthodox views of medicine, health and illness a 'potential dissent scale' was devised using the responses that each subject had made to a number of items on the questionnaire. The method of constructing this scale is described in further detail in section 6.4.2.

The scores on the potential dissent scale were then used to confirm the existence of respondents who might be perceived as mounting a challenge to the orthodoxy, and also identifying such respondents for further enquiry. This further enquiry took the form of a small number of extended, relatively unstructured interviews with

respondents who were high scorers on the potential dissent scale. From these interviews it was possible to establish the position of these high scorers with regards the strategies towards professionalisation, through co-operation with the medically qualified homoeopaths and the medical profession, being made by the sub group of professionalisers. From the analysis of these data it would be possible to determine the existence of any homoeopaths who might be included in the category which could be described as the defenders of the faith.

From analysis of questionnaire and interview data it should be possible to determine if any members of these subgroups exist within homoeopathy in the UK. That is, are there any heretics, dissenters, infidels, professionalisers or defenders of the faith ?

6 METHOD

6.1 Data collection

Investigating a group of practitioners with regard to their motivations for practice can be a sensitive topic. In order to gain such possibly sensitive data from a group of people who might wish to be cautious in their responses it is necessary to proceed with due care. There are a number of data collection methods which can be used in social research, but in order to collect data from homoeopaths in the UK it was decided that two methods would be used. These two methods were questionnaires and interviews.

6.1.1 Questionnaires

The questionnaires used were anonymous, postal questionnaires for self completion by the respondent without the researcher being present. The questionnaire is widely recognised as a standard method of data collection (Hall and Hall 1996). The questionnaire can generate information in a systematic fashion by presenting all of the subjects with the same question in a similar manner and then recording their responses in a methodical way.

The reliability of the questionnaire method is generally well regarded due to the fact that differences between the respondents in the way in which data are collected are reduced or eliminated. This structure does however give rise to concerns regarding the validity of the data collected by this method. This is because the rigid construction of the data collection instrument, which does not allow for probes or prompts or even clarification, may not adequately cover the concepts that are being sought by the researcher (Hall and Hall 1996).

With this in mind the questionnaire was developed with a mixture of closed and open-ended items as the freer use of language and thought that can be made when answering open ended questions can improve the validity of the data collected.

The self completion format questionnaire, with no researcher present, is recognised as being useful when collecting sensitive or controversial data as respondents may be more truthful in answering questions anonymously, away from the researcher (Wellings et.al. 1994).

Self completion questionnaires also avoid any bias due to the manner of the researcher which may be apparent during interviews and other data collection methods involving the physical presence of the researcher. However, due to the private nature of the data collection, there is no control over how the questionnaire is completed, or indeed over who is completing the questionnaire. Another drawback to this form of data collection is that it is impossible to ensure that respondents answer all of the questions or follow instructions correctly.

Another threat to the validity of the data collected by self completion questionnaires arises from the possibility of low response rates. Hall and Hall (1996) stated that although well conducted mail questionnaires with response rates of 60 - 75% have been reported it is not uncommon for the response rate to fall below 50 per cent. This raises the problem of bias, are those who did not respond significantly different from those who did ?

6.1.2 Interviews

The second data collection method used was face to face interviewing. From a methodological stand point interviews can be valuable as a second data collection method in conjunction with questionnaires. This is because, as Hall and Hall (1996) stated, the advantages and disadvantages of interviews are the reverse of those for postal questionnaires.

The threat to validity inherent in the rigid structure of the questionnaire is no longer present in the semi-structured or unstructured interview, clarification, prompts and probes can all be used and the data collection exercise can take on an almost conversation like structure.

The second threat to validity in the questionnaire is the lack of control over answering questions, this is more easily controlled in the interview. Explanations and clarifications can often be given, varying in detail depending upon how structured or unstructured the interview is intended to be.

Bias is introduced into the interview by the presence of the researcher. The age, ethnicity, appearance and sex of the interviewer may all affect the data collection process. It can be possible to introduce bias by attaching more importance to

some statements that the subject makes using verbal and non-verbal cues of interestedness or lack of interest in what is being recounted.

Although response rates are high with interviews, Hall and Hall (1996) state that once entry is gained there is an 80 per cent response rate with interviews, it is a time consuming and exhausting procedure for the interviewer and therefore numbers of informants may be small compared to those obtained with the questionnaire format. This is a threat to population validity, how representative of the population of interest are the respondents? Of course, interview subjects may be chosen because they are not representative of the majority of the population of interest.

The interview does have problems when sensitive issues are being discussed, informants may not be as forthcoming to a researcher who is physically present as they may be to one who is absent, as is the case with the postal questionnaire format.

6.1.3 Triangulation

It can be seen that the use of two different data collection techniques can enhance the validity and reliability of the data collected when the strengths of one method make up for the weaknesses of the other. This form of triangulation was used to enhance the reliability and validity of the data collected in this study from UK homoeopaths by the use of questionnaires and interviews.

6.2 Details of the questionnaires

The questionnaires used to collect data from both medically qualified homoeopaths and professional homoeopaths were essentially similar with slight differences being made to collect some of the demographic data and also with some of the questions related to their motivation to begin homoeopathic practice.

Both questionnaires were four pages in length, printed on both sides of a sheet of white A3 size paper, folded in half to give an A4 size booklet (See Appendix A and Appendix B).

An initial pilot questionnaire was sent to 80 homoeopaths. From this sample 40 completed and returned a questionnaire, the results from these pilot questionnaires gave rise to some slight amendments to the questionnaire and this new version was then sent to the remainder of the sample.

6.2.1 Sample selection

Questionnaires were sent to a randomly generated sample of homoeopaths who appeared on the then current registers of the Society of Homoeopaths (the largest registering body for professional homoeopaths in the UK) and the Faculty of Homoeopathy (the registering body for medically qualified homoeopaths in the UK). The subjects were selected by sending a questionnaire to every alternately named homoeopath in each of the registers who was then currently practising in the UK mainland.

Questionnaires were posted to 200 professional homoeopaths in total, with a postage paid business reply envelope. Questionnaires were sent to 100 medically qualified homoeopaths in total, also with a postage paid business reply envelope. Professional homoeopaths completed and returned 100 questionnaires (50% response rate) and 57 completed questionnaires were received from medically qualified homoeopaths (57% response rate). There were therefore a total of 157 questionnaires returned from all homoeopaths giving a response rate of 52.3%.

6.2.2 The structure of the questionnaire.

Although essentially similar some different questions were asked on the questionnaires for medically qualified homoeopaths and professional homoeopaths.

All homoeopaths were asked to state their age and sex, when they started to practise homoeopathy and the name of any training course they had attended along with the duration of the course.

All homoeopaths were also asked the duration of consultations they held with homoeopathic patients, and how many patients were seen, on average, in a month. All homoeopaths were asked if they worked as a homoeopath on a full time or part time basis, if they were part time homoeopaths they were asked what percentage of their work time was spent practising homoeopathy. All homoeopaths

were also asked if they saw homoeopathic patients within the National Health Service system or in private practice.

Different questions were then asked of professional homoeopaths and medically qualified homoeopaths to elicit similar information, these differences were unavoidable as the experiences of the respondents would be different depending on whether they were medically qualified or not. Medically qualified homoeopaths were asked when they had qualified from medical school and what posts they had held since qualifying as a doctor. Professional homoeopaths were asked what their occupation had been prior to their work as a homoeopath and if they were not working as a full time homoeopath what, if any, other occupation they were undertaking for the remaining time.

Opinions were then sought from all homoeopaths, using identical items on the questionnaires, on whether they thought that homoeopathy was an alternative or complementary practice, homoeopathy was more or less holistic than conventional medicine, the attitude of conventional doctors to homoeopathy, whether patients should only be allowed access to homoeopathy via their General Practitioner and whether statutory registration should be introduced for professional homoeopaths and medically qualified homoeopaths.

A set of visual analogue scales were used to collect data from both medically qualified homoeopaths and professional homoeopaths on the respondent's perception of the interaction between homoeopath and patient. Respondents were asked to score how much input was supplied by the patient in certain aspects of decision making during the consultation.

Although both groups of homoeopaths were provided with a free response section to provide data on why they had started to use homoeopathy, the medically qualified homoeopaths were also given a closed response method of answering this question which allowed them to rank the top three reasons from a selection of six given motivations all of which were developed from interview responses with medically qualified homoeopaths that had been previously conducted. These six reasons were not always appropriate or applicable for professional homoeopaths and were therefore not included in the questionnaire for professional homoeopaths.

Other differences in the questionnaires for professional homoeopaths and medically qualified homoeopaths were that medically qualified homoeopaths were asked if the homoeopathic consultation was more patient centred than a conventional medical consultation, professional homoeopaths were not asked this as it would be unlikely that they could meaningfully compare the two consultations from a practitioners point of view whereas the medically qualified homoeopaths had all carried out conventional medical consultations, and many still did so alongside their homoeopathic practice.

In place of the patient centredness item, professional homoeopaths were asked, in a free response item, what they enjoyed about their work as a homoeopath. When data was analysed it was found that the professional homoeopaths often wrote, implicitly, about the patient centredness of their work as being an enjoyable aspect for them. Medically qualified homoeopaths often wrote about aspects of their work that they enjoyed when they completed the free response section on why they had started to practise homoeopathy.

The use of free response sections after many of the closed response items was often seen to elicit similar information from the medically qualified homoeopaths and the professional homoeopaths, even though the data had been sought by the use of different questions.

Finally, after the pilot phase, two additional items were added to the questionnaire. Firstly a fourth visual analogue scale was added to the existing three scales that explored patient input in consultations. This last scale investigated who the homoeopaths thought was responsible for improvements in the patient's health, the patient or the homoeopath. This was added following comments made in the free response sections of the pilot questionnaires.

Secondly, following comments made by two professional homoeopaths during informal discussions, an item was added that asked both professional homoeopaths and medically qualified homoeopaths whether there should be legally enforced limits placed upon the disorders that professional homoeopaths might be allowed to treat.

All questionnaires were sent out to the respondents with a covering letter explaining the reasons for undertaking the study, to collect data for a research degree with City University. The letter also explained that although some American studies have researched chiropractors and osteopaths, no recent work had specifically studied homoeopaths working in the UK. By representing them as an under-researched, possibly misunderstood profession, it was hoped that the response rate would be increased.

6.3 Details of the interviews.

The subjects interviewed were not randomly selected. The interviewing took place in two phases. The first phase of interviewing took place before designing and distributing the questionnaires. The second phase took place after the analysis of the returned questionnaires and subjects were chosen based on some of the data collected with the questionnaires.

6.3.1 First Round Interviews

The initial interview phase was carried out on a convenience sample. The professional homoeopaths were recruited when contact was made with one of the London based training colleges for professional homoeopaths. Interviews were then arranged with two homoeopaths who were teaching at the college but also ran homoeopathic practices and three graduates of the college who were all working as professional homoeopaths in a part time or full time capacity, based in the south of England within fairly easy reach of London.

The medically qualified homoeopaths in the initial interview phase were all working together in a practice linked to a large teaching hospital in Britain. The director of the department was initially contacted as a renowned opinion former within medical homoeopathy, with a view to obtaining an interview. Although this director was not available to be interviewed it was arranged for three willing colleagues to be interviewed.

All interviews were carried out singly, face to face with one interviewer in the subject's place of work. All interviews were audio tape recorded and then fully transcribed. The same interviewer carried out all eight interviews in the primary

interview phase. Interviews with medically qualified homoeopaths lasted around 25 - 30 minutes each and the professional homoeopath interviews lasted 45-60 minutes each.

Data from this initial round of interviews was used to aid in the design of the questionnaire sent to both medically qualified homoeopaths and professional homoeopaths. Data from the questionnaire was then used to select homoeopaths for interview in the second round of interviews

6.3.2 Second Round Interviews

Homoeopaths who had achieved a high score on a 'potential dissent scale' derived from answers to various items in the questionnaire were selected for interview in the second round. As the questionnaire had been administered as an anonymous postal questionnaire it was also necessary for the high scoring homoeopaths to have agreed to be interviewed by supplying their name and contact details on the last page of the questionnaire. It was found that those questionnaire respondents who had made the slightly more controversial responses that led to a higher score on the 'potential dissent scale' were significantly less likely to agree to an interview and supply the necessary contact details than those respondents scoring lower on the 'potential dissent scale'. This is not surprising as sensitive issues are more likely to be addressed when anonymity is offered, and those making the more 'controversial' statements would only do so under the cover of anonymity. This state of affairs produced a dilemma in which only a small number of homoeopaths scored sufficiently highly on the 'potential dissent scale' to warrant further investigation ($n = 19$) and an even smaller subset of these homoeopaths supplied contact details to enable second round interviews to be undertaken.

Among the medically qualified homoeopaths there were three respondents whose scores were sufficient to warrant further interview but unfortunately none was identified and available for interview. From the professional homoeopaths a sample of three was selected from the nine who had sufficiently high scores and who had made their identities known and were therefore available for interview. Two of these interviews were carried out in the homoeopath's work place following an initial telephone contact. The last interviewee was seen at the researcher's work place in a private office. All three interviews were carried out singly and face to face by the same interviewer. All interviews were audio tape recorded and then

fully transcribed. The second round interviews all lasted in excess of 90 minutes and the longest was just over 2 hours 30 minutes in duration.

All interviews were of the semi-structured type in that there was a list of topics that were to be discussed but the respondent was allowed to range freely around these topics without being brought back to a rigidly structured set of carefully worded questions (Hall and Hall 1996). A checklist was used as an *aide mémoire* to assist the interviewer in ensuring all topic areas were addressed during the interview. This semi-structured style allowed for the interaction to become more of an 'informal discussion' where the respondent may branch off from, or add depth to, a topic without being restrained by the interviewer. Although this was more time consuming during the conduct of the interview, as well as during the subsequent transcription and analysis of the data, it was useful when the interview was being used as a second method of data collection in addition to postal questionnaires as the 'live' interaction allowed probes to be used by the interviewer and gave the interviewer the opportunity to add depth to the data (Hall and Hall 1996).

6.3.3 Topics for discussion

The main topic for discussion in the initial round of interviewing for both the medically qualified homoeopaths and the professional homoeopaths was the reason for starting out in homoeopathic practice. Other topics discussed with the medically qualified homoeopaths were similar to the items on the questionnaire. Topics included when the respondent had qualified as a doctor, when they had started to use homoeopathy and what posts they had held after qualifying in medicine. Opinions were also sought regarding the respondents perception of their conventional colleagues attitudes to their work as homoeopaths and also on how they thought their consultations differed from those of a conventional doctor. Finally opinions on their opposite numbers, the professional homoeopaths, were sought including whether it was felt that state registration was necessary.

In addition to the professional homoeopath's motives for practising homoeopathy, discussion included how long they had been qualified to work in homoeopathy and what had been their occupation before becoming a homoeopath. Opinions were sought regarding registration of professional homoeopaths and the need for GP gatekeepers, whether homoeopathy was an alternative practice or a complementary practice and also whether the interviewee had ever been treated

by heterodox therapies prior to their working in homoeopathy. Finally opinions regarding their opposite numbers, the medically qualified homoeopaths, were sought, especially regarding the perceived differences in the ways in which professional homoeopaths and medically qualified homoeopaths use homoeopathy to treat patients.

The interviews with professional homoeopaths in the second round of interviews also centred on reasons for becoming a homoeopath. Other topics discussed included what their occupation had been prior to becoming a homoeopath, and whether they had received heterodox therapy prior to their becoming a homoeopath. Greater emphasis was given in these second round interviews to discussing the relationship between the homoeopath and the patient as well as debating who was seen as being responsible for improvements in the patients condition. The respondents personal explanation of homoeopathy and how it works was sought. Opinions were sought in greater detail regarding whether homoeopathy was an alternative or complementary practice and whether statutory registration and GP gatekeeping was necessary for professional homoeopaths.

6.4 Analysis of data

The questionnaires consisted of both closed and open response items and the data collected from these had to be analysed in different ways.

6.4.1 Quantitative questionnaire data

The quantitative data from the closed response items was codified and entered onto a computer spreadsheet (Microsoft Excel 5.0). A range of data had been collected at different levels of measurement, for example nominal data relating to sex and whether the respondent was medically qualified or not was collected along with yes / no responses from items on the need for registration and legal limitation of practice for professional homoeopaths. Ordinal data was collected from the interaction visual analogue scales and the 'potential dissent scale' and finally parametric data was collected on age, length of time in practice, number of patients seen per month and length of consultation.

In order to analyse this data it was exported from the Excel spreadsheet and imported into a specialist software package that allowed statistical analysis to be undertaken, both descriptive statistical analysis and inferential statistical analysis. This software package was Statistical Package for the Social Sciences (SPSS for Windows v6.0).

A range of descriptive statistical analyses were performed on frequencies, measures of central tendency and spread of data. Inferential statistical analysis was also performed. Variances in nominal data were analysed using the chi-squared test (χ^2). Ordinal data were analysed using the Mann-Whitney one way analysis of variance. Where parametric data had been collected analysis of variance was undertaken using the unrelated student's t-test. Analysis of correlation was calculated using the Spearman's Rank Order Correlation Coefficient, this is a correlation coefficient suitable for analysis of ordinal data. All inferential statistical analysis utilised two-tailed tests and the level of significance was set at $p \leq 0.05$.

6.4.2 The 'Potential Dissent Scale'

The software package SPSS allows data transformations to be made and using this feature a 'potential dissent scale' was devised from weighted factors calculated from the variables used to measure;

- whether homoeopathy is alternative or complementary (SPSS variable = ALTCOMP);
- the degree of control given to the patient in the interaction scales (3 SPSS variables = WOTTREAT, TREATUSE, DIAG);
- the motivation for becoming a homoeopath being related to a dissatisfaction with conventional medicine (SPSS variable = DISATCON);
- the perception of conventional medicine's view of homoeopathy (SPSS variable = CONVIEW);
- opinions regarding imposition of statutory registration for professional homoeopaths (SPSS variable = PROFREG);
- opinions regarding who brings about improvements in the patients health (SPSS variable = IMPROVE).

All of the variables used were derived from nominal or ordinal data taken from the questionnaire with the exception of the variable DISATCON. This variable consisted of nominal data on whether dissatisfaction with conventional medicine was given as a motive for starting homoeopathic practice. In order for a respondent to score a positive response (yes, dissatisfaction with conventional medicine was mentioned as a motive for starting homoeopathic practice) they had to either rank dissatisfaction with conventional medicine as their first or second choice from six motives on the medically qualified homoeopaths questionnaire or had to mention dissatisfaction with conventional medicine in the free response sections on either the professional homoeopath questionnaire or the medically qualified homoeopath questionnaire which gathered data on motives for starting in homoeopathic practice. Some respondents used phrases that did not explicitly include the words 'dissatisfied with conventional medicine' but which implied such dissatisfaction and a decision had to be made by the researcher as to whether they could be included in the category of those dissatisfied with conventional medicine or not. This was often easier to do than it seems as often the remarks made were strongly negative with regards the use of conventional medicine.

The final model for calculating the 'potential dissent scale' was as follows;

Variable	Possible Score	Inclusion Criteria and Weighting
WOTTREAT	0 - 10	> 6 = 1.5 > 8 = 2.0
IMPROVE	0 - 10	> 6 = 1.5 > 8 = 2.0
DIAG	0 - 10	> 6 = 1.0
TREATUSE	0 - 10	> 6 = 1.0
ALTCOMP	Alternative Complementary Both Neither	Alternative = 2.0
DISATCON	Yes No	Yes = 2.0
CONVIEW	Negative Neutral Positive	Negative = 1.5
PROFREG	No Yes	No = 1.0

Figure 6.1 The Potential Dissent Model

The scores from the various sub sections of the model were added together to give a possible range of scores from 0 to 12.5, where 0 can be seen as no potential dissent and 12.5 would indicate high levels of potential dissent.

This high level of dissent would indicate a homoeopath who feels that the patient has a high level of control in the consultation, and that it is the patient who is responsible for bringing about any healing in themselves. They would also regard homoeopathy as an alternative therapy rather than a complementary one, they express dissatisfaction with conventional medicine, feel that conventional doctors have a negative opinion of homoeopathy and are not in favour of introducing a form of statutory registration of homoeopaths along the same lines as the osteopaths.

The resultant 'potential dissent' score was used in the inferential statistical analysis as ordinal data. A threshold level was set at 5.5 to indicate a high level of potential dissent. Those whose dissent score was 5.5 or above were considered potential dissenters, while those below 5.5 were not considered to be potential dissenters. This data was then used in nominal inferential statistical analysis.

6.4.3 Qualitative questionnaire data

The responses to the open response items on the questionnaires were transcribed into two documents, one for professional homoeopaths and one for medically qualified homoeopaths. Each of these documents was then scrutinised and codified to produce common themes within each group of homoeopaths and between the two groups, these were analysed to allow a comparison to be made between the professional homoeopaths and the medically qualified homoeopaths. Much of the data was in the form of additional comments made after a response had been made to a closed response item, often by way of providing a justification for the response or giving an example of a circumstance when a response might not hold true.

6.4.4 Interview data

All interviews were audio tape recorded and therefore the first stage of analysis was the transcription of these interviews into text. Once transcribed the interview data were used for a number of different purposes. There was, however, a common theme running through the uses to which the data would be put, this was

the theme of comparison. Initially the comparisons were between the professional homoeopaths and the medically qualified homoeopaths and therefore it was important that comparable data were recorded in the interviews with each group of homoeopaths and that this data was then made available for analysis (Mason 1996). In order to achieve this common themes were identified in the data and these were extracted from the whole interview transcript. Originally this material was extracted to a number of files of relevant data segments, one for each interviewee in the first round of interviews. These data files were then scrutinised and where similar themes were identified in separate interviewee files these were amalgamated in order to build up files related to themes discussed and explained in the interview rather than interviewee based files. These themed files were then used to compare the responses of professional homoeopaths and medically qualified homoeopaths on a number of issues.

In the second round interviews comparisons were also made, however as no medically qualified homoeopaths were available for interviews the comparisons could only be made between those professional homoeopaths with high potential dissent scores, who made up the subject group for the second round of interviews, and those professional homoeopaths already interviewed in the first round interviews all of whom had subsequently completed questionnaires and had low dissent scores. In this way a comparison was made between two groups of professional homoeopaths with different dissent scores enabling an analysis of differences in their opinions and attitudes. Once again the themes from the high dissent score professional homoeopaths were extracted and then used to form thematic files with the first round professional homoeopath interviews. A further method of analysis was used on the second round interview data and open response item data from the questionnaires. This method was a discourse analysis, used to further examine the differences between professional homoeopaths with either high or low scores on the potential dissent scale.

6.4.5 An overall analysis of the practice of homoeopathy now and in the future

Finally an analysis of all of the data collected was undertaken with the aim of producing a theory of the methods of homeopathic practice as it is carried out in the UK. Was there a difference in the style of practice between those who might be grouped as potential dissenters and those who could be seen as

professionalisers ? Further to this there was the aim of enabling the prediction of a likely course of events for the future practice of homoeopathy in the UK.

7 RESULTS

Questionnaires were sent through the post to 200 professional homoeopaths and 100 medically qualified homoeopaths. These practitioners were randomly selected from the registers of the Society of Homoeopaths and the Faculty of Homoeopathy. The numbers represented just over 50% of the practitioners on these registers who were then practising in the United Kingdom, homoeopaths whose practices were overseas were excluded from the study.

7.1 Response rate

One hundred professional homoeopaths and 57 medically qualified homoeopaths responded to the postal questionnaire. Due to the anonymous nature of the data collection it was not possible to send follow up letters and questionnaires to non-responders. The response rate was therefore 50% for professional homoeopaths and 57% for medically qualified homoeopaths. The overall response rate for all homoeopaths was therefore 52%. The responses received therefore represent the opinions of 26% of the practitioners on the Faculty of Homoeopathy and Society of Homoeopaths registers.

Homoeopaths, possibly in common with many other heterodox health care practitioners, may be very wary of questions from outsiders regarding their practice. A distrust of questioners was displayed by a small number of respondents, all of them professional homoeopaths, who added comments at the end of the questionnaire after completing it. Examples of the comments were;

'Is your research funded by drug companies who are scared we can cure what they cannot!'

'Who pulls your strings ?'

'What are your motives ?'

'I have been stung once before when an article about homoeopaths was published and was derogatory.'

These statements accompanied either a refusal to answer certain questions on the questionnaire or a refusal to an optional request to supply contact details to demonstrate their willingness to be interviewed at a later date if requested.

This reticence to talk about themselves and their work may be evident in a greater number of homoeopaths who felt that they would rather not return the questionnaire at all and could account for a proportion of the non-responses.

The interview data reported here has been anonymised. The professional homoeopaths were given the letters A to H to identify them. The medically qualified homoeopaths were identified by the letters X to Z. The interviewer is identified in the quotes by the term 'Int'.

The professional homoeopaths A to E were interviewed prior to the sending out of the questionnaire, while F to H were interviewed after they had returned a questionnaire and were selected for interview based on their high potential dissent scores. The medically qualified homoeopaths X, Y and Z were all interviewed prior to the dispatching of questionnaires, no medically qualified homoeopath who scored highly on the potential dissent scale gave their name and address for interview contact purposes and therefore no potentially dissenting medically qualified homoeopaths were interviewed.

7.2 Demographic data

7.2.1 Age

The mean age of all respondents was 48 years, with a range of 28 to 78 years. When the group was divided into professional homoeopaths and medically qualified homoeopaths the mean ages were 46 for the professional homoeopaths and 52 for the medically qualified homoeopaths. The medically qualified homoeopaths were therefore older on average than the professional homoeopaths. This difference in ages was found to be significant when an unrelated t-test was applied to the data ($t = 4.11$; $p < 0.001$).

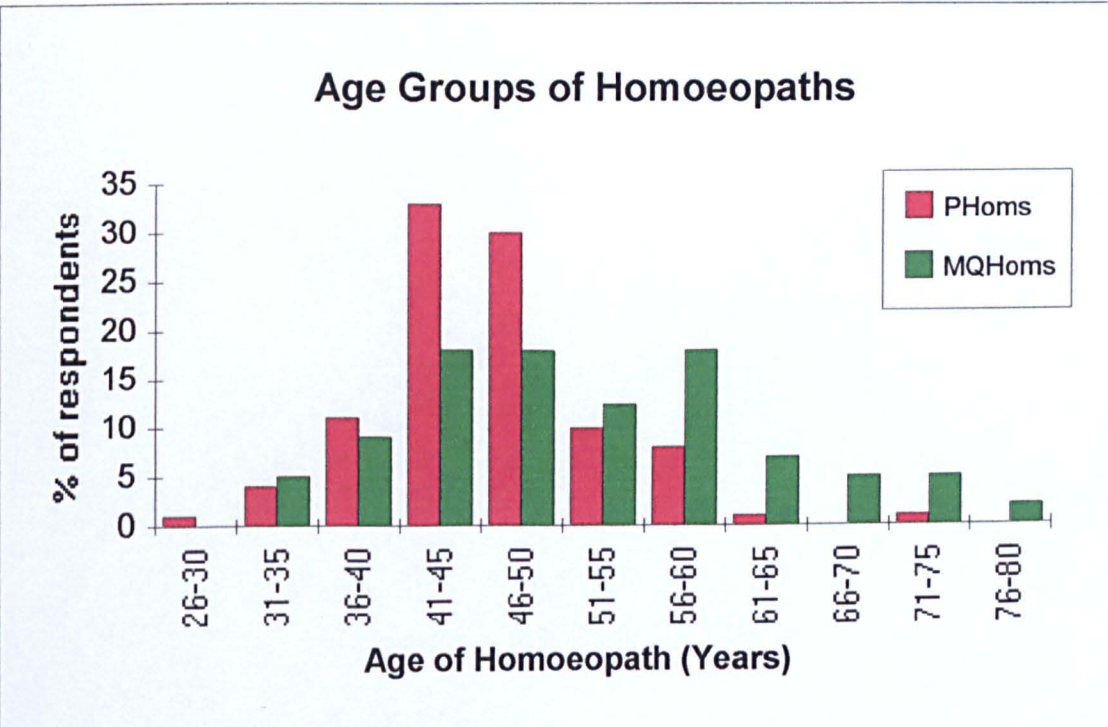


Figure 7.1 Age groups of homoeopaths

7.2.2 Sex

Sixty per cent of all homoeopaths were female, however, when professional homoeopaths and medically qualified homoeopaths were inspected separately a difference became apparent. In the professional homoeopaths females accounted for 78%, whilst females in the medically qualified homoeopaths numbered 29%. When a χ^2 test was applied to these data the difference in sex ratios was shown to be significant ($\chi^2 = 36.62$; $df = 1$; $p < 0.00001$).

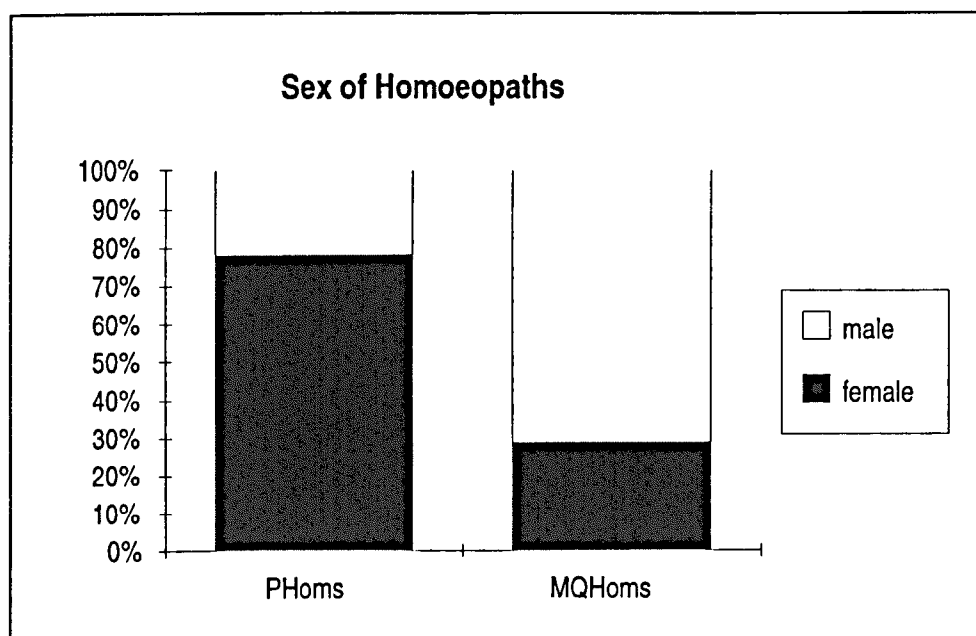


Figure 7.2 Sex of homoeopaths

7.2.3 Age when started homoeopathic practice

The mean age for starting homoeopathic practice was 36 years for all respondents. The range was from 23 to 59 years. For professional homoeopaths the mean start age was 38 and for medically qualified homoeopaths it was 34. Although the difference appears small it was found to be significant when an unrelated t-test was applied to the data ($t = 3.77$; $p < 0.001$). These data therefore show that although professional homoeopaths were, on average, younger than their medically qualified counterparts, they started to practise homoeopathy at a later stage in their lives.

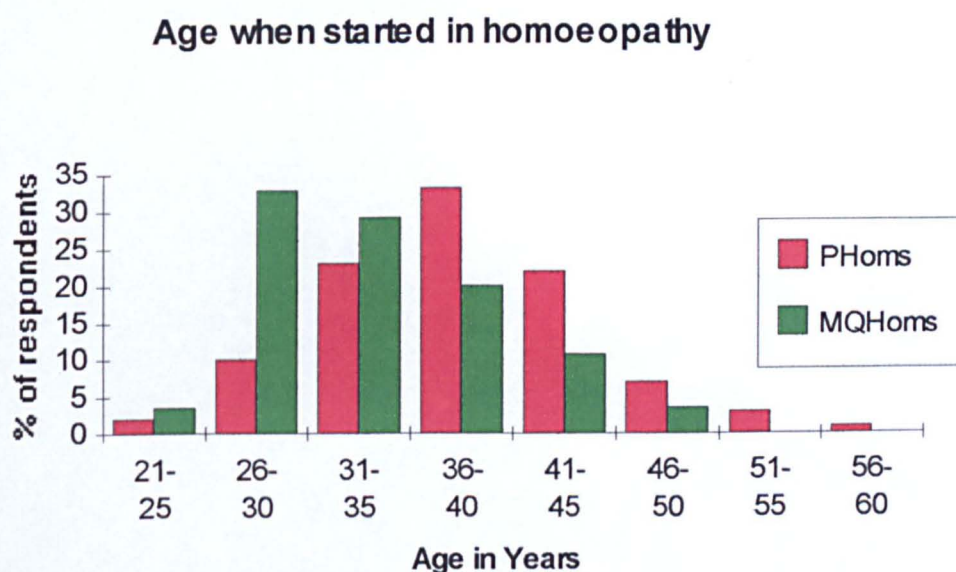


Figure 7.3 Age when started in homoeopathy

7.2.4 Length of time as a qualified homoeopath

The mean length of time qualified as a homoeopath was 11 years for all respondents, the minimum being 1½ years and the maximum 47 years.

When looked at separately the professional homoeopaths average was 8 years and the medically qualified homoeopaths average was 17 years. The difference was significant when an unrelated t-test was applied to the data ($t = 9.21$; $p, 0.001$).

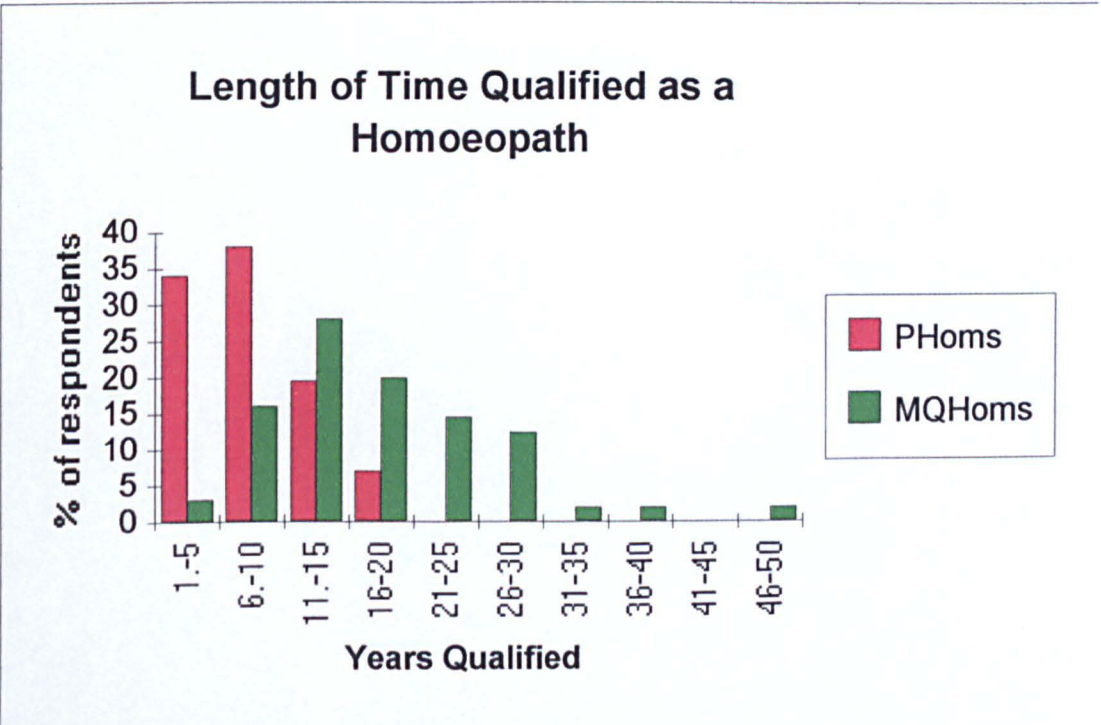


Figure 7.4 Length of time qualified as a homoeopath

7.2.5 Duration of homoeopathic training course

The mean duration of training course for all respondents was 3.25 years with the mode being 4.0 years.

When separated the mean duration of course for professional homoeopaths was 4.25 years and that for medically qualified homoeopaths was 1.5 years, the modal values were 4 years for professional homoeopaths and 3 months for medically qualified homoeopaths.

In each group there was one respondent who stated that they had received no formal training course from an educational establishment, either the Faculty of Homoeopathy or one of the schools and colleges of homoeopathy training professional homoeopaths.

The difference between professional homoeopaths and medically qualified homoeopaths in the length of training courses was found to be significant when an unrelated t-test was applied to the data ($t = 14.0$; $p < 0.001$).

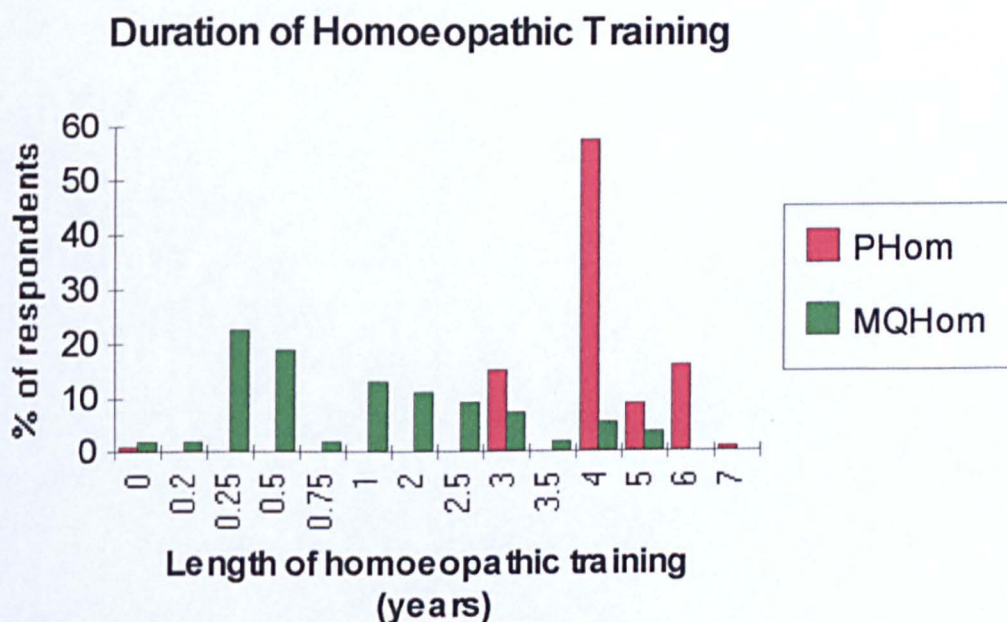


Figure 7.5 Duration of homoeopathic training

7.2.6 What occupation was undertaken prior to homoeopathy ?

Eighty six professional homoeopaths listed a previous occupation. Of these, 22 gave a health care related profession as their previous occupation. Out of the health care related professionals 9 were nurses or midwives, one was a dental nurse and there was a pharmacist, a dietician, an occupational therapist and a paramedic. Some of the other health care related occupations given were doctor's receptionist and microbiologist in the public health laboratory service. Others were involved in heterodox health care other than homoeopathy prior to entering into homoeopathic practice. These included a chiropractor, a counsellor and a yoga teacher who also worked in nutrition.

The next largest group consisted of 15 professional homoeopaths who had a teaching background, ranging from university lecturers and deputy head teachers of secondary schools, to a number of support teachers in special needs.

Social work, secretarial work and working in the arts were all well represented with 6 professional homoeopaths having worked previously in each of these categories.

The medically qualified homoeopaths were all conventionally trained doctors prior to their involvement with homoeopathy. With one exception, who had started a private homoeopathic practice within one year of qualifying from medical school, all had worked in the National Health Service as conventional doctors prior to using homoeopathy. On average doctors started using homoeopathy just under ten years after qualifying from medical school.

When medical specialities were considered 43 of the 52 doctors who supplied this data had worked in general practice prior to using homoeopathy. On average the respondents entered general practice 4 years after qualifying from medical school.

7.2.7 If homoeopathy was not their only employment what other work was undertaken ?

Professional homoeopaths were not all employed on a full time basis in homoeopathy, 43 listed other work that they undertook in addition to their practice as a homoeopath. Of these part timers ten listed work in another aspect of homoeopathy other than as a practitioner, 5 taught in homoeopathic colleges, 2

worked in homoeopathic pharmacies, 2 were involved in work for the Society of Homoeopaths and one produced specialised computer software for homoeopaths.

A further ten professional homoeopaths were working in a health care related field, these were one nurse, a psychotherapist and a dietician, and counselling was listed by three professional homoeopaths. The remaining four professional homoeopaths were also working in other heterodox health care practices, these were one each in chiropractic, radionics, healing and 'Bio-Mobility'.

Part time teaching was listed by 6 professional homoeopaths, the work ranging from teaching water-colour painting to working as a tutor in the Open University.

7.2.8 Summary of demographic data

If the demographic data is regarded in a more holistic fashion, it is possible to speculate that in the group of homoeopaths who responded to the questionnaire, there is a higher probability that a professional homoeopath is;

- a female;
- in her mid to late forties;
- who has been working as a qualified homoeopath for less than ten years;
- previously worked in a health care related occupation or as a teacher;
- and has attended a four year homoeopathic training course.

There is a higher probability that a medically qualified homoeopath is;

- a male;
- in his early fifties;
- who has been working as a qualified homoeopath for more than ten years;
- has spent some time working as a General Practitioner;
- and has attended a homoeopathic training course lasting one year or less.

7.3 Data regarding the practice of homoeopathy

7.3.1 Number of homoeopathic patients seen in a month

The mean number of homoeopathic patients seen per month for all respondents was 81, however there was a high level of variation in these data, the range was 3 to 600. Standard deviation was 83, the median value was 55 and the mode was 40.

The professional homoeopaths saw, on average, 60 patients per month with the medically qualified homoeopaths seeing 123 patients per month, just over double that for professional homoeopaths. Among the professional homoeopaths none saw more than 200 patients in a month while 11% saw in excess of 100 patients. Among the medically qualified homoeopaths 18% claimed to see more than 200 patients per month and 43% saw in excess of 100 patients.

The difference between professional homoeopaths and medically qualified homoeopaths in the mean number of patients seen per month was significant when an unrelated t-test was applied to the data ($t = 4.63$; $p < 0.001$)

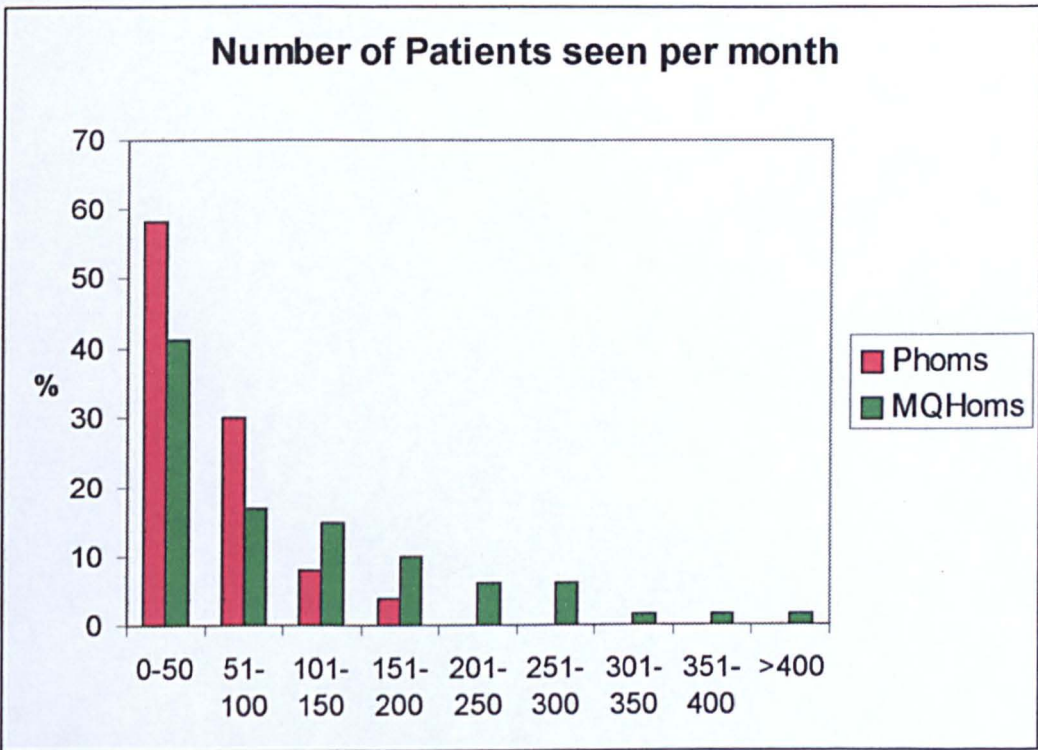


Figure 7.6 Number of patients seen per month

7.3.2 Length of consultation - new patient

The mean duration of consultation for a new patient was 75 mins for all respondents. The mean duration for professional homoeopaths was 88 mins and for medically qualified homoeopaths 53 minutes.

The most frequently quoted times for professional homoeopaths were 90 minutes (51% of responses) and 60 minutes and 120 minutes (17% each). For medically qualified homoeopaths the modal time was 60 minutes (59% of responses) with 30 minutes the next most frequently given time (11% of responses). The difference between the mean times for professional homoeopaths and medically qualified homoeopaths was found to be significant when the unrelated t-test was applied to the data ($t = 10.99$; $p > 0.001$).

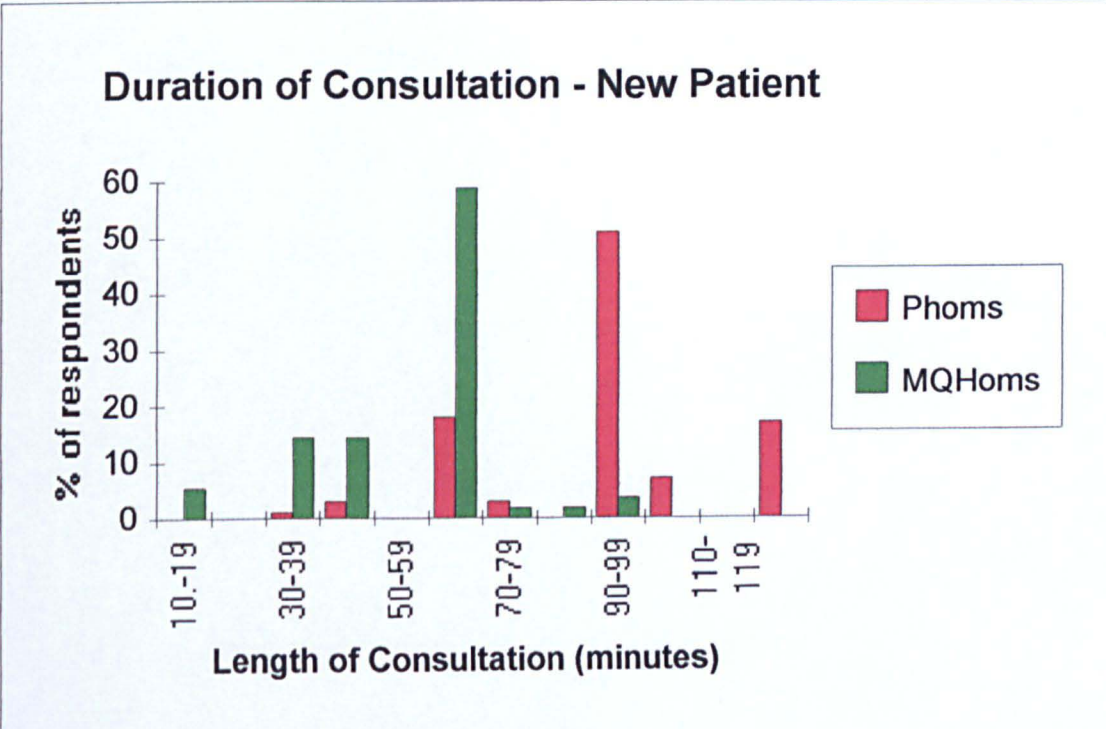


Figure 7.7 Duration of consultation - new patient

7.3.3 Length of consultation - follow up patient

The mean follow up consultation time was 40 minutes for all respondents. On average the professional homoeopaths saw follow up patients for 46 minutes and medically qualified homoeopaths saw them for 28 minutes. The difference between follow up consultation times was found to be significant when an unrelated t-test was applied to the data ($t = 6.53$; $p < 0.001$).

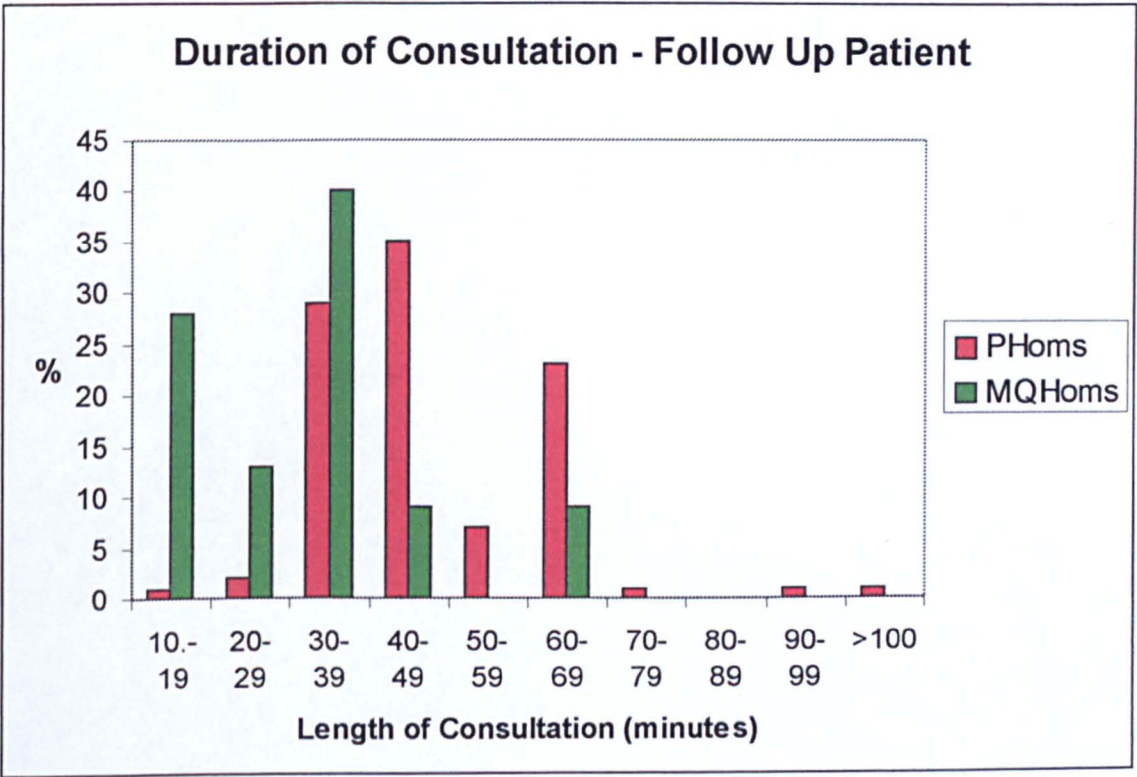


Figure 7.8 Duration of consultation - follow up patient

7.3.4 Work in the National Health Service

None of the professional homoeopaths worked exclusively with NHS patients, 9% of medically qualified homoeopaths worked exclusively with NHS patients. Eleven per cent of professional homoeopaths saw a mixture of NHS patients and private fee paying patients, the remaining 89% seeing only private patients. Working with both NHS patients and private patients was reported by 56% of medically qualified homoeopaths with 35% reporting working only with private patients.

	Professional homoeopaths	Medically qualified homoeopaths
NHS Only	0	5
Both NHS & Private	11	32
Private Only	89	20

Figure 7.9 Private work and National Health Service work

This difference between professional homoeopaths and medically qualified homoeopaths was found to be significant when a χ^2 test was performed ($\chi^2 = 50.9$; $df = 2$; $p < 0.00001$), although with one cell containing less than 5 responses this is a less satisfactory result from the χ^2 test.

Professional homoeopaths expressed some doubts in interviews about working within the NHS;

- C I think there's advantages and I think there's disadvantages and I think we shouldn't leap quite so quickly as it seems to be going.
- D ... but I feel there are real dangers in rushing in to the NHS.
- H I can't see the advantages of it, not for me, I like working for myself. I like working with groups of people but I like that thing about not having to have a hierarchical model, that's where I came from. I don't want to go back to that.

The reasons for these doubts were often given;

- C** If we go into the NHS we run several risks. Losing our autonomy is one that's mentioned in particular ... Do we get back into the bureaucracy of the whole thing again.
- B** I think the arguments against working in the NHS are all with regard to people having to compromise their ethics, such as vaccinations or antibiotics or limiting the types of illnesses one treats.
- D** Are you able to practice in the way that you wish to practice, are you willing to practice an adulterated version of homoeopathy ?

Others were more in favour;

- A** But I do think that that is part of the way forward, is for us to be in health centres where there's a range of therapies or alternatives available, and conventional stuff.
- B** We should be working hand in hand with GP practices ideally.
- D** My ultimate aim would be that homoeopathy was more widely available. And private practice gets in the way of that ...

One professional homoeopath felt that status was a motive for some professional homoeopaths who did wish to work within the NHS;

- E** There are too many professional homoeopaths who want to be seen as doctors, that's what it's all about, they want the status of a doctor. Men, mainly, it has to be said, in the profession, who want the status of being a doctor, they want equal footing and to be respected in the same way.

7.3.5 Full time or part time homoeopath

Full time homoeopathic practices were reported by 60% of professional homoeopaths and 52% of medically qualified homoeopaths. Less than half time homoeopathic practices were reported by 16% of professional homoeopaths and 32% of medically qualified homoeopaths. The mean percentage work time spent in homoeopathic practice was 80% for professional homoeopaths and 65% for medically qualified homoeopaths. A Mann-Whitney analysis of variance showed that this difference did not quite attain significance ($U = 22.3$; $p = 0.0532$; NS).

For the 40% of professional homoeopaths who did not have full time homeopathic practices almost one quarter (24%) also worked in another form of health care,

either another form of heterodox health care such as radionics or chiropractic, or they could be working in an orthodox health care profession such as dietetics or nursing. Counselling proved to be a popular second line of work.

A further 24% worked in a non-patient oriented field of homoeopathy as a second line of work, this included teaching homoeopathy at a college, working in a homoeopathic pharmacy or working for the Society of Homoeopaths in some way.

Twelve per cent of those with second jobs were teachers, other than those listed above as teaching homoeopathy. Some of these respondents taught at degree level in subjects ranging from Heritage Management to Occupational Therapy. Some of the less frequently reported other jobs included antique restoration, writing on health related topics and square-dance calling.

All of the medically qualified homoeopaths worked in conventional medicine in addition to homoeopathy if they were not full-time homoeopaths. One medically qualified homoeopath stated that she used other forms of treatment than conventional medicine and homoeopathy, these included art therapy and psychotherapy. She stated that 10% of her work time was spent using homoeopathy.

7.3.6 Summary of homoeopathic practice data

It is possible to speculate that when a patient sees a professional homoeopath there is a high probability that they will;

- have an initial consultation of 90 minutes or more;
- have a follow up consultation of 40 minutes or more;
- be paying a fee for their consultation;
- see a homoeopath who does no other form of work outside of health care.

It is possible to speculate that if a patient sees a medically qualified homoeopath there is a high probability that they will;

- have an initial consultation of 60 minutes or less;
- have a follow up consultation of 30 minutes or less;

- be paying a fee for their consultation, although there is a greater probability that they will be an NHS patient;
- see a homoeopath who does no other form of work outside of medicine.

7.4 Data on attitudes towards homoeopathy

7.4.1 Is homoeopathy alternative or complementary

Homoeopathy was seen as a complementary practice by 47% of all respondents, 28% thought it was alternative and 21% thought it could be both complementary and alternative. The remaining 4% felt that homoeopathy was neither alternative nor complementary, one of these respondents stated that it should be called 'a complete medicine', another felt it was an 'effective, scientific form of medicine'.

Amongst professional homoeopaths 43% stated that homoeopathy was an alternative and 28% stated that it was complementary, with 26% answering that it could be both. Among medically qualified homoeopaths 2% answered that homoeopathy was an alternative with 81% answering that homoeopathy was a complementary practice, 10% stated that it could be both. When analysed using the χ^2 test this difference between medically qualified homoeopaths and professional homoeopaths was found to be significant ($\chi^2 = 49.9$; $df = 3$; $p < 0.00001$).

Sixty eight professional homoeopaths (68%) and 20 medically qualified homoeopaths (35%) made additional comments to this question.

Eight professional homoeopaths made comments which displayed the view that homoeopathy was a true alternative to conventional biomedicine;

[P4] Philosophically diametrically opposite allopathic medicine.

[P32] Totally working on a different level, philosophically, method and practice.

[P33] Obviously we cannot do without conventional medicine but the philosophy of homoeopathy is so different that I don't rate conventional medicine as complementary to homoeopathy.

- [P37] Most people come seeking an alternative form of treatment as the orthodox treatment isn't working - how can you complement something that doesn't work ! ?
- [P57] The philosophies of orthodox theory of disease and homoeopathy are entirely different. It would be very difficult to marry the two in theory.
- [P80] I don't think it complements orthodox medicine as it works on entirely different principles.
- [P92] The philosophies of homoeopathy and allopathy are diametrically opposed, so homoeopathy really must be classified as alternative, except in marginal cases (eg acceleration of fracture repair after setting in the usual way).
- [P98] Usually works in the opposite way to allopathic treatment.

The majority of statements made by professional homoeopaths indicated their view of homoeopathy as a complementary therapy that works alongside conventional medicine and that both are necessary. Examples of these statements were;

- [P8] I am a homoeopath who will work alongside orthodox medics and orthodox medication.
- [P10] Complementary, inevitably. No one approach has all the answers.
- [P16] Obvious - if I break my hip the x-ray will see it, the surgeon will set it and homoeopathic remedies will speed recovery. Oh and don't forget the anaesthetist !
- [P43] ...there are times when conventional medicine is appropriate and can be used in conjunction with homoeopathy.
- [P58] Alternative medicine would rule out any allopathic contribution, and it does have it's part to play, albeit small (in my opinion).
- [P73] Homoeopathy is equally effective alone or in combination with conventional medicine.

Some professional homoeopaths stated that homoeopathy was complementary with some reluctance;

- [P6] It could be a full alternative system, as it is in e.g. India. In reality here, I practise as a complementary therapist.
- [P76] I think it is complementary but I prefer it if the patient is able to reduce allopathic medicine as I am finding that the remedy doesn't 'hold' as well.

[P106] Ideally I would see it as an alternative medicine (within certain limits). But it is practised as a complementary because it is usually the last resort.

Two professional homoeopaths stated that homoeopathy was complementary, but not because homoeopathy complemented conventional medicine;

[P85] It complements the body's ability to heal itself.

[P96] I see every form of medicine as complementary to each other.

Two professional homoeopaths answered that homoeopathy was neither alternative or complementary and gave explanations for their answers;

[P15] [homoeopathy is] an effective scientific form of medicine based on provings and experiment, neither alternative or complementary.

[P45] For me alternative implies something to be used as second best, when the main option fails. For me allopathy is the alternative and I do not feel that either complements each other in all cases.

Statements were made by three medically qualified homoeopaths that indicated that they felt that homoeopathy was the treatment they would use first and these came the closest to regarding homoeopathy as an alternative;

[M34] ... the first treatment of choice for most conditions.

[M110] Homoeopathy for me is the basis of medicine. Allopathy is an occasional necessity.

[M142] I personally think that homoeopathy should be the primary health care.

The majority of medically qualified homoeopaths, like the professional homoeopaths, felt that the two modes of healing could be combined and were complementary;

[M18] See no problems in combining homoeopathic and conventional treatment.

[M118] [complementary], yes, it doesn't stand alone.

[M151] Always a medical diagnostician primarily - will use drugs if necessary.

[M154] In general practice I use the two together very successfully. I also use homoeopathy alone when appropriate.

One medically qualified homoeopath felt strongly that homoeopathy should not be seen as an alternative therapy;

[M20] Very important to consider it complementary and not alternative. Not appropriate for all conditions.

One medically qualified homoeopath felt that homoeopathy was complementary and used this question to explain his views regarding professional homoeopaths;

[M133] I see the danger of non-medically qualified homoeopaths as their seeing homoeopathy as an alternative medicine.

One medically qualified homoeopath felt that homoeopathy should be neither alternative or complementary but part of conventional medicine;

[M137] Study of homoeopathy should be integrated with that of conventional medicine.

All three medically qualified homoeopaths who were interviewed felt that homoeopathy was a complementary practice, homoeopathy was an additional tool to be used alongside conventional medicine;

Z I think alternative is the wrong word. I think complementary is a far better word, and I find that what I practice is complementary medicine, not alternative medicine.

Y Yes, to try and combine [homoeopathy and conventional medicine] ... to have as many arrows on my bow as possible.

Professional homoeopaths who were interviewed differed in their opinions regarding the alternative or complementary status of homoeopathy;

A Because we are complementary, we're not alternative and I still think that we are complementary ... I felt that the two could work together in tandem ... I think one of the major flaws is that sometimes people, protagonists of either, going to the extremes and become too hardened and I'm not. Homoeopathy is very, very good, but nothing will cure everything.

B No, it has to be complementary, it's complementary I mean it could never replace completely, allopathic medicine ... There is a place for antibiotics, there obviously is a place for different types of allopathic medicine.

C For my patients I think, on the whole, they use it as a complementary and I would tend to lean towards that with them.

- E** Obviously it is alternative, in lots of ways, but I like to see it as a complementary because I think everybody in health care is actually out there to try and improve peoples ability and health and I just wish it wasn't so difficult for them to work together ... I don't think that homoeopathy is the only way. It's not a sort of mission for me in that sense, I feel it's one of many ways.
- F** This is genuinely another system , it is an alternative.
- H** Well I think I started out thinking it was alternative, that clear cut. I now still think it's alternative, however, I feel that I use it more in a complementary way, I don't feel as rigid now about patients taking antibiotics ... It's beginning to be more of a complementary thing in practice, although as you say, the philosophy is still alternative, very much so.

7.4.2 Perception of conventional doctors attitudes to homoeopathy

When all respondent's answers were examined almost half (49%) stated that they felt that conventional doctors had a negative attitude towards homoeopathy, 27% felt that conventional doctors had a positive attitude towards homoeopathy and 24% felt that conventional doctors were either neutral or had no opinion.

The numbers who felt that conventional doctors were negative rose to 62% amongst professional homoeopaths and fell to 32% amongst medically qualified homoeopaths. Positive attitudes were thought to exist among conventional doctors by 12% of professional homoeopaths and 48% of medically qualified homoeopaths. This difference in the perception of conventional doctors attitudes was shown to be significant when the data were analysed using χ^2 ($\chi^2 = 17.28$; $p = 0.00018$)

What opinion do conventional doctors hold of homoeopathy ?

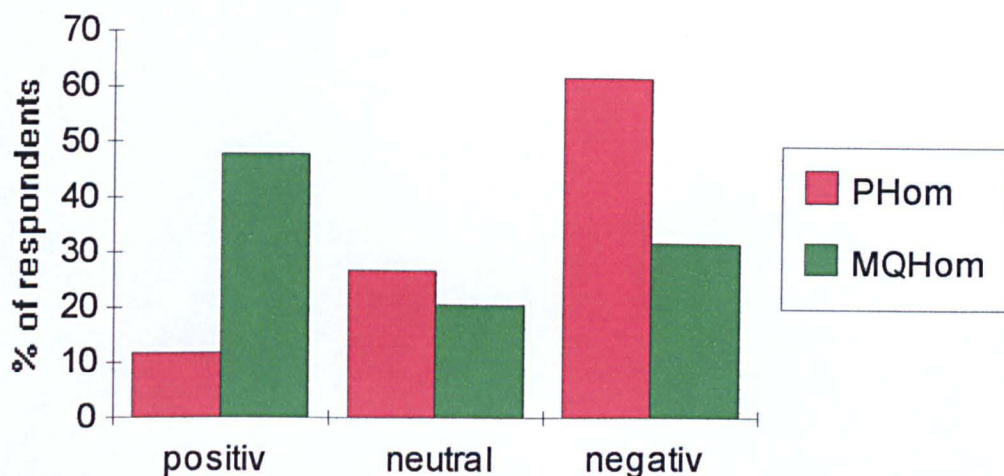


Figure 7.10 What opinion do conventional doctors hold of homoeopathy ?

None of the medically qualified homoeopaths added comments to their answers to these questions. The most common additional response from the professional homoeopaths was that the attitudes can be very variable, that they have met doctors who fit into all three categories.

- [P6] Doctors vary ! Some are very positive, some a bit positive, some neutral, some a bit negative, some extremely negative.
- [P9] It depends on the doctor - I've met all three attitudes.
- [P25] Depends on individual doctors.
- [P41] It just depends so much on the individual doctor. I encounter the whole spectrum where I work and I think most homoeopaths probably do.
- [P42] I have experience of all of these - it is very hard to generalise. I think most doctors don't really understand the breadth of homoeopathy.
- [P45] It seems to vary from area to area and from practice to practice and country to country.
- [P107] My patients have reported all three reactions when telling their GPs they are having homoeopathic treatment, and some GPs have told patients to try it.

Comments also showed that professional homoeopaths could also feel that conventional doctors were extremely negative;

[P10] Most GPs regard homoeopathy as a placebo effect for middle aged, middle class, "neurotic" women.

[P32] They have neither the time to think about it rationally, or the inclination to confront the real issue that they could be promoting disease not alleviating it.

Some professional homoeopaths felt that negative attitudes were based on fear;

[P14] Orthodox medicine has a specialist but restricted kind of knowledge which has a powerful monopoly but which is not based upon reality, but fostered belief. There is fear of that popular belief being undermined.

[P59] ...they still rarely understand what homoeopathy is and can feel very threatened by it. i.e. "ill-health" is big business for them and the drug companies.

[P72] We are basically general physicians and therefore competitors. Traditional doctors are frequently violently elitist & competitive & feel we threaten their status - if successful - and their patients if unsuccessful.

7.4.3 Is homoeopathy more holistic than conventional medicine ?

Five practitioners (3.3%) felt that homoeopathy was not more holistic than conventional medicine. All of these five practitioners were medically qualified homoeopaths.

Some medically qualified homoeopaths felt that conventional medicine could be just as holistic as homoeopathy;

[M113] But depends on individual. A conventional consultation can be holistic as well if the physician makes the effort. Homoeopathy facilitates a more holistic style.

[M114] Conventional medicine practised well can be holistic also.

[M124] Any good doctor, conventional or otherwise, takes whole patient approach.

[M145] Holistic approach is of the practitioner not the system of medicine.

Other medically qualified homoeopaths were convinced of the more holistic nature of homoeopathy;

[M21] We do make a much closer study of the patients psychological make-up than is usually involved in conventional medicine.

[M29] By giving equal importance to the “inner world” of the patient who is sick, as well as the outer signs of pathology.

[M111] It aims to stimulate the body to heal itself so remedies are aimed at the whole person so more “holistic”.

[M118] Hugely so.

[M123] I have cured several patients (including myself) of acute arthritis with the homoeopathic medicines by working on psychology of the patient and not the physical.

[M125] No doubt about this; especially when conventional medicine becomes increasingly fragmented and specialised.

One medically qualified homoeopath gave her reasons for believing that homoeopathy was more holistic than conventional medicine;

[M19] Conventional medicine is entirely controlled by the drug industry.

Two medically qualified homoeopaths related the holistic nature of homoeopathy to the time available for the consultation;

[M18] Only if time available.

[M121] But only due to time differences.

The professional homoeopaths often saw the question as giving them the opportunity to denigrate conventional therapy;

[P10] Conventional medicine isn't holistic at all !

[P14] Conventional medicine is not at all holistic - it cannot see things that way. It can only pretend.

[P36] Conventional medicine in its very approach cannot be practised in a holistic manner.

[P45] In which areas do you consider conventional medicine to be holistic ?

[P46] Conventional medicine is almost wholly reductionist in its viewpoint. It misses out the person.

[P71] [homoeopathy] is light years ahead in many ways and conventional medicine is not at all holistic.

[P78] I see very little holistic philosophy in conventional medicine.

[P81] Conventional medicine is not holistic - it treats separate parts of the body. If you have a pain you take something to block the body's natural response i.e. the pain.

[P83] How is conventional medicine holistic ?

[P88] Conventional medicine is in no way holistic !

[P92] I cannot by any stretch of the imagination see the Cartesian, materialistic approach of conventional medicine as holistic !

[P99] Is conventional medicine holistic ?

[P105] What is holistic about conventional medicine ??!

[P107] If by 'holistic' you mean looking at the person as a whole being and prescribing on the totality (Mental / emotional / physical) what conventional treatment is ever chosen like that ?

Other professional homoeopaths felt that it was possible for conventional medicine to be holistic, but these were fewer in number;

[P8] I believe that conventional medicine is becoming more holistic.

[P16] BUT - I don't think homoeopathy has exclusive rights on holism. As a team, allopathic framework covers most of the ground.

[P42] Sometimes conventional medicine can be very holistic.

[P49] ... But holistic healing can take place using many different methods as long as the real well-being of the patient is considered. Some doctors are able to do this without suppressing the patient. (Not many though).

A number of professional homoeopaths felt that it was hardly worth asking the question;

[P2] Bit of an obvious question ??

[P4] Obvious !

[P5] It wouldn't be difficult !

Often the responses from professional homoeopaths were aimed at explaining why homoeopathy was more holistic than conventional medicine;

[P25] [homoeopathy] treats patients on mental, emotional and physical levels, not just the presenting symptoms.

[P31] Homoeopaths look at the whole person, treating mental, emotional and physical symptoms with a single remedy rather than individual drugs for different complaints.

[P55] Homoeopathy treats the patient as an individual in a holistic way - allopathic medicine is seeking a diagnosis - and having obtained this, treats all patients the same.

[P79] Homoeopathy doesn't think in 'systems' i.e. circulation, digestion, but treats / considers the totality of interaction within a person, not just the body.

7.4.4 Summary of attitudes towards homoeopathy

Professional homoeopaths were more likely to regard homoeopathy as an alternative medicine that was more holistic than conventional medicine but was seen negatively by most conventional doctors.

Medically qualified homoeopaths were more likely to regard homoeopathy as a complementary practice that was more holistic than conventional medicine and which was seen in a positive or neutral way by most conventional doctors.

7.5 Control over homoeopathic practice.

7.5.1 General practitioner referrals

The requirement for GP referrals for all homoeopathic consultations was rejected by 79% of all homoeopaths. This rejection was only slightly stronger from the professional homoeopaths at 80% than the medically qualified homoeopaths at 77%.

Both medically qualified homoeopaths and professional homoeopaths were, on the whole, against the idea of limiting access to homoeopathy to those patients referred by a general practitioner.

One medically qualified homoeopath felt that GPs knowledge of homoeopathy was insufficient;

[M115] Because it largely depends on the knowledge of the Referring Doctor - which is absolutely deficient in a lot of instances.

One medically qualified homoeopath felt that if it was a patient's choice to use homoeopathy then a GP should not be able to stop them;

[M21] If we in private practice relied on referrals from General practitioners or other doctors we would starve ! Also the final arbiter of a patients own body is the patient themselves of course, after all they have to live in it - not the doctor.

The need for contact between a GP and a homoeopath, following a self referral from a patient, was acknowledged by one medically qualified homoeopath

[M141] But liaison should be established when self-referral has occurred.

Whereas only four medically qualified homoeopaths (7%) chose to comment on this question, 66 professional homoeopaths (66%) chose to comment.

Professional homoeopaths mentioned freedom of patient choice in many of the comments (32 comments).

[P2] Freedom of choice for individuals is paramount.

[P37] The individual should have freedom to choose.

[P48] Freedom of health care choice is essential. If GP is anti homoeopathy - the choice is limited.

[P49] Everyone should have the freedom to choose for themselves if they wish.

[P57] There is already too much restriction on what people are allowed to do for themselves. People are becoming unable to think for themselves.

[P69] Health is choice !

[P85] I believe in freedom of choice. Doctors can make the patient feel powerless and therefore to limit access to homoeopathy would be detrimental.

[P88] A person must have free choice and take responsibility for themselves.

[P96] Definitely not. I think ultimately the patient is responsible for their own health and must be allowed to choose what feels right for them, be it conventional or alternative treatment.

This opinion was also voiced at interview by a professional homoeopath;

A I don't see why a private practice shouldn't have somebody ringing up and saying 'can I have an appointment'.

Another popular comment questioned the GPs knowledge of homoeopathy and therefore either their ability to refer, or their bias against referring for homoeopathic treatment;

[P5] certainly not. I think a GP is the least qualified person to have knowledge of alternative medicine and what it can offer.

- [P14] A GP has little, or no, idea of what is involved. Such referral is based upon ignorance, or desperation !
- [P15] Most are negative towards homoeopathy through ignorance.
- [P32] How can the uninitiated, initiate directions for others. They must understand the action and philosophy of homoeopathy before referring.
- [P36] Because homoeopathy does not fit into the conventional framework it would be difficult for GPs to understand how it works etc.
- [P53] I find many patients have difficulty persuading their GPs to refer them. Some have to come privately because their GPs completely refuse.
- [P60] Very few GPs understand the philosophy and potential of homoeopathy. Most medically qualified homoeopaths only study for 6 months at the Faculty and GPs have less grasp of homoeopathy than them. The medical profession, in general, needs educating, from the purchasers down to the providers.
- [P75] This puts too much power in the hands of a doctor who may be prejudiced and ignorant. People need freedom of choice and allowed this responsibility.
- [P81] If the GP is ignorant of homoeopathy and how it works or threatened by it he/she won't refer.
- [P92] This would be a serious infringement of civil liberty. As most GPs do not have a training in homoeopathy they cannot be aware of the scope of it's action, and cannot give informed advice or opinion on it's suitability.
- [P97] GPs not qualified to judge.

Once again, the interview data also showed this attitude of doubting the general practitioner's ability to make referrals;

- E I can see a GP making realistic referrals to an osteopath or a chiropractor but I can't necessarily see them making realistic referrals to a homoeopath. They'd have to be very enlightened really.

Other professional homoeopaths reacted with a sense of disbelief or shock;

- [P6] Ghastly idea !
- [P10] Definitely NOT.

[P61] You're joking !

[P103] Why might I think that ?

One professional homoeopath questioned how this referral system might work with no statutory registration of professional homoeopaths;

[P16] But as yet, the GP has no way of knowing whether the homeopath is competent.

One professional homoeopath felt that the individual should make their own choices but could identify with the conventional GPs dilemma;

[P54] I understand the responsibility rests with GP for patient care however it is the right of an individual to seek the care they choose - it is the individuals body, not NHS body.

At interview some professional homoeopaths just could not see how this form of referral would work, doubting the doctors honesty;

B No, I think that depends too much on the GP to be honest.

Or the patient's willingness to bother their doctor for a referral or let their doctor know that they wanted a referral to homoeopathy;

A But certain [patients] will refuse to give me their GPs name, because they just wouldn't approve of it.

C People wouldn't go through their doctors, they don't like bothering their doctors, they don't like asking their doctors if it's OK. If they've been with their GP for a long time they feel that what they're saying to their GP is that you've failed me, I've got to do something else. And sometimes patients say 'can you not tell my doctor'.

One professional homoeopath who was interviewed believed that such referral was unnecessary as they felt that homoeopaths should be considered as a form of general practitioner;

F I would like to see us considered as physicians, I consider myself as a GP ... I get a great deal more success than the average GP.

7.5.2 Imposed limitations to practice

The concept of legally imposed limitations on the disorders that may be treated by professional homoeopaths was raised during interviews with medically qualified

homoeopaths who felt that this might be a useful method of ensuring the safety of patients consulting professional homoeopaths who had not undergone a conventional medical training. This idea was rejected by 80% of the respondents to the questionnaire. The rejection rate rose to 96% among professional homoeopaths and fell to 50% among medically qualified homoeopaths. This difference between professional homoeopaths and medically qualified homoeopaths was shown to be significant when the data were analysed using χ^2 ($\chi^2 = 32.6$; $p < 0.00001$).

The most frequent response from professional homoeopaths (40% of additional comments to this question) was to point out that professional homoeopaths treat patients not diseases;

[P45] We are treating people not diseases.

[P69] Professional homoeopaths treat patients not diseases.

[P84] ... we are treating the person not the disease.

Other professional homoeopaths pointed out that homoeopathy was a complete medical system capable of treating all manner of diseases;

[P46] Homoeopathy is a full medical system; its practitioners should be trained to treat all people safely by competent colleges and universities.

One professional homoeopath expressed the opinion that collaboration was more desirable than imposed limits;

[P58] We should be working together for the patients well-being.

And at interview a number of professional homoeopaths felt that self limitation with co-operation from conventional doctors was a useful way forward;

C I'm happier when I know that a patient, particularly if I know that they're coming to me with slightly worrying symptoms, that they have been to see a doctor if not a consultant before me.

B If I'm unsure of something, or don't feel experienced enough, I pack them off to the GP to get them checked over.

A More often than not I suggest that they go and get it checked out by the doctor.

Some professional homoeopaths argued for control over the claims that could be made for homoeopathy;

[P42] I think there should be legal limits on the claims people make for their therapy.

Others cast doubt on the competence of some professional homoeopaths to treat everything and anything;

[P44] Depends how well trained they are.

[P63] Depends on the training. No [to limitations] if all homoeopaths properly trained or in co-operative medical practice.

[P101] Hard to answer: I do see homoeopaths over-reaching themselves, especially with psychopathologies, but often with persons who remain undiagnosed.

[P149] This is not a simple question - If the quality of homoeopaths were what it should be I would say no.

This opinion was also voiced at interview by a professional homoeopath who felt that patients safety should be of paramount importance;

F ... yes I think they should [be limited]. For safety's sake, I think if someone comes to you with a pain in the gut, and you don't know the different possibilities ... then it is possible to do damage. And I think patients have been buggered about enough

and by one professional homoeopath who could also understand concerns regarding the patient's safety;

A I can see how some people would feel safer with [limiting practice].

One professional homoeopath explained that there are limitations already in existence regarding claims for cure and the treatment of some diseases;

[P103] It is illegal to claim to 'cure' certain conditions and also illegal to offer primary treatment for a range of infectious diseases including V.D. Anything else begs the question, who would decide which conditions were treatable - the basic tenet of homoeopathy is that we are treating the patient not the disease per se.

A number of professional homoeopaths argued, once again, that this would impose restrictions on the patients freedom of choice;

[P105] It must be up to the patient - or who is going to act as "God" ?

[P99] I have treated patients with cancer and other deep illness who have been helped tremendously. They would be denied this if limits were placed.

Doubts regarding the usefulness of conventional diagnoses and disease labels were raised;

[P75] We do not depend on a diagnosis, which anyway may be wrong.

Hostility towards the concept, and towards conventional medicine, was expressed by a number of professional homoeopaths;

[P83] ? What ? Why ? Do doctors ?

[P92] Such legal limits would undoubtedly be decided upon by the allopathic profession, and would depend upon an allopathic diagnosis. Such diagnoses are often wrong. People frequently turn to alternative / complementary therapies when allopathy has failed or pronounced them incurable, and are frequently helped. Why should they be denied the possibility of help because of the blinkered view of those in one particular profession who do not understand the potential of therapies which operate on the level of biophysical energy.

[P78] Why ? This question expresses conventional medicines condescending attitude to homoeopathy in general, and most other holistic medicine. Should doctors have legal limits on the number of iatrogenic diseases and deaths they can cause ?

This hostility was often expressed by professional homoeopaths at interview also;

- B** I wouldn't necessarily be in favour of strict limitations.
- C** That's saying that we're not quite qualified doctors, we're not quite qualified orthodox doctors.
- D** No, it greatly concerns me that homoeopathy could be curtailed.
- D** The way that homoeopathy would be seen is like aromatherapy, it's a relaxation therapy for all those people who are over anxious about their health and there's nothing really the matter with them, they can go and see a homoeopath.
- H** That would make me angry, I would not be interested in that, I think that's appalling.

During interviews with professional homoeopaths the concept of self regulation was often preferred to imposed limits;

- A** ... if you know your limitations, as such, you're self limiting. Then I think that, really, there is no need to have limitations imposed.
- G** I feel that basically a system of regulation, through our own professional bodies ought to be good enough.

However the drawbacks of a system of self regulation were highlighted by the admission of one professional homoeopath;

- B** I've taken on people that I shouldn't have taken on, I probably still am doing so but, only because I'm feeling fairly idealistic.

A number of professional homoeopaths, when interviewed, felt that conventional doctors and medically qualified homoeopaths felt the need to impose limitations and registration upon professional homoeopaths due to a perceived threat from them;

- C** I think that homoeopathy, more than any of the other professions, threatens orthodox medicine ... I think we're a much greater threat than the chiropractors and the osteopaths are to doctors.
- D** Is homoeopathy a threat, I think it should be, as to whether they perceive that because of the level of ignorance around homoeopathy I'm not sure.
- E** The whole problem with homoeopathy is that we're giving tablets that, say, make people better, and that's too close to what they do really.
- H** It's energy medicine, I think they don't like it. I think they think it's nonsense, it certainly doesn't fit into their model, and I think it makes them very angry, or very scathing.
- H** Because we mirror, because we use a similar technique in terms of giving a pill, it appears to be practising as they might practice, and they don't understand.

Most of the medically qualified homoeopaths felt that although they would not want limitations placed upon disorders that could be treated homoeopathically, they would want professional homoeopaths supervised by doctors in some way;

[M110] But should be under the supervision of a medically qualified homoeopath.

[M111] But medical supervision.

[M120] They should only see patients on referral from a medically qualified practitioner.

Other medically qualified homoeopaths felt that professional homoeopaths should have self imposed limitations;

[M122] They should know their own limitations.

Medically qualified homoeopaths often argued that limitations would be difficult to put in to practice;

[M117] But not sure how this could be done while they are independent practitioners - who makes the diagnosis !

[M112] Difficult to say. How could this work in practice.

[M124] As diagnosis not necessary for treatment this would be very difficult.

[M151] Impossible to answer as so many patients "undiagnosed".

One medically qualified homoeopath gave an example of a condition that should not be treated by professional homoeopaths ;

[M132] eg shouldn't treat appendicitis

One medically qualified homoeopath felt that while it was difficult to decide about limits on what professional homoeopaths might treat, they were sure that no limits should be placed on medically qualified homoeopaths;

[M154] Any legal limit to medically qualified homoeopaths is wrong. I am equivocal about lay homoeopaths.

7.5.3 Statutory regulation of homoeopaths

Statutory registration of medically qualified homoeopaths was thought to be necessary by 75% while statutory registration of professional homoeopaths was thought to be necessary by 86% of all respondents.

When regarded separately each group was more likely to agree that their counterparts needed registration rather than themselves. This difference was small for the professional homoeopaths of whom 84% felt that medically qualified homoeopaths should be registered while 82% felt that professional homoeopaths should be registered.

Amongst the medically qualified homoeopaths this difference was slightly greater with 92% stating that professional homoeopaths needed registration whereas 61% felt this was necessary for medically qualified homoeopaths. The difference between professional homoeopaths and medically qualified homoeopaths regarding statutory registration of professional homoeopaths was not significant with the majority of both groups agreeing with the concept. The difference with regard to statutory registration of medically qualified homoeopaths was significant when analysed using χ^2 ($\chi^2 = 9.3$; $df = 1$; $p=0.002$) with professional homoeopaths more in favour of registration for medically qualified homoeopaths than the medically qualified homoeopaths were themselves.

Some professional homoeopaths were unsure whether they wanted statutory registration for professional homoeopaths;

[P11] The courts still out on this one.

[P13] Don't know - we are registered in our own right.

[P40] Don't know - I'm not very political.

[P41] I still haven't reached a definite position on this for myself yet.

[P52] The debate is on.

Some comments from professional homoeopaths showed that self regulation is seen as a better answer than registration imposed from outside;

[P5] We should be properly qualified and registered by our own body but not necessarily statutorily regulated.

[P44] Society of Homoeopaths has set up a reasonable system. I would not like to see Homoeopathy "controlled" by people who do not understand it.

[P90] Professional self-regulation is preferable at this stage.

[P95] I think there should definitely be a professional register but I'm not sure about CPSM registration.

[P96] I am in favour of self regulation for homoeopathy, not state registration.

[P157] Yes by our own Professional Organisation with its own accreditation procedures and an overview - register etc i.e. Society of Homoeopaths.

No by outside organisations i.e. Government led. I think its important we put our own house in order and set high standards within rather than without.

One professional homoeopath felt that the present self registration system was inadequate;

[P16] I do think that regulation of competent practitioners is vital - that existing awarding bodies (SocHom, ICM, UKHMA) fail in duty to provide that regulation.

A small number of professional homoeopaths felt that although registration was inevitable, whether self registration or imposed from outside, they felt it was not particularly useful;

[P14] Not necessary really, except to give patients greater confidence in some instances. But most relish the 'escape from orthodoxy', which has failed them.

[P107] I suppose so but this still doesn't seem to be a foolproof method of guaranteeing that the homoeopath continues to practice according to set guidelines - but I am increasingly aware that there is no one method.

The opinion that registration may be of limited use in protecting anyone, patient or practitioner, was raised at interview by two professional homoeopaths;

C How many people call themselves a physical therapist and people think they are going to see a physio[therapist] ? And that's a protected name ... You've got people doing applied kinesiology, using 'homoeopathic', in fact isopathic, remedies, and calling it homoeopathy, now how can you stop them doing that ? You can't really stop them doing that ... What's to stop anybody going and making up their own homoeopathic remedies ? So the legislation is, I think it's some good ideas, but I just think, where is it going to stop ?

G I do not see statutory regulation being to our own advantage, and I don't think we should be going courting something that is not to our own advantage ... I see no evidence that incompetent homoeopaths represent a major threat to human health in the UK. I see many things which are a greater threat to human health, which we do less about ... We would need evidence that qualifications or registration correlated with a higher standard of practice ... We would need evidence that there were people practising, in substantial numbers, who lacked qualifications or membership of a professional body, who were doing so badly.

Some professional homoeopaths worried that the conditions that would have to be met to gain registration might be too limiting and might exclude some practitioners;

[P6] I am very unsure about this. I'd like to see a system that provides some security for the patient, but such systems easily become narrow-minded and refuse to register less orthodox practitioners.

[P60] As long as this does not create limitations i.e. certain remedies being made illegal (or potencies), or any other restrictions.

[P106] Provided that by doing so they do not give up their rights to practise in a way determined by the Society of Homoeopaths, rather than by the orthodox medical profession.

Two professional homoeopaths felt that registration was fine as long as they could still practice if they were not on the register;

[P49] I think there should be a register but I think it should be possible to practise without having to be registered - there should be that freedom - then patients could choose.

[P64] Should be their choice so long as public knows who is and who isn't.

One professional homoeopath agreed with statutory registration provided that the professional homoeopaths retained control of the register;

[P75] Provided homoeopaths did this registering and not some bigoted BMA committee !

One professional homoeopath felt (wrongly as it happened) that she was in a small minority who agreed with statutory registration. The reluctant agreement was in order to protect both homoeopathy and the homoeopathic patients;

[P103] I'm virtually alone here among Society [of Homoeopaths] members who fear the dead hand of authority , but I think it's inevitable given the EC's involvement, and desirable since many people call themselves homoeopaths and practise a mixture of dowsing, nutritional therapy etc.

At interview these benefits for patients and practitioners were often mentioned by the professional homoeopaths;

A I think that registration will go some way down the line to bring us the professionalism.

B One has to become part of the establishment to a certain degree.

E Obviously there are advantages into having, you know, being a recognised profession and all the rest of it.

- D** There are definite benefits from the public point of view that they would ... it would really reduce the public's vulnerability to unqualified practitioners.

At interview those professional homoeopaths with lower scores on the potential dissent scale were usually in favour of some form of regulation;

- A** I think it's overdue, I want it and I think it's the way forward. Because there are so many people, as it stands, I mean anybody can slap up a plate and call themselves a homoeopath.
- B** Oh definitely, and I think the battle that's going to be is between the registration and acceptance of doctor qualified homoeopaths and professional homoeopaths.
- E** I think it's got to come, I think it will come, one way or another. But there's always a price for these things. I think, yes that's what I want.

Those professional homoeopaths with high potential dissent scores were usually quite strongly opposed to regulation;

- G** Support from the medical profession for the endeavour of homoeopathic practice is one of the criteria that would be needed for a statutory register to be established, and I think that organisations like the society have underestimated the importance of this and the difficulty of obtaining it.
- H** I'm not very interested in statutory regulation because again I feel that is coming from a mistaken place. I feel that that is coming from a place of anxiety and fear, about what the allopaths will think, or whether we are accepted and acceptable and whether we are credible or not. And I'm not interested in that.
- F** It will lose the wonderful, vibrant, live feeling that it's had, if it goes too far into orthodoxy. And at the moment it's hell bent to do that. And it's sad. The next thing is that it will be accepted by doctors and watered down. And then all the energy will have gone from it ... I think homoeopathy is much better off being outlawed. Much better, as it is in America. It's very lively in America because most people aren't allowed to practise it. The same in France, you know all the lay homoeopaths in France, they have really got to want to do it, because you have to pay the fines all the time, getting caught ... Some things should not be legitimised.

Those medically qualified homoeopaths who made additional comments were broadly in favour of statutory registration for professional homoeopaths;

- [M21] I am on the Faculty Council for Homoeopathy and this has been a bone of contention on our council for at least the last 15 years. That

the non-medically qualified homoeopaths have not been sufficiently trained in biological sciences, and therefore are liable to come out with ridiculous statements on the subject of patients health, i.e. immunisations for instance.

[M111] Very much so.

Some medically qualified homoeopaths went further than statutory registration for professional homoeopaths;

[M112] patients should be made aware that they are not medically qualified.

[M117] This question assumes that there should be NMQH's [non medically qualified homoeopaths]

One medically qualified homoeopath showed a total lack of interest by answering in the same way regarding statutory registration for both professional homoeopaths and medically qualified homoeopaths;

[M122] Who cares ?

With regard to statutory registration of medically qualified homoeopaths most professional homoeopaths were uncertain, some had not considered it before;

[P8] I have not thought about this - interesting concept !

Many professional homoeopaths felt that if the medically qualified homoeopaths were to appear on the same register as professional homoeopaths then the homoeopathic training of the medically qualified homoeopaths would have to be guaranteed as being equal to that of the professional homoeopaths. Some professional homoeopaths insisted that registration should only be given to medically qualified homoeopaths following additional homoeopathic training;

[P5] Many doctor homoeopaths have only done a 6 month course, i.e. few weekends. This could be classed as a first aid course, with encouragement to do a proper training of 4 years leading to registration.

[P6] Not on the same register unless they could demonstrate their ability to practise as holistically as professional homoeopaths.

[P45] Providing they undergo satisfactory training.

[P57] I think they should be tested ? as to their purity of thought as far as homoeopathic philosophy is concerned.

[P59] Depends what you mean by this - doctor homoeopaths generally do not have full homoeopathic training and therefore do not use the true concept of wholistic prescribing. A doctor who substitutes

homoeopathic remedies for drugs is not necessarily treating correctly or effectively as it's not wholistic.

[P78] Some medically qualified homoeopaths have only attended a 6 week first aid course which is no use at all to treat chronic disease.

[P92] Having received a full training, not a short / superficial postgraduate training of a few weekends.

[P103] But only if their training matches ours ! Doctors can be quacks too you know !

[P106] Their ability to practise homoeopathy should be scrutinised by the governing body of homoeopathy and no assumption made that medical qualification exempts that need.

[P107] If this means that this indicates that they have undergone the same rigorous training and registration criteria that we have.

With regard to statutory registration of medically qualified homoeopaths the most frequent comment from medically qualified homoeopaths stated that they felt that they were already registered;

[M19] Not additionally, they have to be post-grad trained so they are registered with the faculty, like other post grad quals, such as obstetrics, child health and so on.

[M21] We are registered already.

[M22] They are already.

[M110] They are registered with the Faculty already - should not have additional registration.

[M140] We have to comply with Medical Registration and Faculty registration already.

7.5.4 Equality in the consultation

WHO IS RESPONSIBLE FOR ANY DIAGNOSIS MADE ?

On a possible score from 0 - 10, where 0 indicated practitioner control and 10 indicated complete patient control, the overall mean score was 3.7 indicating that control was closer to the practitioner than the patient. The mean score for professional homoeopaths was 4.2 and for medically qualified homoeopaths was 2.9. When a Mann-Whitney analysis of variance was applied to these data the difference in scores between professional homoeopaths and medically qualified homoeopaths was significant ($U = 1313$; $p=0.0024$).

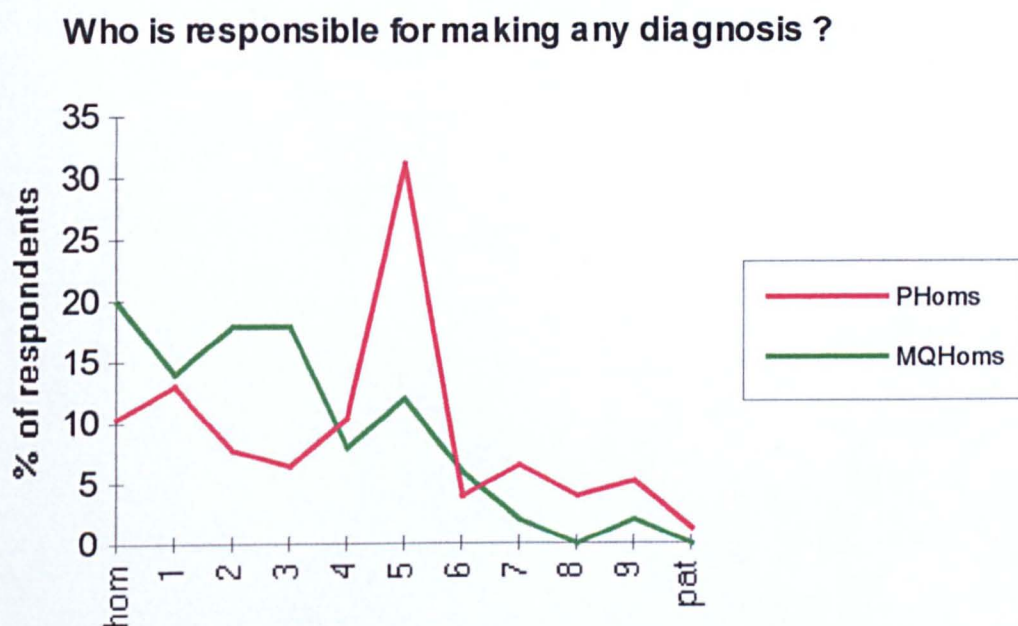


Figure 7.11 Who is responsible for making any diagnosis ?

The majority of professional homoeopaths stated that no diagnosis was made in homoeopathic consultations and this meant that either no one made a diagnosis or that the patient's GP had already supplied a diagnosis for the patient;

- [P8] The GP makes the diagnosis. The homoeopath treats the symptoms and patterns, not the disease.
- [P28] This depends. Many patients come with a diagnosis from a GP. If I make a diagnosis - it is within the context of homoeopathy - as opposed to conventional medicine.
- [P30] c.95% diagnosed already by GP.
- [P44] Patients usually come with a medical diagnosis which I don't do.

[P66] DON'T DIAGNOSE - am not trained to do it. I may make one secretly, but usually the patient comes with one already.

[P81] Diagnosis is not important as we deal with symptoms. I always ask a patient to see their GP for diagnosis if necessary.

[P99] Homoeopaths don't make diagnosis - they just treat the symptoms. I tell patients to see their GP if they want a diagnosis.

[P103] The point is, most patients come when allopathy fails to alleviate their symptoms. A diagnosis (not always infallible) has usually been made by GP/tests etc.

[P104] Homoeopaths never diagnose.

[P105] We don't diagnose - diseases are unimportant.

Other professional homoeopaths interpreted 'diagnosis' to mean the homoeopathic evaluation of the case in order to prescribe a remedy;

[P14] This process of evaluation is essentially a dialogue based upon equality.

[P51] We analyse the patients symptoms but guided by patient information.

[P53] Usually the GP gives the diagnosis i.e. the name of the disease = the effect / outward manifestation of the underlying imbalance. I usually look more broadly with the patient and attempt to find the aetiology. I reflect back what they tell me and they usually confirm that this may well have triggered their problem.

[P82] I don't really make diagnoses - just decide on the most appropriate prescription for symptom totality.

[P87] Diagnosis is inappropriate - assessment may be more so.

[P100] Homoeopaths do not treat disease so emphasis is not on diagnosis. We treat people as a whole - their symptom picture, their history, their lifestyle and surroundings and their family history. All contribute to remedy selection. In raising the level of health, the body throws off disease.

There was no great difference in the comments from medically qualified homoeopaths;

[M135] Not applicable, diagnosis usually already made by orthodox GP.

[M151] Many patients remain undiagnosed, either conventionally or unconventionally.

The exception was a medically qualified homoeopath who felt that medically qualified homoeopaths carried out a different role to professional homoeopaths;

[M128] I think diagnosis is the doctors province in any branch of medicine, though doctors will normally try to find out what the patient thinks is wrong, or what could be causing his illness. Homoeopathic diagnosis does not differ from orthodox diagnosis, to a homoeopath trained in orthodox medicine. Non-medical homoeopaths may have theories about the cause of disease with which medical homoeopaths would disagree.

WHO DECIDES WHAT IS TO BE TREATED ?

The mean score for all respondents was 4.2. The mean score for professional homoeopaths was 3.9 while the medically qualified homoeopaths mean score was 5.3. Analysis with the Mann-Whitney analysis of variance did not reach significance (U = 1853; p = 0.069; NS).

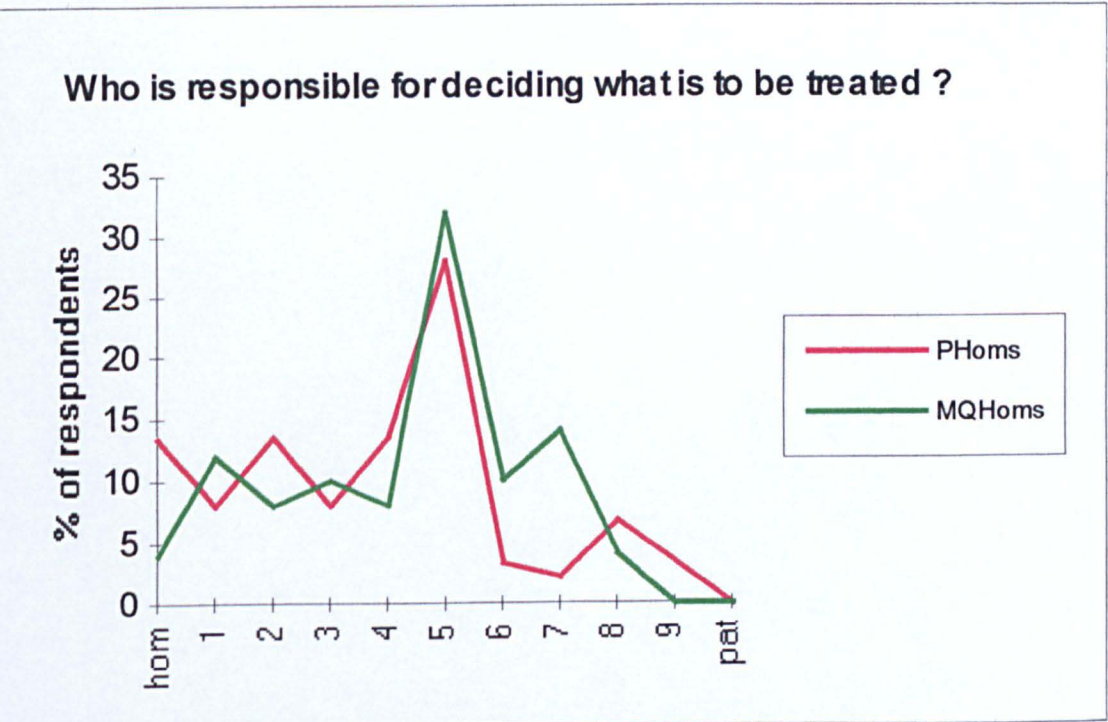


Figure 7.12 Who is responsible for deciding what is to be treated

WHO IS RESPONSIBLE FOR DECIDING WHAT TREATMENT IS TO BE USED ?

The mean score for all respondents was 2.7. Professional homoeopaths had a mean score of 2.6 and the medically qualified homoeopaths mean was 2.9. There was no significant difference between these scores.

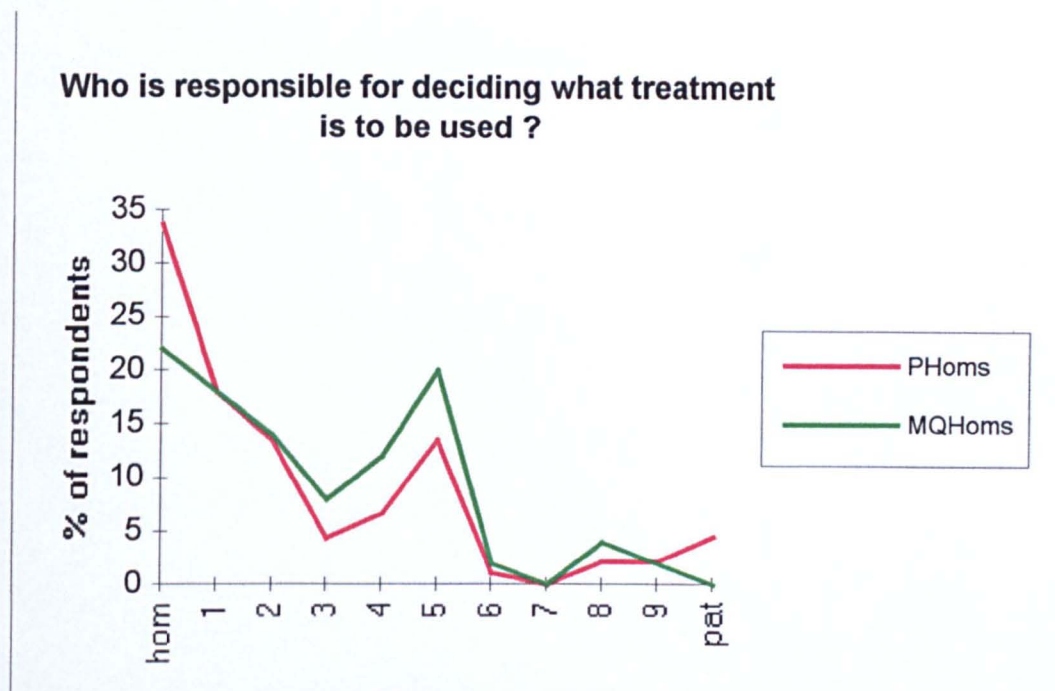


Figure 7.13 Who is responsible for deciding what treatment is to be used ?

Very few professional homoeopaths made additional comments on either of the questions 'Who decides what is to be treated ?' and 'Who decides what treatment is to be used ?'. Those who did indicated that as an expert and a professional the homoeopath's role is to make these decisions at the request of the patient. This was seen by many as the role they were being paid to perform;

- [P30] Patient has already chosen homoeopathy therefore comes to me for selection of remedy.
- [P53] Mainly me, but I always check out that the patient is happy with my approach.
- [P81] I will choose the remedy on the symptoms and nature of the patient. Also give advice on any adjunctive treatment.
- [P86] The homoeopath keeps an eye on the whole person and tries to educate the patient to think in this way, while also taking into account the presenting complaint by the patient. The homoeopath prescribes his remedy(ies) and gives advice to the patient about

adjunctive treatment if necessary. It is always up to the patient what happens ultimately.

[P103] They can hardly prescribe for themselves or they wouldn't have come !
They retain the power of veto of course.

Once again the medically qualified homoeopaths did not differ greatly in their comments;

[M128] Again I think this is a doctors decision - the patient is paying him (directly or indirectly) to use his specialist knowledge. But I tell patients what the remedies are and they are free to refuse e.g. strict vegetarians might not accept a medicine derived from animals.

[M152] patient choice of treatment but I chose remedy.

WHO IS RESPONSIBLE FOR ANY IMPROVEMENTS IN THE PATIENT'S HEALTH ?

The mean score for all respondents was 5.9. Professional homoeopaths had a mean score of 6.1 and the medically qualified homoeopaths mean was 5.6. There was no significant difference between these scores.

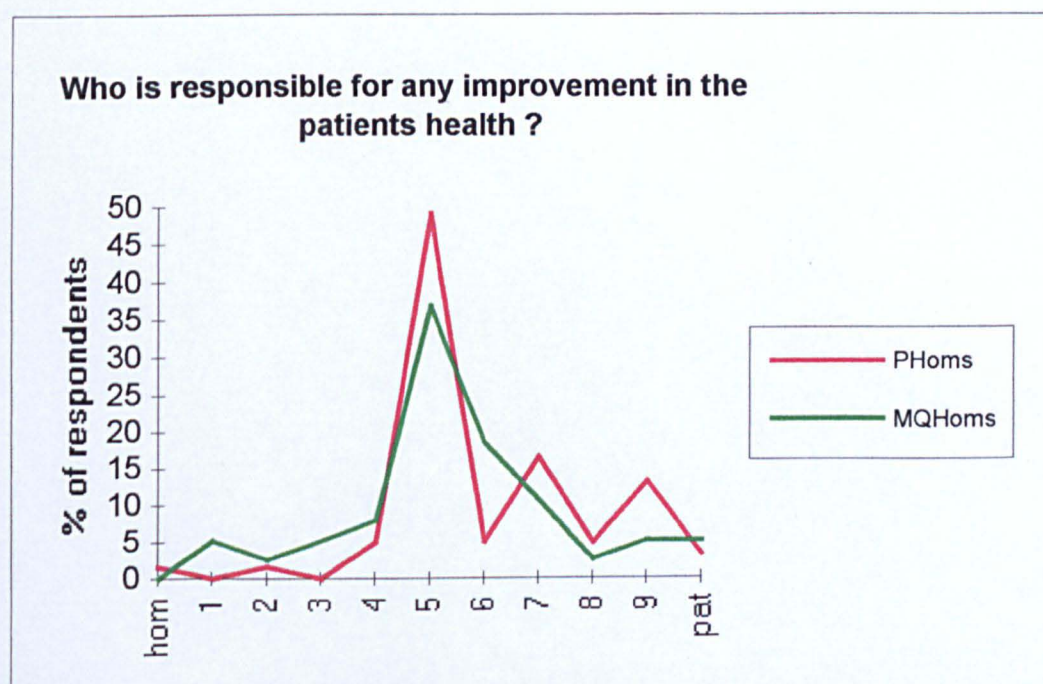


Figure 7.14 Who is responsible for improvement in the patient's health ?

Many professional homoeopaths felt that the patients were responsible for bringing about any improvements in health, with the aid of the correct remedy;

[P53] The patients own healing energy is ultimately responsible, but I am responsible in that I must choose an appropriate remedy to which the patients vital energy can respond.

[P81] Patient is always responsible, providing the remedy is well chosen. The importance of the patient / homoeopath relationship is one of support and encouragement.

[P86] The remedy is responsible. The homoeopath solely locates this healing substance which stimulates the body to heal itself.

[P106] Remedies merely instigate a healing process carried forward by the patient.

[P149] NATURE HEALS !

One professional homoeopath chose to divide the responsibility among what he saw as the key players;

[P90] The homoeopath is responsible through choice of treatment. The patient is responsible through providing accurate and full information on which a prescription can be made. Also by following any advice given and, finally, through his/her own ability to heal.

Many of the medically qualified homoeopaths who commented also felt that patients cure themselves;

[M120] Patients ultimately cure themselves with (or without) our aid !

One medically qualified homoeopath was blunt and to the point;

[M122] Who knows.

THE POWER BASE

At interview both the professional homoeopaths and the medically qualified homoeopaths described the differences that they felt were present between their own homoeopathic practice and conventional medical practice. The professional homoeopaths pointed out differences in the power base that is present in professional homoeopathic encounters, with patient and practitioner sharing power and responsibility whenever possible;

A This is where there is a major difference between medicine and homoeopathy, is that a homoeopath recognises that they don't have any power. Power is within the person, and the power base is completely different.

C You're still taking someone who is, for whatever reason, dysfunctional and you're working towards their functional abilities without you being overall responsible for it, you're working with them.

- B** But I'm under no illusions, it's not me. It's just that I've got the right skills to find the right remedy, perhaps the right skills to enable them to feel confident to open up to me.
- F** Often if I'm not sure about a remedy I'll describe why I'm trying to decide between them and ask them which one is right. And they always know.
- F** If you don't tell them what you know, they're telling you what they know, then you're making the gradient of the relationship that you are always looking down on them, you have the power, the control, you make the decisions.
- F** They've got far more invested in getting it right than I have.
- F** Why do we not make use of a patient's knowledge of themselves much more. Instead of extracting information from them, why don't we ask them to help us.
- F** I put power where it belongs, as far as I can, which is with the patients.
- F** First being powerful for them, appearing powerful to them, and then giving them that power. Because of course they are then empowered and they get better.
- H** I try really hard to make it an equal relationship ... I do feel that empowering people to look at themselves, and to go on that journey with them feels like a shared experience, so I feel that that's important for their own development and so on.

One medically qualified homoeopath felt that the depth of the consultation was important;

- X** Because you spend an hour with your patient you can make a deep connecting consultation. I think the consultations have a chance of being therapeutic in themselves.

Control was still in the hands of the homoeopath however;

- X** What you're able to do is to be more open to the consultation developing in a manner that you're not expecting. And to allow that. But I still think we're in charge of the consultation ... I don't feel any less in control than I did in general practice.

7.6 Motivation for practising homoeopathy

7.6.1 Why start practising homoeopathy ?

Medically qualified homoeopaths were asked to rank the top three reasons for starting to use homoeopathy from a list of six reasons. The six options were;

- Felt that there was more than just conventional medicine.
- Allows you to spend more time with patients.
- Felt that homoeopathy was an additional 'tool' I could use.
- Wanted to do something different.
- Felt dissatisfied with conventional therapy.
- Felt unsatisfied with the high pressure world of conventional medicine.

The most frequently given reason, regardless of whether it was ranked first, second or third, was motive 1, 'Felt that there was more than just conventional medicine'. This reason was given by 72% of the medically qualified homoeopaths, with 51% of them listing it as their first choice.

Placing the motives in order of popularity we find a distribution as given in Figure 7.15

	total responses	first choice	second choice	third choice
1. Felt that there was more than just conventional medicine.	41	29	7	5
5. Felt dissatisfied with conventional therapy.	33	11	12	10
3. Felt that homoeopathy was an additional 'tool' I could use.	33	9	16	8
2. Allows you to spend more time with patients.	10	0	7	3
4. Wanted to do something different.	6	1	0	5
6. Felt unsatisfied with the high pressure world of conventional medicine.	5	0	2	3

Figure 7.15 Medically qualified homoeopath's motives to practice

As can be seen in Figure 7.15, no medically qualified homoeopaths gave motive 2, 'Allows you to spend more time with patients' or motive 6, 'Felt unsatisfied with the high pressure world of conventional medicine' as a first choice.

When the relationship between first and second choices was examined it was shown that those respondents choosing motive 1 as their first choice were more

likely to choose 5 as their second choice than would be expected if the second choices were distributed as they were for all responses (see Figure 7.16).

First Choice = Motive 1							
Second Choice	1	2	3	4	5	6	Missing
Actual distribution %	na	15	30	0	50	5	0
Expected Distribution %	na	19	28	0	31	6	17
Actual - Expected	na	-4	+2	0	+19	-1	-17

Figure 7.16 Second choice motives for Motive 1

Those respondents opting for motive 5 as their first choice were less likely to choose 2 as their second choice (see Figure 7.17).

First Choice = Motive 5							
Second Choice	1	2	3	4	5	6	Missing
Actual distribution %	27	0	36	0	na	9	27
Expected Distribution %	22	22	31	0	na	6	19
Actual - Expected	+5	-22	+5	0	na	+3	+8

Figure 7.17 Second choice motives for Motive 5

Those respondents choosing motive 3 as their first choice were more likely to have motive 1 as their second choice and less likely to opt for motive 5 as their second choice (see Figure 7.18).

First Choice = Motive 3							
Second Choice	1	2	3	4	5	6	Missing
Actual distribution %	50	13	na	0	0	0	37
Expected Distribution %	20	21	na	0	33	6	18
Actual - Expected	+30	-8	na	0	-33	-6	+19

Figure 7.18 Second choice motives for Motive 3

In addition to the choice of motives given to medically qualified homoeopaths some respondents made additional comments. A small number of medically qualified homoeopaths stated that they had been influenced through personal contact with a homoeopath;

[M17] Influenced and persuaded by Dr Margery Blackie.

[M24] My father (My GP) used it and I was very interested. Natural development from there.

[M120] The real reason is that a friend said I should check it out.

[M124] Senior Partner in my first practice was a homoeopath.

[M135] Father was a homoeopathic physician (100% !)

[M143] My father was a homoeopathic medical practitioner.

One medically qualified homoeopath spoke at interview of meeting a homoeopath and being influenced by his practice;

Y I guess it's because my father attended a homoeopath in South Africa, and then as a medical student I had the chance to sit in with him and I was struck by the amount of time he gave patients, by his warmth and his interactive, almost healing session he had with the patient.

Other medically qualified homoeopaths aired their dissatisfaction with conventional medicine;

[M19] Was morally opposed to indiscriminate use of drugs.

[M20] Side effects of conventional drugs.

[M26] Conventional treatments unsuccessful. Side effects of conventional medicine.

[M125] Conventional medicine may do more harm on the patient.

This theme was also aired during interviews with medically qualified homoeopaths;

- Y It's more than just a pill for anti-pain, anti-this, anti-this. I didn't like that, it's too limited.
- X I was taking morning surgery and reviewing what I'd done that morning and thinking, is this what being a doctor's about ? And it didn't feel that it had much to do with healing.
- Int So you say you were starting to get a bit disillusioned with general practice, in the conventional practice ?
- X Which is ultimately why I left. I'd struggled to make it work for me and I feel I can't, not for me, maybe it can for some people, but I doubt it. I think trying to squeeze your life into seven minute slots is, at the end, impossible.
- Z I do remember seeing a lot of people in general medical clinics as an SHO with chronic arthritis and asthma, and couldn't do anything, and people just tinkered around with the drugs, pretended they were doing something and off they went, they had their ten minutes or five minutes worth. That was inadequate.

The client centred nature of homoeopathy was mentioned by two medically qualified homoeopaths;

[M111] Client centred instead of mechanistic approach.

[M112] It is a more complete way of dealing with patients - you get to know them because of the time spent - you reach a deeper level of understanding.

Being able to respond to the individual nature of disease was a reason given by two medically qualified homoeopaths;

[M141] Opportunity to respond to the individual nature of illness and it's many facets.

[M152] Homoeopathy made sense of many of my own observations regarding individuality of symptom pictures.

The very fact that they had seen that it worked was a reason for three medically qualified homoeopaths;

[M136] Fell into it by 'mistake', initially deeply sceptical. Saw inexplicable results - studied.

[M146] I found it worked !

[M154] It was fascinating and it worked - kept me sane as the Government imposed the new GP contract.

One medically qualified homoeopath had experienced homoeopathy as a patient and felt that this had triggered an interest;

[M26] Personal illness and experience as a patient.

One medically qualified homoeopath stated at interview that he did not like the competitive nature of conventional medicine;

Z ... the ethos in conventional medicine in hospitals is really pushy, you know, get your exam, go for it, get your MD, get on, do this, do that, if you want to be a cardiologist work all the hours, goodness me, you know sort of get on with, get on with it, and I just didn't like that and I didn't feel comfortable with all that.

The same medically qualified homoeopath also stated at interview that homoeopathy also satisfied his desire to be 'different' in some way;

Z I've always satisfied the two sides in me, I've actually, I've become respectable, surprisingly respectable and yet I've managed to keep myself 'strange' as well.

For the professional homoeopaths one motivation was mentioned by more respondents than any other in the questionnaires. A personal experience of illness treated homoeopathically was mentioned by 45% of professional homoeopaths. The illness experience was not always one which afflicted the respondent themselves, often the illness affected a close relative or, on one occasion, a pet;

[P6] Interested in healing generally. Homoeopathy cured my dog when nothing else did. Then got fascinated by the way homoeopathy viewed the person, health and sickness.

[P8] My husband had had successful treatment, then I had successful treatment, then my children. I read about it and became interested.

[P13] My own health promoted by homoeopathy.

[P15] I was successfully treated for a long-term illness by a homoeopath. I had wanted to train in medicine as a child but was unable to do so .

- [P28] Positive result from homoeopathic treatment. Mainly a curative response from homoeopathic medicines prescribed for my asthma.
- [P31] Successful treatment of my family by another homoeopath.
- [P37] It cured eczema I had suffered from for several years.
- [P40] Serious illness of my daughter and death of my mother which might have been avoided.
- [P45] Had medical condition that conventional medicine couldn't touch - Homoeopathy cured ! Used it at home for kids - got good results. Decided it was too good to keep to myself and applied for training.
- [P49] My own hay fever treated homoeopathically. Met someone studying homoeopathy.
- [P69] Having been ill for many years and treated unsuccessfully with allopathic medicine - in desperation turning to alternative medicine and making a full recovery - who wouldn't want to practice after that !!
- [P81] Daughter benefited from treatment, which provoked an interest in self healing - the how's and why's. The philosophy behind homoeopathy is very empowering.

The second most frequently stated reason for practising homoeopathy for the professional homoeopaths in the questionnaire data was a stated disillusionment with conventional medicine (29% of professional homoeopaths). Many of the professional homoeopaths giving this reason had previously worked in conventional health care;

- [P3] Failure of orthodox medicine. Interest in natural health.[paramedic]
- [P4] Total disillusionment with conventional methods which seemed both un-emotional and unscientific.[microbiologist]
- [P25] I was disillusioned by the effects of drugs and surgery used in conventional medicine (I am a nurse) and at the non-involvement of patients in their healing process.[registered mental nurse]
- [P43] Seeing people become sicker under conventional treatment and wanting to do something that went deeper and had more integrity. [registered mental nurse]
- [P51] Frustration at NHS and its blinkered approach led to my search for help for both daughters who have (i) mentally handicapped from birth, (ii) schizophrenia and HIV+ve. The arrogant attitudes of Consultants / Drs / Dentists.

- [P55] Felt the way allopaths viewed health was too narrow and that there must be a different way of treating ill-health. Also the cause of ill-health was rarely looked in to so often palliation and suppression was all that was achieved.
- [P58] I felt that allopathic medicine lacked the answers to health and was largely suppressive. I learnt through running a yoga school and being Matron of a naturopathic establishment that 'magical' things were happening. So along with my allopathic background and the above I augmented this with homoeopathic training.[nursing sister]
- [P62] My own research and dissatisfaction with orthodox medicine, both for myself, my family and my hospital patients.[nurse]
- [P95] Dissatisfaction with conventional medicine, particularly its inability generally to view patient as a whole and to see mind and body as connected.[state registered dietician]
- [P99] I felt unhappy as a nurse that the patients were often not 'cured', just given drugs, which ultimately pollute the body and make companies like ICI richer.[nurse]
- [P104] Disenchantment with 'normal' medicine. Working with pregnant and new mums (N.C.T.) I was looking for a 'safe' method to treat them.[nurse]

Knowing a homoeopath or attending a lecture on homoeopathy was the reason given by six professional homoeopaths;

- [P10] ... my Aunt is a Homoeopath.
- [P12] Working with a doctor in general practice [as receptionist/dispenser] who was also a practising homoeopath.
- [P49] Met someone studying homoeopathy.
- [P92] Having attended a talk by a homoeopath.
- [P98] Inspired by a talk given on homoeopathy.

In common with this theme from the questionnaire data, professional homoeopaths also stated at interview that meeting a homoeopath or other heterodox practitioner was often a motivation to investigate homoeopathy further, undertake an educational course and finally practise;

- B** I'd met someone to do with homoeopathy, a nurse from New Zealand who was a homoeopathic nurse.

- D** Very early on I had exposure to McTimmony chiropractic. My brother was taken to see him, as a child, so I was always influenced by that.
- E** My first child was diagnosed as having nephrotic syndrome when he was eighteen months old I literally started touting him around, you know, I just went everywhere I could trying to find somebody to make him better. I finally started reading about homoeopathy and got a referral to the Homoeopathic Hospital and [name of child] started to have treatment there.
- F** And then one night I met [gives name of a homoeopath] at a party, he was studying acupuncture with my brother, and he blew my head off, and I now realise that probably nobody else in the country could have described homoeopathy to me in a way that would have appealed to me.

The benefits of a self employed status were mentioned by three professional homoeopaths;

[P27] ... desire to be self-employed.

[P41] ... welcomed the versatility of self-employment.

[P66] Not altruism really - money, mostly, and that I could fit in a practice with raising my son (I am a single parent).

Self employment was also a motivator amongst the professional homoeopaths interviewed;

B I'd been working in a big industrial corporation and the management of that wasn't, at times, very pleasant and yes it was nice being my own boss.

Int Would you say that you wanted to get away from being employed by someone ?

D Definitely.

Int Why was that ?

D I guess partly family background, we ran our own farm, so I had that upbringing that you could do things on your own.

Among professional homoeopaths a number of themes emerged from the interview data that were not evident in the questionnaire data. Caring for people and being in a 'caring profession' was often mentioned;

- C** I think it was always 'C is good with people', I couldn't play piano like everyone else in the family, but I could change bandages.
- Int** You wanted to be with people and caring ?
- C** Yes, I wanted to be a nurse until I saw someone vomit and then I decided I didn't want to be a nurse.
- B** When I was a student ... I worked as an auxiliary nurse ... I really enjoyed my auxiliary nursing, and have always felt that I wanted to be in a caring profession.
- D** I had to be working with people in some way and see that it was actually improving their situation.

Dissatisfaction with their previous occupation was also noted in the professional homoeopaths;

- B** I didn't get big buzzes out of winning contracts, and things like that, it just didn't motivate me.
- D** "Do I really want to be working in London, do I really want to be in a job", I'm the sort of person who becomes disillusioned very quickly.
- H** The quality of my life was completely work orientated, very stressful ... I was actually disappointed when I became a deputy head, I was quite shocked at how I was no longer in a position where I could work as creatively as I wanted to ... I realised that it wasn't what I wanted to do anymore, and also I was still drawn to reading and thinking about alternative medicine.

The concept of homoeopathy as something different, as a challenge, was also a common theme for professional homoeopaths;

- C** I found it just a different way of looking at things that I hadn't come across before, so I found it quite exciting.
- A** I mean it was a challenge, it was something completely different.
- H** It was completely philosophy orientated and it was the philosophy that just somehow spoke to me and interpreted everything I believed in both materially and spiritually, it was a kind of the final piece in the jigsaw puzzle that I'd been putting together all my life.

7.6.2 What do homoeopaths enjoy about their work ?

For the professional homoeopaths there was one overwhelming response to this question, 53% mentioned seeing a patient getting better as an enjoyable aspect of their work;

[P10] Curing people.

[P13] Seeing them get better, so they no longer have to come back.

[P53] I see people getting better and I know it's genuine improvement.

At interview professional homoeopaths mentioned the caring, helping aspect of health care as a satisfying element in their work;

B It gives me a great deal of satisfaction when I get the remedy right and they become so much better.

E What keeps me going is that I know it makes people better, I know that it cures illnesses. Unlike some other people I don't need proof of it all, I don't need to know how homoeopathy works, I don't need doctors to approve of me or what I'm doing, I don't need any of that stuff because it's a deep conviction within me that I know it works.

Following this, perhaps unsurprising, result 29% of professional homoeopaths stated that they enjoyed the interactions that they had with their patients;

[P9] I enjoy the human interaction.

[P13] Rapport with patients.

[P27] Meeting people.

[P42] The opportunity to hear people's life stories.

[P53] It's fulfilling, I make real personal contact with patients.

The idea of changing peoples lives for the better - not only improving their health, but changing people in many other ways was mentioned by 25% of professional homoeopaths;

[P3] The ability to change peoples lives on all levels - mental / physical / emotional.

[P27] Enabling people to change their lives simply and without further harm.

[P36] It is a pleasure to see how people transform as a result [of homoeopathic treatment], enabling them to grow as human beings, in a significant way.

[P49] Seeing people change, grow, strengthen, develop.

[P50] To help people to get what they want, to discover themselves.

[P75] Seeing people change their lives.

Empowering people to take control of their own health was mentioned by 15% of professional homoeopaths;

[P4] Re-empowering people to take responsibility for their own health.

[P74] Watching people get better and seeing them take responsibility for their health. Empowerment.

[P79] Empowering my patients.

The challenge of finding the correct remedy was mentioned by 13% of professional homoeopaths. Many of these respondents used the phrase 'detective work' to describe this challenge that they enjoyed;

[P7] To be a "detective" finding the accurate remedy.

[P16] The detective work in finding the remedy to fit.

[P28] Very challenging and often very satisfying.

[P31] Always a new challenge.

This was also an aspect of homoeopathy for the professional homoeopaths who were interviewed;

C It's like having a big crossword and having to put it all together and find the name of the television programme in the middle.

G I always enjoyed the intellectual puzzle element of homoeopathy my mind is quite good at problem solving type situations, I think in quite an analytical way, and I like that element about homoeopathy.

The escape from bureaucracy and restraint to work independently in a self employed status was mentioned by 8% of professional homoeopaths;

[P6] Flexibility of working hours etc.

[P31] Flexible hours as a self employed person.

[P37] Self employed status - independence.

A small minority (3%) summed up all that they enjoyed in their practice by stating that they liked to make people happy;

[P53] I make people happy !

[P79] Seeing them happier.

[P153] Seeing them out of pain and happy in all ways in their life.

For the medically qualified homoeopaths there were no overarching themes to emerge at interview.

Two medically qualified homoeopaths mentioned that homoeopathy broadened their therapeutic repertoire;

- Y** Having homoeopathy as a tool has made it possible to open doors that weren't there for me before ... It gives you a tool that's just un.. un.. there's nothing else that can approach it.
- Z** You should be able to offer people what they need. It might be surgery, it might be coronary care unit, it might be diuretics, it might be acupuncture, it might be homoeopathy. But it's very nice to be able to choose.

One medically qualified homoeopaths wanted to 'heal' and felt that conventional medicine did not satisfy this desire;

- X** I became a doctor because of a sense of healing, I wanted to be involved in healing. And I don't know that mainstream medicine heals. It saves lives, but I don't think it heals.

The same doctor also cited the opportunity to interact more closely with the patient in order to collect the detailed history that is necessary in homoeopathic practice;

- X** To understand how that disease is affecting the person's life and how their life is affecting their disease is also of interest, even as a GP it was of interest. But in homoeopathy you actually need that kind of detail and that's nicer.

One medically qualified homoeopath stated that he was able to utilise so much more data that, in conventional medicine, would be seen as useless;

- Z** I always used to collect all the information, that people used to tell me about these funny things that they had before their periods, but I never knew what to do with it. Now I've got something ... now I know what to do with it.

7.7 Homoeopath's opinions of their opposite numbers

Direct enquiries regarding both types of homoeopaths opinions of their opposite numbers were only made during interviews. The questionnaires often contained such opinions in answer to questions regarding the need for registration but it was felt that this question might require a lengthier response than was allowed for in the questionnaires.

7.7.1 Professional homoeopath's opinions of medically qualified homoeopaths

There were many criticisms of medically qualified homoeopaths, particularly about the way in which they practice homoeopathy;

- A** But we are better trained as homoeopaths, generally speaking, than they are ... The doctor homoeopaths actually get confused and prescribe symptomatically because their training has been in that way, and understandably so. That is really my concern.
- B** I feel that medically qualified homoeopaths don't have enough true classical training in homoeopathy.
- C** You have this problem of doctors thinking they're doing homoeopathy after a few weeks training, or no training, they don't need it, they can get the computer programme
- C** From the little that I've seen they're awful. I think that they work as allopathic doctors giving out homoeopathic medication.
- D** There is just a conflict of ideologies there.
- E** They were very allopathically based.
- G** I felt that it was using homoeopathic remedies in an allopathic way.
- H** I am shocked at the way they prescribe ... I can't believe the way they treat, and it makes me a bit cross actually. Because I don't want people to get sick.
- H** Generally I think they are pretty scathing and I also feel that they are pretty frightened ... I think they become defensive and very angry out of fear and bewilderment ... You're not in our club and yet you're trying to play the game that we play in this club and I think it makes them very angry.
- H** In fact I hate the way they are so patronising and scathing.

Some professional homoeopaths acknowledged that the medically qualified homoeopath's medical knowledge was an advantage for them;

- A** They've had both training. They know how to diagnose. They have clinical experience which we don't have.
- H** I think I have more respect for the allopathic set up if you like, all the peripheral equipment that they've got, and the institutions, and sometimes the way that they look at things too, which I think can be useful.

7.7.2 Medically qualified homoeopath's opinions of professional homoeopaths

The idea of regulation to define limits of competence was a topic that all medically qualified homoeopaths raised;

- Z** If they're well trained I see no problem at all. But they should just do homoeopathy. They should recognise their ignorance, like I recognise my ignorance of, say, surgery ... They should just recognise their limits of competence. If they practice in that way I see no problem at all.
- X** I think they have to define themselves. I think they have to define what they can do and they have to define what they can't do.
- Y** I think that they ought to be regulated, and that goes for homoeopathic training for doctors as well. I don't think that the fact that you are a doctor makes you a homoeopath after attending two courses.

One doctor was defensive of medically qualified homoeopaths regarding the professional homoeopath's criticism of their practice;

- Z** I think that they are completely wrong in their generally expressed view that doctors don't know what they're doing. I think that they do not understand the first thing about what it means to become a doctor, the process that you go through ... They haven't got the first idea of what it's like to actually have to see everybody that comes through your door. They can just pick and choose, generally speaking, they see nice, middle class, white people who have got the money.

8 THE DIFFERENCES BETWEEN HOMOEOPATHS

8.1 Who becomes a homoeopath ?

8.1.1 Age

The mean age of the respondents was 48 years, the youngest was 28 and the oldest was 78 years old. These data represent the ages of both the professional homoeopaths and the medically qualified homoeopaths, when these were considered separately there was a significant difference in the mean ages of the two groups. The mean age of the professional homoeopaths was 46 years and the medically qualified homoeopaths were 52 years old on average.

Sharma (1992) found a mean age of 42 for the mixed group of 34 heterodox practitioners that she interviewed. Sharma's interviewees were all non medically qualified practitioners and therefore can be compared with the professional homoeopaths whose mean age was 46, this is closely comparable and suggests that the two groups were not too dissimilar in age. It could be hypothesised that some of Sharma's interviewees were younger than the professional homoeopaths as some of them may not have needed to follow such a long course of training as the homoeopaths who usually follow a four year course of training. This hypothesis may not be particularly useful however as Sharma's group consisted of many practitioners who would also attend lengthy periods of training such as chiropractors, osteopaths and acupuncturists.

The difference in mean age between professional homoeopaths and medically qualified homoeopaths was found to be significant ($p = 0.001$). The six youngest respondents were all professional homoeopaths and the four oldest were all medically qualified homoeopaths. When considering those homoeopaths who were aged over 60 years there were 2 professional homoeopaths (2%) and 11 medically qualified homoeopaths (20%). This was an interesting difference that was found between these groups, why does it exist ?

One possible explanation which can be suggested is that homoeopathy, as a 'lay' practice, had been in a period of decline from the late 1930s to the late 1970s (Morrell 1995), the first ever training college for professional homoeopaths being opened in 1978. This decline would suggest that few practitioners entered the profession in the period between 1950 and 1980, with a large increase in training,

and subsequently in practitioners entering the profession, in the 1980s. Medical homoeopathy also suffered a slump in popularity in the middle decades of the twentieth century and also witnessed a renaissance around the same time as professional homoeopathy in the late 1970s. The Faculty of Homoeopathy, however, had continued to train a small number of medically qualified homoeopaths throughout the years of declining popularity this century and therefore the medically qualified homoeopath group probably contains a number of older practitioners who were trained in the period from the 1950s to the 1970s at the Faculty of Homoeopathy, when there was very little provision for the training of professional homoeopaths.

A second factor may have been working alongside the dearth of training for professional homoeopaths before 1978. Just as there was a decline in teaching homoeopathy in the middle decades of the century, there was also a similar decline in the popularity of homoeopathy as a treatment option amongst the members of the general public (Morrell 1995). This decline in popularity may have had a more profound effect upon professional homoeopathy, with its market driven ethos, than upon medical homoeopathy, the practitioners of which were also qualified orthodox medical practitioners who could offer homoeopathy to the small number of devotees who requested it, while still earning a salary from their orthodox medical practice. In short, a very small market for homoeopathic treatment led to a small market for trained professional homoeopaths, until the 1980s when homoeopathy witnessed an increase in public popularity. The decline in homoeopathy's popularity may have had a far less profound effect upon the medically qualified homoeopaths who could still make a living out of a mixture of homoeopathy and orthodox medicine. With the prospects of making a professional homoeopathic practice profitable so small it is possible that this also contributed to the lack of professional homoeopaths in the 1950s to 1970s, and thus for the age differential.

8.1.2 Sex

When all of the homoeopaths were considered together there were 94 female practitioners and 62 male homoeopaths in the group, this equates to 60% of the respondents being female. When the professional homoeopaths and the medically qualified homoeopaths were considered separately there was a striking difference noted. In the professional homoeopath group there were 78 females and 22 males, females outnumbering males by almost four to one. In the medically

qualified homoeopath group there were 16 females and 40 males, 29% and 71% respectively, the males outnumbering the females by two and a half to one. This difference in the ratio of males and females between the two groups was significant when tested with the χ^2 test of variance ($\chi^2 = 36.62$; $p < 0.00001$).

What possible explanations are there for this gender difference between the professional homoeopaths and the medically qualified homoeopaths ? It is an established fact that the medical profession has always been a male dominated profession (Stacey 1988) and this, in all probability, accounts for the larger number of males in the medically qualified homoeopath group. There are more male doctors than female doctors and this inequality is merely reflected in the number of doctors who choose to practise homoeopathy.

This fact, however, does not answer the question of why there are so many females in the professional homoeopath group. There may be a number of explanations for this phenomenon and they may also be acting synergistically to produce such a large discrepancy in the gender ratios of the two groups.

Firstly, many of the professional homoeopaths enter the profession from previous work in the health care sector. Many of these homoeopaths are ex nurses who became disillusioned with their work as nurses in the National Health Service and wished to change profession. Nursing, in the UK, is a profession where females outnumber males. Sharma (1992) showed that many heterodox health care professionals had previous occupations such as nursing, teaching and counselling, and these all tend to be female dominated professions. This fact alone may account for a large proportion of the gender inequality in professional homoeopathy. Of course it may also be argued that some other factor is responsible for females choosing homoeopathy as a second career and this means that professional homoeopaths will tend to preferentially come from female led previous occupations.

This leads us to a second possible explanation. Work as a professional homoeopath is often carried out in the practitioners own home, or very close to home. The work is also carried out as a self employed practitioner in most cases. These two factors mean that work hours can be made extremely flexible, to suit the individual practitioner's needs in addition to those of the client. This, and the fact

that the homoeopathic practice was a part time commitment for many of the professional homoeopaths, may make working as a homoeopath an attractive proposition to many females who may wish to work part time, during hours that suit them, in their own home, so that other commitments may also be fitted in, for example child care for pre school and school age children which can be fitted around the homoeopathic practice. Sharma (1992) reported that the desire to work independently, or at least free from bureaucratic restraints, was a strong motivator for the heterodox practitioners that she interviewed.

A third point that may help to explain the gender ratio in professional homoeopaths is that in order to qualify as a professional homoeopath an individual must initially undertake, and fund, either a three year full time or a four year part time course of study and then set up in practice, attracting enough clients to make the practice pay. It may be that these factors dissuade many males from homoeopathic practice if they are the main contributor to the household income as, in order to set up in practice, they may need to forego the security of a regular income from full time paid employment and gamble on setting up a practice that may not be successful, or may take a number of years to become successful.

Fourthly, Sharma (1992) describes the concept of a cult of affliction, whereby those who have suffered illness and have been successfully treated by heterodox medicine are far more open to the idea of studying heterodox medicine in order to practise it later on in their life. Although such previous heterodox treatment is thought by Sharma to be a relevant experience rather than a deciding factor, this experience may explain some of the gender inequality in the professional homoeopath group.

A difference in the attendance rate of males and females at general practitioners has been reported by many sources (Nathanson 1984; Office of Population Censuses and Surveys 1982) with females attending more frequently than males. It has also been shown that women outnumber men as patients of heterodox practitioners (Kelner and Wellman 1997b) including homoeopaths (Furnham and Smith 1988). This would suggest that as more women will be treated by homoeopathy, and therefore undergo the relevant experience that Sharma (1992) suggested might lead to a greater possibility of developing an interest in studying

the therapy, more women will eventually qualify and practice as professional homoeopaths.

8.1.3 Age when started in homoeopathic practice

The mean age for starting in homoeopathic practice for all respondents was 36 years. The youngest reported age was 23 and the oldest was 59 years. When professional homoeopaths and medically qualified homoeopaths were considered separately the mean age differed significantly when measured with the t-test. Professional homoeopaths were shown to have a mean start age of 38, this accords well with Sharma (1992) whose sample of heterodox practitioners were calculated to be in their mid to late thirties when they had started in their heterodox practices. Medically qualified homoeopaths, however, had a mean start age of 34. These data show that although, on average, the professional homoeopaths are presently younger than the medically qualified homoeopaths, the professional homoeopaths are older than the medically qualified homoeopaths when they start in homoeopathic practice. This difference in age is most noticeable when the ages are grouped, it can then be shown that 33% of the medically qualified homoeopaths started homoeopathy between the ages of 26 and 30 (the modal age group for these homoeopaths), while 33% of professional homoeopaths started between the ages of 36 and 40 (the modal age group for these homoeopaths), a ten year age difference.

The large number of medically qualified homoeopaths who started at or just before they were 30 years of age may be explained by the fact that this time frame allows them to qualify from medical school and spend two or three years working in conventional medicine before deciding that they wish to add another form of therapy to their repertoire. Does the two or three years just give them sufficient time to conclude that they would like to make this addition ?

The difference between the professional homoeopaths and the medically qualified homoeopaths in their start ages may be explained by the different nature of the change involved for individuals in each group. The medically qualified homoeopaths are still working in their originally chosen field of medicine even after they decide to practise homoeopathy. Indeed for many of them homoeopathy is an addition to their conventional practice rather than a substitute. This change is therefore closer to a change in medical speciality than it is to a change in career.

For the professional homoeopaths the change to becoming a homoeopath is often a greater change in their occupational circumstances. Many professional homoeopaths have changed from one professional career to another very different one when they start to practise homoeopathy. Although many of the professional homoeopaths would have been working in the health care sector prior to becoming a homoeopath they would normally be in paid employment within the National Health Service, the change to self employed homoeopath status is often a great one. A substantial number of the professional homoeopaths had no previous experience of working in health care, many seemed to come from the teaching profession, this was also reported by Sharma (1992).

In order to make such a change in both career and personal circumstances many professional homoeopaths will have made a switch from paid employment to self employed status. This switch may require a high degree of financial and personal, emotional security, both of which may only come later in life thus accounting for the differences in age between professional homoeopaths and medically qualified homoeopaths when they start their homoeopathic practise. From the data collected it could be suggested that many professional homoeopaths do not reach this state of security until they are in their forties, with 34% of professional homoeopaths starting in practice during this time in their lives.

8.1.4 Length of time as a qualified homoeopath

The mean time as a qualified homoeopath for all respondents was 11 years. However, when professional homoeopaths and medically qualified homoeopaths were considered separately there was a significant difference noted, with professional homoeopaths being qualified for an average of 8 years and medically qualified homoeopaths for an average of 17 years. More than one half of the professional homoeopaths had been working for seven years or less, with three quarters of them qualified for 10 years or less. The longest qualified professional homoeopath had been in practice for 20 years, this length of time is not surprising as it would coincide with the burgeoning of 'lay' homoeopathy in 1975, the formation of the Society of Homoeopaths in 1977 and the opening of the first college in 1978. Over half of the professional homoeopaths had been qualified between 3 and 7 years, centring on 5 years. By contrast, five years was the shortest period of qualified practice for the medically qualified homoeopaths. The

longest period of qualified practice was 47 years for one medically qualified homoeopath, with one third of the medically qualified homoeopaths being qualified for 20 years or more, this was the same duration as the longest qualified professional homoeopath in the sample.

The increase in the number of training establishments for professional homoeopaths in recent years may account for the fact that over half of the professional homoeopaths qualified between 1988 and 1993. A similar surge in numbers does seem to have occurred amongst the medically qualified homoeopaths with 45% of the respondents having qualified between 1979 and 1985, almost ten years before the rise in professional homoeopaths. This earlier surge in their numbers, coupled with the fact that, on average, medically qualified homoeopaths started in practice when they were ten years younger than their professional counterparts, leads to a significant difference in the length of time they have been qualified ($p < 0.001$).

The ten years delay in the increase in numbers of professional homoeopaths may be accounted for by the fact that although both lay and medical homoeopathy were enjoying a renaissance in the last years of the 1970s it was faster for the medically qualified homoeopaths to achieve a qualification in homoeopathy, almost half reported a training period of 9 months or less, than the professional homoeopaths who usually trained for three or four years. It may also be the case that the professional homoeopaths, knowing that they would be at the mercy of market demands for their services waited for a few more years into the renaissance to ensure that it was a stable phenomenon and not a transient growth that might disappear once again leaving them in a financially vulnerable position.

Perhaps by the late 1980s it was perceived to be a safe enough gamble to spend four years, and a considerable sum of money, training as a professional homoeopath with the prospect of a practice at the end of training that was financially viable.

8.1.5 Duration of homoeopathic training

For all respondents the mean duration of homoeopathic training was 3.25 years. However, once again, when considered separately the professional homoeopath's average was 4.25 years and the medically qualified homoeopath's average was 1.5

years. The modal responses were 4 years for professional homoeopaths and 3 months for medically qualified homoeopaths. This difference in the duration of training was found to be significant when the t-test was applied to the data ($t = 14.0$; $p < 0.001$).

Although the Glasgow course leading to Membership of the Faculty of Homoeopathy (MFHom) is currently a three or four year part time course, similar in duration to the courses offered to professional homoeopaths, there was a large proportion of medically qualified homoeopaths with only three months of training (26% of the sample of medically qualified homoeopaths had 3 months homoeopathic training, or less).

Some of the differences in the duration of training might be explained by the fact that the medically qualified homoeopaths should already possess a number of necessary skills and a core of knowledge that was gained during conventional medical training, that must be acquired by the professional homoeopaths in their training courses, hence the need for extra tuition time. Examples of this would be case taking skills, differential diagnosis skills and a knowledge of anatomy and physiology as well as the conventional treatment regimes for a number of common complaints. These skills must be taught to professional homoeopaths to enable them to carry out a safe practice, enabling them to identify patterns of symptoms that allow them to advise their clients of suspected serious pathology or to refer patients back to their general practitioner where they feel that this might be advisable. These skills and this knowledge are already in the possession of the medically qualified homoeopaths, but must be taught to professional homoeopaths.

These differences aside there would still appear to be significant differences in the amount of tuition time available for the principles of homoeopathic practice to be taught to professional homoeopaths and their medically qualified counterparts.

Some of these differences might be explained by the different emphasis placed upon learning what is usually referred to as 'Homoeopathic Philosophy'. Colleges for professional homoeopaths often utilise a large proportion of their time, commonly 20 -25%, on the teaching of the works of Hahnemann and his followers such as Kent and Hering, learning about the Vital Force, provings, potentisation and the rules of prescribing and cure. Hahnemann's Organon (Hahnemann 1988)

is often studied in minute detail to enable students to follow his methods of prescribing and to understand Hahnemann's theories on the ways that homoeopathy works.

Hahnemann is typically given very little time on the courses offered to medically qualified homoeopaths and the methods of prescribing are often simplified and demystified by the application of a small number of straightforward paradigms.

With no need for the teaching of medical sciences and very short work being made of Hahnemann and his theories and philosophy of homoeopathy the courses for medically qualified homoeopaths can be made shorter. However the professional homoeopaths would still claim that even with these omissions, what is left to be taught still requires more than three months (in essence this is 3 weekend seminars), and that this lack of time results in medically qualified homoeopaths who can only utilise homoeopathy in a very mechanistic fashion. This style would mean that they often prescribe remedies on a pathological basis, using the same one or two remedies for all patients presenting with a certain set of similar symptoms, for example menstrual problems, rather than individualising each patient, and their symptoms, and prescribing the most similar remedy as in the Classical or Hahnemannian method. This mechanistic, pathological form of homoeopathy is seen by the professional homoeopaths as an inferior therapy to that which they carry out and have received a full and thorough education in. This topic will be revisited in another section of the report when the opinions of the professional homoeopaths were sought regarding their medically qualified counterparts.

The length of the courses for professional homoeopaths may also be linked to the drive for professionalisation that is originating from the Society of Homoeopaths. Colleges wishing to avail themselves of the direct method of entry onto the Society of Homoeopaths register for their graduates must obtain prior validation of the course and its content from the Society of Homoeopaths. A four year part time, or three year full time, course is seen as the minimum training required to meet the conditions necessary for direct entry onto the Society of Homoeopaths' register. This strategy of excluding those with insufficient training is one of the core elements of the Society of Homoeopaths drive for professionalisation and for registration (Cant and Sharma 1995).

Interestingly only one professional homoeopath stated that they had not attended a training college at all, this contrasts strongly with data collected in 1980 by Fulder and Munro (1985) which showed that only half of the heterodox practitioners in their sample had attended a full time or part time course at a college. Fulder and Munro's sample was made up of a mixture of heterodox practitioners rather than made up entirely of homoeopaths, but this difference in college attendance rates is nevertheless an indication of the changing importance placed upon educational courses by all heterodox practitioners since the early 1980s.

What is even more surprising is that when the homoeopaths from Fulder and Munro's sample are considered in isolation it is seen that, compared to most other therapies they had one of the lowest percentages of college course attenders in the sample, with only 25% attending a college or correspondence course. This compared with 92% of acupuncturists, 100% of Alexander Technique teachers, 75% of chiropractors and 64% of osteopaths who had attended a college or undertaken a distance learning course. These figures must be treated with care, however, as they represent only 4 homoeopaths, representing 2.9% of the entire sample of 136 heterodox practitioners.

It is possible that if the data had been collected only five years later there may have been a difference in the number of homoeopaths attending courses. The first college for professional homoeopaths had only been open for two years when the data was collected in 1980, and there would not have been any graduates from this course in practice in 1980. The mean time in practice for the homoeopaths in Fulder and Munro's sample was 6.2 years, this would indicate that the average homoeopath in the sample had been in practice for 4 years before the opening of the first course in 1978.

8.1.6 What was the respondents occupation prior to homoeopathy ?

Amongst the professional homoeopaths the largest group of previous occupations was that of health care related occupations. There were 22 respondents who listed such occupations, with 14 of these being directly related to patient care professions such as nursing and midwifery, occupational therapy and dietetics. Other members of this group had previously been engaged in practising one or more heterodox therapies other than homoeopathy.

The next largest group was 15 professional homoeopaths with a background in teaching, these included a number of university lecturers, teaching in a number of diverse subjects as well as a deputy head teacher in a secondary school and several special needs support teachers.

These two groups would appear to be evidence in support of Sharma's data showing that health care and teaching made up the bulk of previous occupations of the heterodox practitioners interviewed (Sharma 1992).

It is understandable, perhaps, that those already working in the health care sector should look for a different health care related occupation when they feel that they wish to change careers. The motives that initially led to them wishing to become a nurse or a dietician are probably not too different from those that draw them into homoeopathy, caring for people, wishing to help people who are ill. It may be, and this will be discussed more fully in a later section, that they became disillusioned not only with their previous role, but also with the conventional medical care that they were involved in and a change of career may have offered a change of therapeutic model also.

It is less easy, perhaps, to explain why there are so many ex-teachers and lecturers working as professional homoeopaths and, as Sharma pointed out, as other heterodox health care practitioners (Sharma 1992). It may be the case that teachers are more likely than other professionals to become disillusioned with their careers and wish to change to something different, this would lead to a large proportion of ex teachers appearing in other professions also. Is there a desire within teachers who leave to change careers to join health care professions specifically ? It is beyond the scope of the data collected to answer these questions definitively.

It is no surprise to find that prior to working in homoeopathy, all medically qualified homoeopaths had been working in conventional medicine. One medically qualified homoeopath stated that he had started a private homoeopathic practice within one year of qualifying from medical school but all other medically qualified homoeopaths had worked within the National Health Service in conventional medical practice prior to starting to use homoeopathy. On average medically

qualified homoeopaths had been qualified as conventional doctors for just under ten years before they first used homoeopathy.

Over 80% of medically qualified homoeopaths had been employed in general practice prior to working with homoeopathy, often starting in general practice within four or five years of qualifying from medical school. It might be suggested that many of these medically qualified homoeopaths who moved into general practice so soon after qualifying were not comfortable in the environment of hospital medicine and preferred the work of general practice which is, arguably, more patient centred than the work of a hospital registrar. It could be further argued that the introduction of homoeopathy into their practice was a further move away from high pressure medicine, towards an even more patient centred therapeutic technique such as homoeopathy.

8.2 Characteristics of homoeopathic practices.

8.2.1 Number of homoeopathic patients seen per month

For all respondents the mean number of patients seen in a month was 81, however, the numbers ranged from one medically qualified homoeopath who saw three homoeopathic patients each month, to another medically qualified homoeopath who reported seeing 600 homoeopathic patients per month. There was a significant difference between professional homoeopaths and medically qualified homoeopaths with the professional homoeopaths seeing an average of 60 patients per month and the medically qualified homoeopaths seeing an average of 123 patients per month, double that seen by professional homoeopaths.

The number of patients that are able to be seen in a month is dependent upon a number of factors including the length of the consultation time and the number of days worked in the month, that is, whether the practitioner is working full time or part time in homoeopathy. As has already been demonstrated in the results section (sections 7.3.2 and 7.3.3) the mean length of appointment was shorter for medically qualified homoeopaths than for professional homoeopaths and this would affect the number of patients it was possible to see in any given time frame. There was also, as would be expected, a significant positive correlation between

the percentage of time spent in homoeopathy and the number of patients seen ($r_s = 0.49$; $p < 0.0001$).

Fulder and Munro (1985) using data collected in 1980 showed that the mean number of patients seen per week by homoeopaths was 21, this equates to around 80 per month. This is somewhat higher than the homoeopaths who responded to questionnaires in the present study, 70% of respondents were not seeing as many as 80 patients per month. This would seem to suggest that over the past 15 years or so the average number of patients seen by professional homoeopaths has decreased. What might explain this apparent decrease during a period when interest in heterodox medicine and numbers of heterodox consultations were increasing (Lewith and Aldridge 1991; Fisher and Ward 1994) ? A number of factors may have a part to play in the drop in mean numbers of consultations per practitioner per month.

The first point to make is that the number of homoeopaths practising in the UK in 1980 was given by Fulder and Munro (1985) as 360, this number has increased over the intervening 15 or so years. If the numbers of professional homoeopaths on the 1997 registers of the Society of Homoeopaths, the Association of Natural Medicines (ANM), the United Kingdom Homoeopathic Medicine Association (UKHMA) and the General Council and Register of Consultant Herbalists, Homoeopaths Register (GCRH) are added together they total 1170 registrants. Even allowing for the fact that the UKHMA allows medically qualified homoeopaths to join their register, and that some professional homoeopaths may appear on more than one register, it is easily plausible to suggest that the number of professional homoeopaths had at least doubled by the year 1997 since Fulder and Munro's figure of 360 in 1980.

Secondly, Fulder and Munro state that the mean duration for a consultation in their mixed group of heterodox practitioners was 51 minutes for a first appointment and 36 minutes for a follow up. They did not give a breakdown for homoeopaths but did state that acupuncturists, hypnotherapists and homoeopaths gave longer consultations than naturopaths, osteopaths and chiropractors. As has been shown in the results section (section 7.3) the mean duration of first appointment for professional homoeopaths is now 88 minutes and for follow ups the consultation averages 46 minutes, both times are longer than those given for 1980 by Fulder and Munro (1985).

To summarise, although it can be shown that the number of patients consulting homoeopaths in the UK has increased during the period 1980 to 1995 the mean number of patients seen by individual professional homoeopaths has decreased from 80 to 60 per month. Suggested explanations for this are that the number of professional homoeopaths in practice has dramatically increased during this time and that professional homoeopaths are giving more time to each patient consultation in 1995 than they did in 1980.

8.2.2 Length of the consultation.

Although only the length of consultation was requested on the questionnaire, all but 14 of the respondents chose to differentiate between the duration given for a first appointment and that for a follow up appointment, of the 14 who did not differentiate only one was a professional homoeopath. It was found that the first consultation usually lasted twice as long as a follow up consultation.

For all respondents the mean first appointment duration was 75 minutes and the mean follow up appointment lasted for 40 minutes. When professional homoeopaths and medically qualified homoeopaths were considered separately substantial differences in the length of consultations became apparent. The first appointment with a professional homoeopath would last, on average, for 88 minutes, while first appointments with medically qualified homoeopaths lasted for an average 53 minutes. This difference was found to be significant when the t-test was applied to the data ($t = 6.53$; $p < 0.001$).

A similar picture emerged with the follow up consultations, with a professional homoeopath this would last, on average, for 46 minutes, while the medically qualified homoeopaths averaged 28 minutes for a follow up appointment. Once again this difference was significant ($t = 6.53$; $p < 0.001$).

These differences in the times given for consultations can be related back to the discussion in the previous section (section 8.2.1) where numbers of patients seen per month were considered. The professional homoeopaths see fewer patients per month than the medically qualified homoeopaths and this fact is related to the length of consultations. If a medically qualified homoeopath sees in excess of 500 patients per month it is inconceivable that each consultation can last for 60

minutes, or 120 minutes for a first appointment, and yet these times were reported by 20% of professional homoeopaths.

Using a rough rule of thumb of 10% of appointments being first appointments a homoeopath seeing 500 patients a month, with 120 and 60 minute consultations would be accumulating 550 patient contact hours each month, or 20 hours per day for 27 days of the month. In reality the medically qualified homoeopath who reported seeing 600 patients per month gave appointment times of 30 minutes and 15 minutes for first and follow up appointments respectively, this results in a more manageable 165 hours per month or 7½ hours per day for five days each week, seeing around 27 patients per day. This would still represent a very large work load for one person.

This can be compared to a more commonly reported workload. The modal follow up appointment for professional homoeopaths was 45 minutes. Those professional homoeopaths who gave this figure reported a mean number of patients per month of 50. Using the 10% first appointment rule of thumb this would result in these professional homoeopaths seeing 2 or 3 patients per day spending 2 hours per day over a five day week. A more plausible scenario, especially if the homoeopath was working from a consultation room which was rented on a daily basis - or half daily basis - would be two days per week for 5 hours per day, seeing around 6 patients per day, or 12 patients in 10 hours.

Working in the same fashion for medically qualified homoeopaths the modal follow up appointment was 30 minutes and an average medically qualified homoeopath with this length follow up appointment saw 90 patients per month. Using the same 10% rule for new patients results in a medically qualified homoeopath spending 2½ hours per day seeing about 4 or 5 patients for 5 days per week, or 24 patients in 12½ hours.

Comparing the professional homoeopaths and the medically qualified homoeopaths in this way it may be suggested that the average professional homoeopath spends 5 hours seeing 6 patients on two days of the week while a medically qualified homoeopath spends half as much time per day seeing a similar number of patients on five days of the week. It is therefore not unreasonable to suggest that, on average, professional homoeopaths spend more time with their

patients than medically qualified homoeopaths, presumably extracting an extremely detailed case history and questioning follow up patients for a longer period of time regarding the effects of their treatment. The data showed that only 3 (3%) professional homoeopaths held follow up consultations lasting for less than 30 minutes (two at 20 minutes and one at 15 minutes) and 25% held follow up consultations lasting between 60 and 120 minutes. In contrast to this 3 medically qualified homoeopaths (7%) held follow up consultations of 10 minutes.

8.2.3 Working in the National Health Service.

None of the professional homoeopaths worked exclusively within the National Health Service compared to 5 medically qualified homoeopaths (9%) who reported working exclusively in the National Health Service. This can be explained primarily by the presence of Homoeopathic Hospitals in Glasgow, London and Tunbridge Wells which offer homoeopathic treatment on the National Health Service. These hospitals are staffed by medically qualified homoeopaths and there are no professional homoeopaths working in them.

A mixture of both National Health Service patients and private patients was seen by 11 professional homoeopaths (11%) and by 32 medically qualified homoeopaths (56%). These homoeopaths were mostly seeing National Health Service patients who had been referred to them by a fund holding general practitioner who had chosen to provide this service from the practice budget. Referral to professional homoeopaths was far less common than to medically qualified homoeopaths as can be seen by the data presented. Although Stephen Dorrell opened the way for general practitioners to refer to any heterodox practitioner, medically qualified or not (Society of Homoeopaths 1992), it would seem from the data that it is safe to say that general practitioners are happier to refer to another doctor, who practices a heterodox therapy, than to a 'lay' heterodox practitioner with no medical qualifications.

Exclusively private work was reported by 89 professional homoeopaths (89%) and by 20 medically qualified homoeopaths (35%). The data suggest therefore that the majority of professional homoeopaths see patients only on a private basis, whilst the majority of medically qualified homoeopaths see patients on both a private basis and through the National Health Service.

Homoeopathic patients seen through the National Health Service were given a shorter consultation than those seen privately by the same medically qualified homoeopath. On average the 32 medically qualified homoeopaths who saw both National Health Service and private patients spent 38 minutes on a follow up appointment with a private patient and 23 minutes with a National Health Service patient, ten medically qualified homoeopaths had equal length appointments for National Health Service and private patients. This difference in the duration of consultations may be another factor in enabling some medically qualified homoeopaths who see National Health Service patients, to see more patients per month, on average, than the professional homoeopaths whose private patients are paying for the homoeopath's time as well as their professional expertise.

The longer consultation for private patients in orthodox medical care was one factor that Wiles and Higgins (1996) suggested could lead to an individual deciding to pay a fee for their medical care and the privately funded heterodox patients are undoubtedly expecting a similarly lengthier consultation than that which they are accustomed to receiving from their National Health Service funded general practitioner.

Using Friedson's concepts of client control and professional control (Friedson 1960 and 1975), Sharma (1992) argued that heterodox practitioners were largely independent practitioners and this was born out by the data collected from professional homoeopaths showing that 89% see patients privately rather than through the National Health Service and all stated that their primary source of patients was through self referral. This would suggest that the professional homoeopaths are subject to client control rather than professional control and, as such, they must attract fee paying clients and then convince them to continue in their treatment. One way of ensuring that patients are well motivated to both initiate and then continue in their treatment is to deliver to them what they want. One of these desires is a longer consultation that allows a more effective two way communication to take place. For this reason the professional homoeopaths may find it more advantageous to offer more time for the fee than the medically qualified homoeopaths who are also subject to professional control because they also require National Health Service referrals from general practitioners, who may be far more interested in cheaper consultations that may reduce their drugs bill, rather

than longer, and consequently costlier, consultations that might lead to enhanced patient satisfaction.

Almost one quarter of the professional homoeopaths had worked within the National Health Service prior to changing career and working as a homoeopathic practitioner. Many of these professional homoeopaths with some experience of the bureaucracy of the National Health Service felt that one of the reasons for working as a homoeopath was to escape the bureaucracy of the National Health Service and set up in an occupation that provided self employed status. Working as part of the National Health Service, even as a homoeopath, was not something that many of these ex National Health Service workers considered as a viable employment strategy. During interviews the phrase 'being your own boss' was used extensively and Sharma (1992) showed that this independence of thought and the desire to escape an employer's bureaucratic regime was quite commonly seen in heterodox practitioners of all types.

8.2.4 Full-time or part-time homoeopathic practice

Full time homoeopathic practices were run by 60% of the professional homoeopaths and by 52% of the medically qualified homoeopaths. A practice that took up less than 50% of the practitioners working time was reported by 16% of professional homoeopaths and by 32% of medically qualified homoeopaths. On average the professional homoeopaths spent 80% of their work time in homoeopathic practice while the medically qualified homoeopaths spent an average of 65% of their time practising homoeopathy.

It is possible that many of the medically qualified homoeopaths were using homoeopathy as a supplementary practice to their conventional practice and the time may not have been available for too many lengthy homoeopathic consultations. In contrast however, professional homoeopaths may be required to work more of their time in homoeopathy if they wish to maintain a successful practice with satisfied clients who will personally recommend them to friends, relatives and work colleagues in order to keep a steady supply of new patients entering the practice.

The fact that more of the medically qualified homoeopaths saw homoeopathy as taking up a smaller part of their work time might also be interpreted as evidence of

a lower commitment to homoeopathy as a different healing technique, and the utilisation of homoeopathy as not only a complementary technique to orthodox medicine, but even as a supplementary technique, utilised to help along conventional treatment. There is no data here to show this to be the case, however, as we shall see in a later section when the opinions are sought of both medically qualified homoeopaths and professional homoeopaths, this is something that the professional homoeopaths have always suspected, and have often accused, the medically qualified homoeopaths of doing. This idea was certainly suggested by the professional homoeopaths during interviews when asked what they thought of medically qualified homoeopaths and the ways in which they practised homoeopathy.

8.2.5 Equality in the consultation

Four areas of decision making and responsibility were explored, these were;

- who makes decisions about the diagnosis,
- who makes decisions about what is to be treated,
- who makes decisions about what treatment is to be used,
- who is responsible for any improvements in the patient's health.

It was hypothesised that the professional homoeopaths would engage their patients more in the decision making process and would also consider the patient as being the partner in the consultation who was primarily responsible for any improvements in their own health.

When the data were examined it became evident that for two out of the four areas listed the most popular response for both professional homoeopaths and medically qualified homoeopaths was to share the responsibility equally between the practitioner and the patient. These two areas were 'who decides what is to be treated' (see Figure 7.12) and 'who is responsible for improvements in the patient's health' (see Figure 7.14). Professional homoeopaths and medically qualified homoeopaths were very similar in their responses to these two items and no significant differences were found.

Many of the practitioners may feel that both the patient and the practitioner are equally responsible as there is so much input from both partners in order to arrive

at a decision. What is to be treated relies on the patient to report their symptoms and the rest of their history accurately and truthfully, while the practitioner is responsible for interpreting these data in order to decide what needs to be addressed in the analysis of the case and the making of a prescription for a remedy.

Similarly, many of the practitioners would probably argue that the patient's own self healing mechanism, working in conjunction with the homoeopathic remedy selected by the homoeopath, and possibly with a placebo effect from the belief that the practitioner has in the system and in the selected remedy, is responsible for improvements in the patient's health, making this, once again, a shared responsibility.

In the remaining two areas of responsibility, although there were many respondents who indicated that they had an equally shared responsibility with the patient there were differences between the professional homoeopaths and the medically qualified homoeopaths.

When it came to making a diagnosis the familiar peak of responses for equally shared responsibility was seen for the professional homoeopaths, however the medically qualified homoeopaths showed a moderately steady decline in responsibility from the practitioner to the patient (see Figure 7.11). One in five medically qualified homoeopaths placed the responsibility solely with the practitioner and 50% of the respondents placed the responsibility at least 75% with the homoeopath. More professional homoeopaths were happy to devolve this responsibility, at least in equal proportions, to the patient than medically qualified homoeopaths were.

One reason for this difference may lie in the unease that many professional homoeopaths had with the use of the word 'diagnosis'. Many comments were added to this item by the professional homoeopaths all stating that they did not make diagnoses in homoeopathy, they were unnecessary as the remedy was prescribed due to its similarity to the symptom picture rather than because it fitted with a specific disease label, a diagnosis.

A second reason for the medically qualified homoeopath's desire to be in control of diagnosis may be that they do feel that a conventional medical diagnosis is useful in a homoeopathic case and as the starting point in conventional medicine is the taking of a history in order to make a diagnosis, and they had all been trained in this skill, it may have seemed only natural to them to take responsibility for making the diagnosis rather than letting the patient have too much input.

Finally professional homoeopaths are not trained in making medical diagnoses, although the recognition of certain diseases is often taught, and this would undoubtedly have dissuaded many professional homoeopaths from accepting responsibility for this task.

The second area of responsibility that was not centred around equally shared responsibility between homoeopath and patient was 'who decides what treatment is to be used'. Although there was a slight upward surge in opinion at the equal responsibility mark from both professional homoeopaths and medically qualified homoeopaths (see Figure 7.13), on the whole the responsibility was seen by both groups to lie almost entirely with the homoeopath, although there was a very small number of professional homoeopaths who felt that patients should be heavily involved in this decision making process.

If anything the professional homoeopaths were more strongly desirous of maintaining control of this area of responsibility than the medically qualified homoeopaths with 33% of professional homoeopaths placing the responsibility entirely with the homoeopath, compared to 22% of medically qualified homoeopaths.

It is highly probable that this responsibility, more than any other, is seen as the role that the patient is paying the homoeopath to perform. This is the area where the homoeopath has expertise and the patient does not, if the patient did possess this knowledge then, arguably, they would have no need to consult the homoeopath. The reason that this may have been felt more strongly by the professional homoeopaths than by the medically qualified homoeopaths is that this is, arguably, the only role that the professional homoeopath is trained for. The medically qualified homoeopath is also trained as a conventional doctor and can utilise these skills as a fall back position if necessary. There is no reason for consulting with a

professional homoeopath other than because they should possess this skill of knowing what treatment to use to a high degree.

8.2.6 A summary of the differences between professional homoeopaths and medically qualified homoeopaths and their practices

It has been shown that professional homoeopaths and medically qualified homoeopaths differed in a number of ways, they differed in mean age, how long they had been in practice, how long their training in homoeopathy had lasted and lastly they differed in the ratio of males to females, with professional homoeopaths being predominantly female while medically qualified homoeopaths were predominantly male. This difference in gender may offer some explanations for the ways in which professional homoeopaths and medically qualified homoeopaths differed in their respective practices.

The mean length of both first and follow up appointments were significantly longer when undertaken by professional homoeopaths. This may signify a slower, less rushed consultation style that also includes a more detailed history and possibly the inclusion of topics into the history that the medically qualified homoeopaths may deem irrelevant. This would lead to a longer, more person centred consultation, with the opportunity for patients to ask questions and take part in the decision making. Hall et al (1994) found that within orthodox medicine female physicians conducted longer consultations than male physicians, they also smiled and nodded more. Female doctors also asked more questions and made more partnership statements than male doctors. It is possible that the female homoeopaths were also acting in this sensitive manner more than the male homoeopaths, this would suggest that, as there were more female professional homoeopaths than female medically qualified homoeopaths, then as a group the professional homoeopaths would interact with their clients in a more positive manner.

One other aspect of gender is also useful in attempting to explain differences between professional homoeopaths and medically qualified homoeopaths. Mechanic (1978) suggested that orthodox medical schools tended to recruit students who display a number of personal attributes that can be associated with maleness. Klass (1984) further suggested that the medical school then inculcated what can be seen as male attitudes into their students, resulting in medical schools

converting both male and female medical students into doctors with masculine, macho attitudes.

Allowing for the fact that at interview and in the questionnaire a small number of medically qualified homoeopaths identified this sort of macho, high pressure environment that exists in orthodox medicine as a motive for moving away from conventional medicine to use homoeopathy, all of the medically qualified homoeopaths had been initially selected and then socialised by medical schools towards these supposedly masculine ways of thinking, acting and interacting. None of the professional homoeopaths had undergone medical training and it could be suggested that because of this difference in socialisation the male professional homoeopaths may use a less masculine style of interaction than their male medically qualified homoeopath counterparts.

If this is the case then it might be suggested that patients desiring a more egalitarian partnership with a homoeopath would do well to see a professional homoeopath, and probably a female one as they will normally give more time to the consultation than either a conventional doctor or a medically qualified homoeopath.

A further factor that may be influencing a difference in style between the professional homoeopaths and the medically qualified homoeopaths is the fact that homoeopathy is usually a form of private medicine. In the case of professional homoeopathy it is almost always a form of private medicine, with medically qualified homoeopathy there are a larger number of practitioners who are offering homoeopathy to National Health Service patients.

This difference may influence the time given to patients as National Health Service homoeopathic patients receive, on average, shorter consultations than private homoeopathic patients. If patients of professional homoeopaths are paying for private consultations it is not inconceivable that, as Sharma (1992) suggests, it is market forces that are responsible for differences in the practice style between the predominantly private practices of the professional homoeopaths and the mixed National Health Service and private practices of the medically qualified homoeopaths.

8.3 Why practice homoeopathy ?

8.3.1 Medically qualified homoeopath's motivations

The question 'why practice homoeopathy ?' has a different meaning for medically qualified homoeopaths and professional homoeopaths. For the medically qualified homoeopaths the question has few implications concerning career change and is related more closely to the development of an interest in a new medical specialism.

On the questionnaire the medically qualified homoeopaths were given a closed response item with six options with the instruction to rank the top three important motivators.

The most frequently chosen motivator was 'I felt that there was more than just conventional medicine', with 41 medically qualified homoeopaths (72%) placing this in their list of top three motivators and 29 medically qualified homoeopaths (51%) placing it in the first choice position. This suggests that many of the medically qualified homoeopaths may have felt that homoeopathy was something that could be used to supplement conventional medicine.

A further 33 responses were made listing the motivator 'I felt that homoeopathy was an additional 'tool' that I could use', which also suggests the use of homoeopathy as a supplementary technique to conventional medicine, a broadening of the therapeutic repertoire. This could be described as a form of 'therapeutic eclecticism' such as was practised in the United States of America in the middle years of the nineteenth century (Coulter 1982).

A slightly more radical stance was taken by 33 respondents who listed the motivator 'I felt dissatisfied with conventional medicine', eleven of these responses were ranked as the primary motivator. This might suggest that around 20% of the medically qualified homoeopaths had made a more radical move towards homoeopathy at the expense of their conventional medical practice, unlike the majority of medically qualified homoeopaths who gave motivations that suggested, at most, a complementary role for homoeopathy, and at least a supplementary role in a pluralistic, eclectic therapeutic model.

When combinations of motivations were considered a difference did emerge between those listing 'more than just conventional medicine' as their primary motive and those listing the 'additional tool' motive. Although these two motives seemed to be quite similar when initially considered, there was a difference in their choice of second ranked motivator. Half of those giving 'more than just conventional medicine' as their first motive gave 'dissatisfied with conventional medicine' as their second choice. Not one single respondent who had listed 'additional tool' as their first choice gave 'dissatisfied with conventional medicine' as their second choice, however, half of them did list 'more than just conventional medicine' as their second choice.

These seemingly confusing data seem to suggest that those who chose the phrase 'additional tool' did not feel dissatisfied with conventional medicine as they were using homoeopathy in conjunction with conventional medicine in their practice. Those who chose 'something more than just conventional medicine' may have been stating that they were dissatisfied with conventional medicine and they therefore felt that there must be something more to therapeutic systems than just conventional medicine.

What was it that dissatisfied the medically qualified homoeopaths with regard to conventional medicine ? Not one of those respondents who chose 'dissatisfied with conventional medicine' as their first choice opted for 'allows more time with the patient' as second choice, suggesting that the time constraints that often accompany conventional medical consultations were not the main cause of the dissatisfaction, some other factors were at work.

When the data from the open response item regarding motivations on the medically qualified homoeopaths questionnaires were examined there were some clues given regarding the dissatisfaction with conventional medicine. Those whose responses to the closed item mentioned dissatisfaction with conventional medicine often spelt out in the open responses that their dissatisfaction was with the possible side effects that were often linked to the drugs used in conventional therapy.

For a small minority of medically qualified homoeopaths it would seem, therefore, that a growing dissatisfaction with the increasing use of powerful drugs, many of

which may be accompanied by unpleasant side effects, was the prime motivator that led to their use of homoeopathy. For the majority of medically qualified homoeopaths however, this did not seem to be the case.

The comment that was added most frequently was that personal contact with a homoeopath was an important deciding influence, for many of these the influencing homoeopath was their father, suggesting that such close personal contact is a powerful motivator among medically qualified homoeopaths. This form of 'therapeutic evangelism' may be a necessary factor when convincing a doctor to try a form of medicine that, on initial inspection, seems to make no scientific sense. A personal contact with a 'convert' may be necessary to enable the doctor to make an initial 'leap of faith' and give a trial to what must seem to be an unscientific form of 'magic'. The personal contact not only allows anecdotal evidence to be presented alongside an explanation of homoeopathy, but it also allows for questions to be asked. If good results are then witnessed, and patient's conditions are seen to be improved, then an interest in homoeopathic prescribing may be cultivated. It would therefore seem that a personal contact may be useful in overcoming any initial barriers to homoeopathic practice.

A further group of motivators given by medically qualified homoeopaths centred on the doctor patient relationship. The more client centred, individualistic approach attracted some of the respondents to homoeopathy, two of the medically qualified homoeopaths had made observations regarding the individualistic nature of patient's illnesses and symptoms and found that homoeopathy was ideally suited to respond in an equally individual nature in its treatment of these symptoms. This individuality of patients is more apparent when a deeper, client centred approach is taken rather than, as one respondent described it, the 'mechanistic approach' of conventional medicine.

The fact that homoeopathy worked, and was seen to work when it was tried, was a strong influence on a number of medically qualified homoeopaths. This factor may be linked to the eclectic, pluralistic approach of the 'additional tool', the approach of using anything that might help. If conventional medicine does not have an answer then try anything else that may be of use, if it works then include it in the therapeutic repertoire for future use. As one medically qualified homoeopath put it at interview, 'I want as many arrows on my bow as possible'.

Only one medically qualified homoeopath gave personal illness experience, and subsequent successful homoeopathic treatment as an influence on their initial interest in practising homoeopathy. It would seem therefore that, unlike the 'lay' homoeopaths that Sharma (1992) interviewed, personal illness experience is unimportant in motivating doctors to add homoeopathy to their conventional medical practice. This may be explained by the fact that the doctors were already involved in a form of health care when they first became interested in homoeopathy. The personal illness experience of Sharma's sample appears to motivate their interest in initiating a career in treating people who are unwell rather than altering the health care technique used by someone who is already practising a therapeutic technique.

8.3.2 Professional homoeopath's motivations

For professional homoeopaths the question 'why practice homoeopathy ?' is a question related to career changes and may involve greater changes in lifestyle than the change in medical specialism that medically qualified homoeopaths tend to undergo when practising homoeopathy. The question can quite often be interpreted as 'why did you choose homoeopathy as a new career when you left your previous occupation ?'.

The most frequently given motivation for professional homoeopaths was a personal experience of illness, this was mentioned by 45 professional homoeopaths (45%). This finding is in agreement with Sharma (1992) who found that a substantial number of her interviewees (33%) reported similar illness experiences prior to their work as heterodox practitioners. For Sharma's interviewees and for the professional homoeopaths answering the questionnaire this illness experience often had two separate focuses or phases. Initially the illness appears to have been treated by conventional medical methods and, when these did not result in an improvement or caused unwanted side effects, the person formulated their own hypothesis regarding the inadequacy of conventional medicine in the treatment of their particular complaint. The second phase would seem to have started with their initial involvement with heterodox medicine as a patient, with homoeopaths this involvement was with homoeopathy as a rule. When the homoeopathic treatment resulted in some improvement in their condition the original hypothesis regarding the failings of conventional medicine seems to have been proved to the patient

involved. It is possible that those who subsequently become involved in the study and practice of homoeopathy, or the other heterodox practices that Sharma's interviewees used, may then broaden the range of their hypothesis. No longer is it a hypothesis relating solely to their own personal illness experience, the inability of conventional medicine to provide all of the answers to *society's* ill health and disease replaces the initial egocentric hypothesis.

Sharma (1992) likens these illness experiences in the practitioners to those in a cult of affliction whereby those who have suffered and undergone treatment acquire the capacity to heal others. Sharma especially likens the experience of spiritual healers in the United Kingdom to the concept of the cult of affliction. The usefulness of the cult of affliction is questionable amongst homoeopaths. Certainly, as has been shown, the medically qualified homoeopaths gave no evidence of a strong influence from personal illness experiences with only one respondent reporting such an occurrence. Among the professional homoeopaths illness experiences were the most commonly quoted influence, however, for many of the respondents this was not a personal illness experience, the illness was often experienced by a significant other, often their partner or offspring and on one occasion it was the respondent's dog who had experienced illness that had been subsequently treated successfully by homoeopathy. It would seem therefore that for many the experience of illness may have helped them to formulate their ideas about the efficacy of conventional medicine and of homoeopathy that then led to subsequent study and practice, but it seems that the experience of suffering is not a necessary experience in order to acquire a healing capacity as Sharma (1992) suggests might be the case with Spiritual Healers in the United Kingdom.

Sharma (1992) does however state that these illness experiences are relevant experiences rather than deciding factors, the experience of heterodox treatment merely opening up the possibility of study more than it would have been without the illness experience. This may be the case for many of the professional homoeopaths, however there would appear to be a small number for whom the experience could be regarded as a deciding factor. A small number of professional homoeopaths wrote of such a powerfully positive effect from homoeopathy that they felt the need to study and practice this therapy. Often this study followed a short period of using homoeopathy for self prescribing and prescribing for immediate family. Unlike many other heterodox therapies, especially the

manipulative therapies such as osteopathy and chiropractic, it is possible to 'dabble' in homoeopathy by making simple prescriptions for acute conditions with the use of remedies that are available over the counter in many pharmacies and health food stores, together with a basic booklet that would also be available in these retail outlets. More detailed books are also now available for home prescribers although these usually carry a recommendation to consult a qualified homoeopath for more complex or chronic prescribing.

This wide availability of simple homoeopathic remedies and knowledge may make it easier for people with illness experiences to use those experiences as a deciding factor in initial, low key, use that leads to further study. In this way it is possible that these people are using the illness experience as a deciding factor in their eventual practice. For the majority of the professional homoeopaths, however, it is probably true to say, in concurrence with Sharma, that the illness experience is a relevant experience rather than a deciding factor.

Many of the professional homoeopaths had been working in the National Health Service prior to their work as a homoeopath and for many of these the primary motivator was a disillusionment with conventional medicine. Working in the field of conventional medicine supplied much evidence that helped their feelings of disillusionment to grow, the side effects of drugs and the 'unscientific' nature of orthodox treatments were often cited, as was the inability of conventional medicine to see the patient in a holistic manner. Safety concerns regarding the use of conventional drugs were also often cited in the responses.

For these ex National Health Service workers, homoeopathy was seen as a way of using a safer, holistic form of medicine that would involve the patient in their own healing process. Their disillusionment with conventional medicine would also have resulted in a disillusionment with their role in this form of medicine, and presumably with their career, leading to a desire to change careers. It is possible that many ex National Health Service heterodox practitioners may initially wish to incorporate their heterodox practice alongside their role in conventional medicine, as suggested by Sharma (1992), and this might be envisaged as happening with some forms of heterodox therapy such as reflexology, massage, aromatherapy and maybe some counselling techniques. It is more difficult to see homoeopathy being used by a nurse or a physiotherapist alongside conventional therapy due to the

interventions that are made by the ingestion of tablets of homoeopathic remedies. This intervention might be seen as rather too invasive, and rather too similar to their own interventions, by the conventional physicians in charge of the patient. Massaging feet may be acceptable but giving tablets may not. The process of holistic case taking is also too complex to lend itself to the use of homoeopathy as a supplementary technique in the hospital ward situation. It is indeed interesting to speculate on the reactions of both the British Medical Association and the Royal College of Nursing to the unauthorised giving of homoeopathic remedies to patients in a hospital ward by one of the nursing staff. It was stated by Sharma (1992) that often a training in heterodox medicine was not seen as an escape route from National Health Service employment, however it would seem that homoeopathy was seen in this way more frequently than other forms of heterodox therapy due to the inherent difficulties of trying to incorporate it with conventional therapies and the negative reaction that this might provoke from those within conventional medicine. Those who decide on homoeopathy as their chosen heterodox practice are, therefore, more likely to be undertaking study with escape from National Health Service employment as their goal than those studying some of the other heterodox practices.

Another influence on the initial decision to practice homoeopathy that was mentioned by professional homoeopaths both in questionnaires and in the interviews was that of engaging in an interaction with a practising homoeopath, this might be a friend or relative who was a homoeopath, or even seeing a homoeopath giving a public lecture. For many professional homoeopaths this was the starting point for researching more about a subject that was to become their career later on in life. This matches the influence noted upon medically qualified homoeopaths from personal contact with a homoeopath who can inspire an interest and answer some questions, someone who can make a seemingly inexplicable idea far more concrete.

Sharma (1992) suggested that there were two strong motivational forces reported by her interviewees. The first of these was the desire to work with people, to help and to heal. This did not appear very strongly in the questionnaire data from professional homoeopaths as a motivational factor in its own right. It may be the case that those professional homoeopaths who had previously worked in health care and wished to stay in health care, albeit a heterodox form of health care, were

originally influenced by the people oriented aspect of the work and the helping aspect. In the interviews however, this factor became more obvious and all of the professional homoeopaths interviewed mentioned that they felt that they were good with people, and wanted to help people or to heal those who were sick.

Sharma also mentioned a motivator that was allied to this wish to work with people. This allied motivator was an interest in psychology and human interaction and this was also evident in the interview data from professional homoeopaths. This interest in human interaction and psychology might be stronger in homoeopaths than in some other heterodox practitioners as the homoeopathic consultation is such a deep and lengthy investigation of the patient's mental and emotional states as well as their physical condition that it has the potential to satisfy the most ardent curiosity regarding human thought and behaviour. In many ways these characteristics of the homoeopathic consultation mean that it is closer, in some respects, to a counselling session than a conventional medical encounter.

Sharma's second important motivational factor was the desire to work independently, or at least free of the bureaucratic restraints found while working in large organisations such as the National Health Service. Sharma calls this dislike of hierarchy and bureaucracy 'a kind of occupational individualism'. Although the questionnaire data did not indicate that this was a major factor in influencing career changes in professional homoeopaths there were a number of explicit statements of occupational individualism made, in fact one professional homoeopath denied the 'human interaction, desire to help' motivator in favour of the independence gained through homoeopathic practice;

'not altruism really - money, mostly, and that I could fit in a practice with raising my son (I am a single parent).'

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In the interview data it is possible to identify a stronger motivational factor in the self employed status, with most practitioners relishing the freedom from the restraints that they had often felt were imposed in their previous occupations. Some respondents did mention that the other side of this independence was the loss of security, especially financial security, that often accompanied such freedoms. As one interviewee stated, 'try getting a mortgage as a self employed

homoeopath' when she was relating the difficulty that she had experienced when trying to buy another, bigger house.

For the professional homoeopaths a necessary factor seemed to be a dissatisfaction with their previous occupation, this was necessary in order to motivate the person into considering career change at all, let alone one that would take them into homoeopathy. Many interviewees spoke of a lack of creativity in their previous occupations, not getting any excitement from their work, this seemed to be a factor in their work life that they needed and it seemed that homoeopathy supplied it. The concept of homoeopathy as a challenge, as something different was quite common in both interview and questionnaire data.

8.3.3 The motives of professional homoeopaths and medically qualified homoeopaths compared

The professional homoeopaths and the medically qualified homoeopaths would often appear to have different motivational influences working upon them. Dissatisfaction with conventional medicine was a greater factor among the professional homoeopaths as was an illness experience followed by successful treatment with homoeopathy.

Escaping from bureaucratic restraints would seem to be a greater factor influencing the professional homoeopaths than the medically qualified homoeopaths when the number of medically qualified homoeopaths working within the National Health Service is compared to the numbers of professional homoeopaths working within the National Health Service. It is also clear that a number of the professional homoeopaths had previously worked within the National Health Service and had left it in favour of independent practitioner status. The medically qualified homoeopaths would however, seem to be freer of National Health Service time constraints in consultations than their conventional medical colleagues and this may be indicative of freedom from bureaucratic restraints influencing medically qualified homoeopaths also.

The desire to work with people, to cure, to heal is probably equally strong in both the professional homoeopaths and the medically qualified homoeopaths. Before utilising homoeopathy medically qualified homoeopaths were all working as conventional doctors, treating the sick and working with people. Many of the

professional homoeopaths were in previous occupations that involved human interaction, for example teaching and health care. For those who were not working with people previously, there was a desire to move into an occupation where human interaction was a major part of the role played and it seems unlikely that an individual would wish to enter such an occupation if they were not wishing to work with people and to help them.

8.3.4 What do homoeopaths enjoy about their work

The main theme to emerge from both interview data and questionnaire data gathered from the professional homoeopaths was that of wishing to help people. Seeing a patient get better was the aspect of the work that was mentioned most frequently as being enjoyable. This is not really a surprising result, Sharma (1992) stated that the desire to help people was a major motivator of the group of heterodox practitioners that she interviewed.

There are probably two distinct aspects to the enjoyment of witnessing a patient's health improving. Firstly the homoeopaths undoubtedly found enjoyment in the fact that the patient's health was improving, the fact that they had helped to bring about a higher level of health and perhaps relieved some pain or discomfort. This is an unsurprising source of joy, the joy of seeing another person's distress relieved. The enjoyment of this aspect of their work is undoubtedly shared with many other heterodox and conventional health care workers and those working with sick animals in veterinary practices.

The second aspect is that of the homoeopath seeing that they have solved the case correctly, their calculations, analyses and intuitions were correct and they have been proved to be so by the improvement in the patient's health. This aspect of enjoyment may be especially marked in homoeopathy where the task is complicated by the necessity of finding the one, and only one, remedy from a list of thousands, that most closely matches the total symptom picture of the patient. This symptom picture is a truly holistic one that includes not only the patient's presenting symptoms but also their mental and emotional state and all other physical symptoms that are not part of the presenting complaint. The process of collecting this data often takes up to two hours and, without the use of computers the process of analysing the data to arrive at a prescription might take another two or three hours following an initial appointment with a new patient. The use of

computer software designed to help in the repertorisation and analysis of the case has reduced the time taken to arrive at a prescription but it is often in excess of one hour.

With follow up appointments adding new data and requiring further analysis as the treatment progresses a classical homoeopath will have invested a great deal of time and effort into bringing about a cure and it may be the case that when the cure is seen to be evident this proves that this highly complex and time consuming task was carried out correctly. The joy of seeing the patient's health improve is also the joy of having your expertise confirmed once again.

This enjoyment of finding the correct remedy was also seen in the interview data from professional homoeopaths who stated that they enjoyed the challenge or the 'puzzle' aspect of their work. One professional homoeopath likened finding the remedy to solving a crossword puzzle and another stated that she enjoyed the problem solving aspect of the work. In the questionnaire data a number of professional homoeopaths (13%, n = 13) mentioned the challenge of finding the correct remedy as an enjoyable part of their work, many of them likening it to 'detective work'.

This intellectual puzzle with constantly changing symptoms which require a change in the remedy, imitating a medical game of chess, may be unique to homoeopathy amongst the heterodox therapies. There is often no immediacy about the results in homoeopathy and it is often necessary to completely reassess the case after each prescription, this is not usually the case with, for example, the manipulative therapies where a small number of treatments over a short space of time are often all that is required to bring about improvements in the patients condition. Perhaps Traditional Chinese Medicine is the only other form of heterodox practice that approaches this puzzle aspect with its use of acupuncture, acupressure and herbal medicines and detailed case taking and taking of pulses to arrive at a treatment regime that may also continue for an extended time period.

None of the medically qualified homoeopaths referred to this 'intellectual challenge' in interviews or in questionnaires and it is probable that some professional homoeopaths would argue that this confirms their suspicions that medically qualified homoeopaths prescribe through the use of simple paradigms, or in an

allopathic, pathology specific manner rather than analysing holistic data to individualise the remedy to be given to the patient. The enjoyment of healing was however mentioned, with one medically qualified homoeopath stating that homoeopathy allowed him to heal whereas conventional medicine, although it undoubtedly saved lives, could not enable him to heal patients.

For the professional homoeopaths, following the enjoyment of seeing their patient's health improve, there were a number of replies that indicated that they enjoyed seeing changes that affected more than just their patient's health. Many professional homoeopaths (25%, n = 25) described how they enjoyed seeing their patients changing in many other aspects of their lives, allowing personal growth and development, seeing patients 'discovering themselves'. This aspect of heterodox practice was described by Fulder (1988) when he spoke of practitioners accompanying their patients on a journey back to health and to self discovery. This would certainly appear to be an important part of the service provided to the patient amongst those practitioners of the dynamic or vitalistic heterodox therapies which include homoeopathy. No medically qualified homoeopath referred to this aspect of the work, this may be taken as evidence of their desire to distance themselves and their practice from the vitalistic and spiritualistic claims of the professional homoeopaths in favour of the scientific proof of homoeopathy's efficacy provided by improvements in the patients health alone.

The professional homoeopaths also enjoyed the interactions that they had with their patients, this aspect of the work was also mentioned by Sharma (1992) as a great motivator, being with people, being interested in people and 'what makes them tick'. Owing to the depth of the consultation that takes place between a classical homoeopath and their client the interaction is an extreme example, perhaps only a counselling session or a psychotherapy session might 'dig deeper' into the patient's psyche than a homoeopathic encounter. The holistic nature of the prescription requires that detailed information on the patient's fears and desires as well as past history, often including sexual history, must be obtained. This enquiry into such intimate information requires a careful and tactful, but nevertheless very close and deep, interaction between the patient and the practitioner with a very high level of trust required between the two participants. For anyone interested in 'what makes people tick' the homoeopathic encounter is probably enormously satisfying and would be an enjoyable part of their work.

The medically qualified homoeopaths also mentioned the deeper interaction that was possible with homoeopathy as an enjoyable aspect of the work. The need to understand how disease is affecting a person's life, and how a person's life is affecting their disease, was noted by one medically qualified homoeopath at interview, stating that as a general practitioner this had been interesting but as a homoeopath it was a necessity, and this led to a closer interaction with the patient. The desire for a close, mutually trusting relationship with the patient is, therefore, probably a feature of most homoeopaths, whether they are medically qualified or not.

For many professional homoeopaths the idea of empowering their patients was both an important and an enjoyable part of their role. The use of phrases such as 'taking responsibility for their own health' and 'empowering patients' was seen in 15% ($n = 15$) of the questionnaire responses from professional homoeopaths, this was not an aspect of homoeopathy that was mentioned by any of the medically qualified homoeopaths. There may be a number of reasons for this desire to empower patients, and for the fact that no medically qualified homoeopaths mentioned it. Firstly, if we follow Sharma in her scepticism it is possible that, with almost all appointments with professional homoeopaths being on a private, fee paying basis, there might be a consumerist element in this empowerment of the patient. The patient may wish to be more involved in the decision making regarding their treatment because they are paying for that treatment. It may be the case that many professional homoeopaths feel that, in order to keep their paying clients coming back for further treatment, and therefore paying further fees, it is necessary for the homoeopaths to relinquish some control and promote the patient's empowerment. There is a problem with this scenario however. Wiles and Higgins (1996) point out that the consumerism desired by patients may not concern the choices regarding treatment, rather it may concern their needs in the practitioner patient relationship. Ong *et. al.* (1995) further suggested that patients are not dissatisfied with their doctors medical expertise, they are dissatisfied with the relationship that they have with them. If this is the case then consumerism is unlikely to be playing a major role in the empowerment of the patient, if anything, the extended, mutually trusting relationships that many homoeopaths have with their patients are probably satisfying the majority of the consumerist demands

made by the patients of homoeopaths. It may be that these relationship demands are partially responsible for initially driving patients towards homoeopathy.

An alternative explanation for the empowerment of patients may, in fact, be a reflection of the amount of control that a professional homoeopath may be able to use in the consultation. Professional homoeopaths are not medically qualified and therefore may not command the respect for their expert knowledge that conventional doctors, and medically qualified homoeopaths, can command from their patients. If this were the case 'empowerment of patients' might be a way for professional homoeopaths to come to terms with their weaker control over the situation. There is, however, a problem with this explanation also. The patient is paying to see a professional homoeopath for expert advice, just because the expert knowledge is not conventional medical advice does not reduce its worth in the eyes of the patient. The advice being sought, and paid for, is homoeopathic advice and if this is worth paying for it is also capable of empowering the homoeopath, they are in possession of expert knowledge that the patient requires, the control is therefore placed in the hands of the homoeopath.

It would seem, therefore, that the professional homoeopath's desire to empower their patients is indeed a genuine desire that they delight in. The empowerment is possibly an element of the journey back to health and to self discovery that Fulder (1988) described, an element that eventually leads to the patient being able to accomplish the journey on their own, unaccompanied, as a true voyage of self discovery. This may explain the medically qualified homoeopaths lack of references to empowerment, once again it can be related to the spiritual side of homoeopathy rather than the scientific facet that the medically qualified homoeopaths are eager to be seen to be endorsing.

Escape from occupational bureaucracy was suggested by Sharma (1992) as a motivator for heterodox practitioners to start in practice and this was mentioned by 8% (n = 8) of the professional homoeopaths in their questionnaire responses making it a facet of the work that a number of homoeopaths found enjoyable, on the whole however, it was not the first mentioned enjoyable aspect of homoeopathic practice. This does not deny the importance of self employment and flexible working arrangements as an initial motivator, as the interview data from professional homoeopaths shows. It may be that questionnaire respondents may

have felt that they wished to portray themselves as altruistic practitioners and therefore mentioned the patient's improvement and empowerment rather than any benefits for themselves as practitioners. This may be borne out by the fact that only 3 professional homoeopaths mentioned self employment as an initial motivator to start practice, and yet at interview all professional homoeopaths mentioned self employment as a benefit that they enjoyed in their work as a homoeopath. Further evidence of altruistic responses may be seen in the three professional homoeopaths who wrote that making people happy was a particularly enjoyable aspect of their work.

The medically qualified homoeopaths enjoyed the expansion of their therapeutic repertoire by the addition of homoeopathy, this might be mentioned as a benefit for both the client and the practitioner, or as a useful benefit for the homoeopath. This enjoyment of the inclusion of homoeopathy into an already wide repertoire of conventional techniques is further evidence of the 'additional tool' status that many medically qualified homoeopaths afforded to homoeopathy and would probably be cited as evidence by professional homoeopaths proving their suspicions of the supplementary, allopathic nature of the homoeopathy used by medically qualified homoeopaths.

9 THE TENSIONS WITHIN HOMOEOPATHY

9.1 Is homoeopathy alternative or complementary ?

This issue was addressed both in the questionnaire for all homoeopaths and also in the interviews undertaken with professional homoeopaths and medically qualified homoeopaths. When this question was asked at interview the initial response was often a groan and a statement indicating that this question had been expected. At interview there was often a response given that indicated that the interviewee did not particularly like either of the terms and, when free response items on the questionnaire were completed they sometimes included other terms that could be used in preference, for example “a complete medicine” or “an effective, scientific form of medicine”.

The majority of all respondents to the questionnaire felt that homoeopathy should be described as a complementary therapy. However, when responses from professional homoeopaths and medically qualified homoeopaths were considered separately there was a difference in the responses made. Professional homoeopaths felt more comfortable with the alternative description than medically qualified homoeopaths, of whom only one respondent described homoeopathy as alternative compared to 43 professional homoeopaths who used the word alternative to describe homoeopathy. This difference was found to be highly significant when the χ^2 test was applied to the data ($\chi^2 = 49.9$; $df = 3$; $p < 0.00001$).

Despite this significant difference it is plain that the professional homoeopaths who described homoeopathy as alternative are still in a minority, 57% of professional homoeopaths described homoeopathy as either complementary, both alternative and complementary or neither of the two.

When the practice of ‘classical’ or ‘Hahnemannian’ homoeopathy is considered and compared to conventional medicine it is plain that there are a number of differences present, disease causation is explained differently and drugs are selected in a different fashion. In addition the supposed action of homoeopathic drugs is very different to conventional drugs, opposite in fact.

Hahnemann originally devised the system of homoeopathy as an alternative to the conventional medicine of the late 18th and early 19th centuries that was being

used in Europe. Conventional medicine has changed greatly in the intervening two centuries but homoeopathy, as a therapy, can still be regarded as opposing much that is undertaken in conventional medicine. It is, therefore, interesting to note that after 200 years of homoeopathy the majority of practitioners no longer regard it as an alternative medical system. Many of the respondents saw homoeopathy as being able to complement the conventional system, the two being used alongside each other rather than exclusively.

This state of affairs may, of course, be more of a question of semantics than philosophy, what is understood by the term alternative, what does it denote ? If homoeopaths associate the term alternative with exclusion, that is, with the prohibition of any other form of treatment being given concurrently, then it is perhaps understandable that many medically qualified homoeopaths, who may use homoeopathy as an additional tool to supplement their conventional practice, would be more unhappy with the use of the term alternative than the professional homoeopaths.

If the term alternative were to be used to convey the fact that the homoeopathic system of medicine was a different system from conventional biomedical therapy then it is unlikely that many homoeopaths, whether medically qualified or not, would argue with this. The two systems are different, even when used in a complementary fashion the two systems work differently in order to complement each other.

With only one medically qualified homoeopath using the term alternative to describe homoeopathy it is not unreasonable to suggest that the medically qualified homoeopaths are perceiving the term alternative medicine as one that describes homoeopathy in the role of a replacement for conventional medicine rather than as different from conventional medicine. As registered medical practitioners it might be considered dangerous for the medically qualified homoeopaths to assert that they were attempting to replace the accepted orthodox form of medicine with an alternative therapy and this may account for their overwhelmingly negative response to the term alternative.

It is perhaps not such an easy task to speculate about the professional homoeopaths and their use of the term alternative, with 43% preferring the term

alternative to complementary. When additional comments were analysed it was noted that some of the professional homoeopaths who preferred the term alternative were using it to describe homoeopathy as a replacement to conventional therapy because it was so different that the conventional medicines were seen to be possible interferences with the homoeopathic treatment being given;

“If mixed with allopathy we get poorer results. Allopathic medicine conflicts with homoeopathy”

Professional homoeopath 7

Some respondents who preferred alternative might have been basing this on what the patient wanted;

“Most people come seeking an alternative form of treatment as the orthodox treatment isn’t working - how can you complement something that doesn’t work ?”

Professional homoeopath 37

This is also a replacement strategy rather than a strategy based solely on the differences.

However, many of the professional homoeopaths seemed to use the term to highlight the differences between homoeopathy and allopathic medicine rather than to promote the replacement aspect of alternative medicine;

“[Homoeopathy is] philosophically, diametrically opposite allopathic medicine”

Professional homoeopath 4

It could be suggested, therefore, that the medically qualified homoeopaths almost universally used the term alternative to describe a threat to conventional medicine, as a way of replacing one form of therapy with another. Their reluctance to be associated with a threat to the medical status quo, of which they are a part, is understandable and probably explains their preference for the use of the term complementary medicine to describe their homoeopathic practice.

Professional homoeopaths are more equally divided in their use of the terms alternative and complementary. Those preferring the term complementary may be

mirroring the medically qualified homoeopaths use of this term. With the increasing pressures for professionalisation to occur and for professional homoeopaths to become more acceptable to conventional medicine, thus helping to advance the cause of statutory registration, many professional homoeopaths may be anxious to dispel the perception of homoeopathy as a threat to conventional medicine and replace it with a picture of co-operation and complement.

Those professional homoeopaths preferring the term alternative may be using it to attract patients by emphasising that homoeopathy is a different system to conventional medicine, a conventional medicine that may have no answers to a particular patient's medical problems. Others, however, may be keen to promote the idea of replacing conventional techniques with homoeopathic therapy, and not using the two together, these would appear to be a minority within the minority of professional homoeopaths who prefer the term alternative.

A comment from one professional homoeopath who stated that homoeopathy was both alternative and complementary probably sums up the attitude of many professional homoeopaths;

“alternative in its philosophy, complementary in the service it offers”.

Professional homoeopath 94

9.2 Is homoeopathy more holistic than conventional medicine ?

Homoeopathy was considered more holistic than conventional medicine by all but 5 (3.3%) respondents, all of whom were medically qualified homoeopaths. Of this minority four felt that conventional medicine had the potential to be practised holistically and one mentioned that homoeopathy could be practised ‘un-holistically’ (sic). One further medically qualified homoeopath asked what was meant by the term ‘holistic’ and stated that this was a very loose term.

Holistic, unlike alternative, is a term which carries only positive connotations for both the professional homoeopaths and the medically qualified homoeopaths. As Sharma (1992) states, although all heterodox practitioners claim to be holistic in their approach to the patient, this claim is being increasingly made by conventional medical practitioners also. With all forms of therapy ‘clothing themselves’ in holism

it is unsurprising that such an overwhelming majority of homoeopaths felt that their practice was more holistic than conventional medicine.

Medically qualified homoeopaths added comments that may give some extra information regarding why they felt that homoeopathy was more holistic. This was one of the few items where medically qualified homoeopaths used superlatives quite freely in their praise of homoeopathy, comments such as “Hugely so” and “No doubt about it” were used to back up the assertion of homoeopathy’s superior claim to holism. Others took a more circumspect approach by stating that the increased holism was only possible due to the increase in time available for the consultation. A few of the medically qualified homoeopaths espoused whole person theories and the concept of working via mental symptoms to treat physical disease. Only one medically qualified homoeopath used this question to make an attack upon conventional medicine when the comment “Conventional medicine is entirely controlled by the drugs industry” was added to their answer.

Contrarily, many professional homoeopaths used additional comments to this item to make quite pointed attacks upon conventional medicine. Comments such as;

“Obvious !”

“It wouldn’t be difficult !”

“I don’t see how you could doubt it !”

and “I cannot, by any stretch of the imagination, see the Cartesian, materialistic approach of conventional medicine as holistic”,

expressed incredulity at the thought that anyone could imagine that conventional medicine was holistic in any way whatsoever. Out of a total of 63 additional comments made by professional homoeopaths to this item, 23 were of this kind. The idea of conventional medicine being holistic in any way, shape or form was anathema to these respondents. Was this response prompted by the challenge that might be mounted if conventional medicine could persuade the public that it was as holistic as homoeopathy, would this remove one of the homoeopath’s greatest strengths for attracting clients ? Alternatively it could be suggested that these respondents had all had experiences of conventional medicine that were not holistic and were eager to discredit conventional medicine’s claims that they might be holistic.

A further 23 of the comments appended by professional homoeopaths dealt with the whole person aspect of homoeopathy, basing a prescription upon mental and emotional information as well as upon physical symptoms. This was an approach that was felt not to occur in conventional medicine with its reductionist stance and its multiple specialities.

There is no doubt that both the medically qualified homoeopaths and the professional homoeopaths all wished to be positively associated with such a desirable characteristic as holism, although the two groups may have had different motives for this desire. The professional homoeopaths may have been emphasising a strong selling point for their therapy, the possession of a positive characteristic, denied by them to conventional medical practitioners. For medically qualified homoeopaths this may have been an obvious opportunity to ensure that they were included in the holistic bandwagon to distinguish themselves, in a positive way, from their conventional colleagues. Many of the medically qualified homoeopaths may have felt that the whole person aspect was somewhat lacking in conventional medicine and this feeling may have been instrumental in their move to homoeopathy. If this were the case then it is not unreasonable to suggest that they should be quite strong in their support of homoeopathy's claims to holism.

9.3 Homoeopath's perceptions of the attitudes of conventional doctors towards homoeopathy

Almost half of all respondents felt that conventional doctors held a negative opinion of homoeopathy, with just over one quarter stating that the opinions were positive. The remaining 24% were a mixture of those who felt that the opinion was neutral, those who felt that it could be positive or negative depending on the individual doctor concerned and those who felt that conventional doctors held no particular opinions regarding homoeopathy.

Once again, by separately considering the professional homoeopaths and the medically qualified homoeopaths a significant difference in perception was noted. Amongst the professional homoeopaths 62% felt that opinions were negative with 12% stating that opinions were positive. Amongst medically qualified homoeopaths

the perception was reversed with 32% reporting that they felt opinions were negative and 48% reporting positive opinions.

This difference in opinion amongst conventional doctors may in fact exist, the deciding factor being what qualification the homoeopath holds. It is possible that the respondents may have interpreted the question as asking what opinion conventional doctors held about the respondent's own type of homoeopath, whether medically qualified or 'lay'. Consequently professional homoeopaths may have been reporting that conventional doctors have a negative opinion of professional homoeopaths while the medically qualified homoeopaths were reporting the view of conventional doctors towards medically qualified homoeopaths. The view of conventional doctors towards medically qualified homoeopaths may be less negative as they hold a medical qualification and may be seen as conventional doctors working in a somewhat unconventional speciality.

Professional homoeopaths, however, may be seen more negatively by the conventional doctors due to their lack of orthodox medical qualifications and knowledge. It is possible that these homoeopaths may even be seen as unqualified 'quacks' whereas medically qualified homoeopaths cannot properly be regarded as quacks as they possess similar medical qualifications to doctors working in more conventional fields.

An alternative explanation of the difference between medically qualified homoeopaths and professional homoeopaths may be more closely allied to the homoeopath's perception than to the actual opinions of homoeopathy held by conventional doctors. Medically qualified homoeopaths, as doctors, may regard conventional doctors as medical colleagues who work in a different speciality, in the same way that presumably a cardiologist regards a urologist as equally a doctor but one who works in a different speciality. In this scenario there would be less reason for medically qualified homoeopaths to assume that they, or their speciality, would be seen in any less positive way than any other speciality or specialist.

Professional homoeopaths, however, are not qualified as conventional doctors and may regard those who are, not as colleagues but as judges of their work as health care professionals. Some professional homoeopaths even saw conventional

doctors as adversaries who made life difficult for them in an unfair competition, patients being able to see conventional doctors for free within the National Health Service but having to pay a fee for the services of a professional homoeopath, thus reducing the numbers of potential patients to those who can afford to pay for it. If this adversarial role was given to conventional doctors by some professional homoeopaths then it would be more probable that they would also feel that the doctors would hold negative opinions of homoeopathy.

Homoeopaths who regard their practice as an alternative that could replace conventional medicine would, presumably, accept that this would be perceived by conventional medicine as a threat to its well being, and this would probably result in a negative opinion of homoeopathy. The concept of homoeopathy as a replacement alternative for conventional medicine was only held by professional homoeopaths and therefore only professional homoeopaths might perceive conventional doctors opinions as being negative due to any threat posed to them by homoeopathy. A number of additional comments made by professional homoeopaths who felt that conventional doctors opinions were negative centred around the threat and competition that they felt doctors perceived was inherent in homoeopathy.

Interestingly if there are a majority of professional homoeopaths who believe that the medical profession as a whole holds negative opinions of them, what effect does this have on the drive for professionalisation, which relies on fostering the good will of the medical profession as a major strand in obtaining support for statutory regulation ? At present there might seem to be a need for a campaign to foster two way improvements in relations between professional homoeopaths and the medical profession in order to move forwards in terms of professionalisation.

9.4 The published attitudes of conventional doctors to homoeopathy

The actual views of the medical establishment and the orthodox medical practitioners regarding homoeopathy are of obvious interest when examining the homoeopath's perceptions of these views. Published materials were therefore analysed to measure the attitudes of orthodox medical practitioners and any changes that might have occurred in their attitudes over time.

9.4.1 Material from before the 1986 British Medical Association report

The earlier material was published from 1980 - 1986, prior to the publication of the British Medical Association report on 'Alternative Therapy' (British Medical Association 1986). There was an overwhelmingly negative attitude evident in the material from these years.

Complementary medicines were attacked in the British Medical Journal in its first editorial of the 1980s under the title 'The Flight from Science' (British Medical Journal 1980). The writer's objections to heterodox therapies were clearly evident when chiropractic was initially singled out with the phrase;

'[chiropractic] ought to be as extinct as divination of the future by examination of birds entrails. Yet instead it is flourishing.'

(British Medical Journal 1980)

Flourishing or not the author still felt that a brief explanation of chiropractic was necessary for his conventionally trained readers. The rise of chiropractic was used to warn readers of a trend that the author felt had been evident throughout the 1970s - the flight from science.

Evoking such feats of technological achievement as the landings of men on the moon, jet aircraft, nuclear power and the modern motor car, the author despaired of the negative opinions that held sway regarding these technological masterpieces.

The authors main theme here was to deny the heterodox therapies any scientific credence. Conventional medicine was defined as scientific,

"the randomised double blind trial [has] been described as one of Britain's most important contributions to medicine since the war."

(British Medical Journal 1980)

while heterodox medicine was definitely unscientific,

"the underlying theory [of chiropractic] has not been subjected to scientific testing - it is an article of faith, no more rational than the acupuncturist's belief in yin and yang."

(British Medical Journal 1980)

Three years later The Lancet also launched an attack in their editorial on the “frankly fraudulent and the foolishly harmless” practices of the heterodox practitioners (Lancet 1983). Again the author pointed out the unscientific nature of heterodox medicine in order to differentiate scientific, conventional medicine from such practices. The heterodox approaches were described as “phony, pseudoscientific constructions”.

Both of these editorials were blunt and to the point, heterodox medicines were compared to divination of the future by examining bird entrails and both authors also mentioned astrology. The practices were described as being “based upon the obsolescent relics of the prehistory of modern medicine”(Lancet 1983).

9.4.2 The 1986 British Medical Association report on Alternative Therapy

The theme of denying scientific credibility to any form of health care intervention other than conventional medicine was continued when, under pressure from their president the Prince of Wales (Cohen 1983), the British Medical Association conducted an enquiry into alternative therapy. The report of the enquiry, carried out by the British Medical Association’s Board of Science and Education, was published in 1986.

The working party that conducted the enquiry consisted of 3 pharmacologists, 2 anaesthetists, a psychiatrist, a professor of medicine and a chief scientist of the Department of Health and Social Security. This would appear to be an unlikely choice of specialists to;

“consider the feasibility and possible methods of assessing the value of alternative therapies, whether used alone or to complement other treatments”

as their terms of reference stated (British Medical Association 1986). However on reading the report it becomes clear that these terms of reference were not convincingly adhered to throughout most of the document.

In the report Britain was described as having become a more materialistic, less law-observing, less caring society with a growing hostility to technology and science, allied to a distrust of innovation. The ‘flight from science’ was being revisited. Biomedicine was portrayed as a developing science that was not immune to the public’s hostility. As a victim of its own success it was now the target of a ‘demand

which is hardly rational' from the public for instant cures for the currently incurable diseases of mankind. It was also stated that the public had an ill-founded suspicion that nothing was being done to tackle these problems (British Medical Association 1986).

The public was, according to the report, 'turning back to primitive beliefs and out-moded practices, almost all purposeless and without sound base' (British Medical Association 1986). This then was the opinion of the working party on heterodox medicine.

In the report the history of modern medicine was described alongside the history of science. In order to ensure its scientific credentials, the development of medicine was described alongside the achievements of some of the great scientists of history, including Galileo Galilei, William Harvey, René Descartes and Isaac Newton. This treatise on modern medicine and science runs for 19 of the 78 pages that make up the body of the report (excluding appendices). It is therefore noteworthy that 25% of a report on alternative therapy was concerned only with ensuring that the reader was made fully aware of the reportedly scientific and rational background of orthodox medicine.

When the report did discuss alternative therapies it stated, with regard to a number of therapies,

"these systems are incompatible with the corpus of scientific knowledge, and must be rejected by anyone who accepts the general validity of the latter."

(British Medical Association 1986)

Homoeopathy was described as 'an extreme form of metaphysical dogma, with an emphasis on miasm and vitalism' (British Medical Association 1986). The discussion section of the report used such terms as 'superstition', 'magic' and 'supernatural' to describe heterodox health care practises in order to differentiate them from the scientific basis of orthodox medicine.

The distrust of 'religious cults' and their 'brainwashing' reputation was utilised when it was claimed that 'alternative therapies may be used by these groups to induce belief'. The authors then concluded that 'many of those who adhere steadfastly to

belief in a given alternative therapy have halted in their intellectual progress' (British Medical Association 1986).

The report concluded that part of the appeal of alternative practitioners is the time and compassion that they are able to offer to their patients. The authors further allowed that it was possible that some of the techniques were therapeutic, 'even beyond placebo effect'. The report added that this possibility needed careful study, with a view to bringing such beneficial techniques 'within the safeguards offered by a registered profession'. Presumably this registered profession would be the orthodox medical profession.

Within days of the publication of the report the British Medical Association was being accused by the British Holistic Medical Association of being 'hostile and patronising' to alternative practitioners, and of 'denouncing by innuendo' their range of treatments (Prentice 1986). The Faculty of Homoeopathy felt that the report was 'deplorable' and alleged that it 'masquerades as a scientific document' (The Times 1986).

9.4.3 Material from after the 1986 British Medical Association report

Various research reports were published after the 1986 British Medical Association report that described a more positive attitude towards heterodox medicine among medical practitioners. In early 1987 a research report showed that 41% of general practitioners questioned thought that alternative systems were valid and only 16% defined alternative medicine as 'unscientific' (Anderson and Anderson 1987). Had the British Medical Association working party misread the situation amongst the doctors on the 'shop floor' of medicine ? The possibility of providing complementary medicine on the National Health Service was raised in a letter to the British Medical Journal (Yung 1989). Interestingly the term 'complementary' was now being used more frequently, in addition to 'alternative' to describe the heterodox therapies.

Throughout the 1990s there were reports and letters published that displayed positive attitudes towards complementary medicine. In many of these, however, it became apparent that homoeopathy was often seen in a less favourable way than many of the other therapies that were also studied. Many of the positive writings are often qualified by a call for more study or more 'scientific investigation' (Ernst 1993).

Negative attitudes were still in evidence in the 1990s. Doctors were going on record as describing homoeopathy as 'delusional medicine' (Baran *et.al.* 1993), it was stated that it was 'fraud to sell bottles of homoeopathic remedies when there is not one molecule of the active ingredient in ten bottles' (Herbert 1993). It was argued that 'inflated and unsubstantiated claims about the efficacy of any particular treatment, while apparently acceptable in ... complementary treatments, are rightly condemned in orthodox medicine' (Johnson 1993). Johnson further stated that there was 'no protection for the public from the universal scourge of quackery' (Johnson 1993).

In an effort to urge the US Food and Drug Administration to act against homoeopathy Skolnick (1994) described homoeopathy in America as a '\$250 million-a-year scam. Its so-called remedies don't work. They are the equivalent of a car with no engine or a phony stock certificate'.

Despite these negative opinions the acceptance of heterodox medicine was growing amongst conventional doctors. Jacobs (1993), writing to the New England Journal of Medicine, stated that it was now clear that conventional medicine did not have all of the answers and it was therefore time to give consideration to alternatives. St.George (1993) in a letter to the British Medical Journal gave anecdotal evidence of the superior diagnostic skills of a chiropractor over two conventional general practitioners in diagnosing a spinal tumour. Smith (1995) urged those commissioning treatments in the National Health Service to substitute complementary medicine for conventional treatments rather than adding them as another treatment option in the list of available techniques. This last writer could almost be described as bordering on the heretical when he writes in favour of heterodox therapies replacing conventional ones.

However, when homoeopathy is singled out from the variety of heterodox therapies available it becomes clear that there is a certain ambivalence in doctor's attitudes towards its use as a viable treatment or referral option.

Lynoe and Svensson (1992), reporting on doctors in Sweden, showed that although many complementary medicines were regarded as viable treatments homoeopathy was given a negative opinion by 73% of the respondents. This was

compared to 18% negative for acupuncture, 15% for manual therapies and 21% for a vegetarian diet. The authors stated that the respondent's negative opinion of homoeopathy was due to 'its out moded concept of disease and its 'potentified' (sic) solutions' (Lynoe and Svensson 1992).

Referrals to homoeopaths were more often patient initiated than general practitioner initiated (Perkin *et.al.* 1994). This was different to reported referrals for acupuncture, chiropractic and osteopathy, where the numbers of general practitioner initiated and patient initiated referrals were almost equal.

Homoeopathy proved to be deeply unpopular with American general practitioners in research reported by Borkan *et.al.* (1994). Referrals to spiritual healers were three times more frequent than to homoeopaths, while acupuncturists, hypnotherapists and spinal manipulators received 4 to 5 times more referrals than the homoeopaths. A similar situation was shown to exist in Canada. When physicians were asked to rank heterodox therapies as useful or very useful, homoeopathy was beaten into 7th place in a list of nine heterodox therapies by Faith Healing in 6th place. Homoeopathy was thought to be useful or very useful by 12% of respondents, Faith Healing by 16% and acupuncture, at the top of the list, by 71% of respondents (Verhoef and Sutherland 1995).

Berman *et.al.* (1995) showed that more American general practitioners referred patients for prayer (30%), acupuncture (27%), art therapy (8.5%), acupressure (18%), massage (35%) and chiropractic (56%) than for homoeopathy, with 5.9% of respondents referring to a homoeopath.

The picture that begins to emerge is of a growing acceptance of many forms of heterodox healing, including prayer and faith healing, by the medical profession. However, there is still a reluctance from the doctors to embrace homoeopathy. Where research has shown a high level of acceptance of homoeopathy from doctors the authors often single this fact out for special comment. When Knipschild *et.al.* (1990) found that 45% of general practitioners in The Netherlands felt that homoeopathy was efficacious in respiratory tract infections they commented 'we are surprised about the high amount of credit that is given to certain (to us) incomprehensible practices such as acupuncture and homoeopathy'.

Why is it that this scepticism of homoeopathy can still be in evidence when acceptance of other heterodox therapies is growing ? One answer might be that homoeopathy is seen as a practise that resembles conventional medicine's drug therapy too closely. Homoeopaths, like conventional physicians, listen to the patient's account of their symptoms and, based on this case history, prescribe a form of drug therapy with the aim of curing, or at least alleviating, the patient's symptoms. May and Sirur (1998) give an example of this similarity when quoting a doctor who, when talking about 'lay' homoeopaths, states 'I think homoeopathy involves prescribing which means you have got to have [conventional medical] diagnostic skills'. This example suggests that, far from seeing 'lay' homoeopaths as dangerous heretics, this doctor, at least, sees them as carrying out a practice that is far too close to conventional medicine.

9.5 Professional homoeopath's opinions of medically qualified homoeopaths

Before discussing the data regarding professional homoeopath's opinions of medically qualified homoeopaths it should be noted that the data upon which the discussion will be based was mainly collected at interview and, as the number of interviews was small (eight professional homoeopaths were interviewed) these opinions may not be representative of all professional homoeopaths. This problem of representativeness was compounded by the fact that three of the professional homoeopaths interviewed (those labelled F, G and H) were selected for interview based on their high scores on the potential dissent scale and by this fact these three homoeopaths were not representative of all professional homoeopaths who returned a questionnaire. However, having made this distinction the three high scorers all held remarkably similar opinions to the other interviewees regarding medically qualified homoeopaths.

The professional homoeopaths were mainly critical of the methods used by medically qualified homoeopaths in their practice of homoeopathy. The amount of homoeopathic training received by medically qualified homoeopaths was thought to be insufficient in the extreme, 'true classical training in homoeopathy' was felt to be lacking. Professional homoeopaths felt that the two different ideologies of allopathy and homoeopathy were bound to clash and that medically qualified homoeopaths would inevitably end up using a hybrid form of medicine drawing on

both forms of therapy, 'prescribing allopathically' was a shorthand form often used by the respondents to express this doubt regarding the medically qualified homoeopath's practice of homoeopathy.

It would appear that the information on which these opinions was formed was rarely gained at first hand. Only one interviewee had consulted a medically qualified homoeopath professionally when her son required treatment at one of the homoeopathic hospitals in the UK. When she then trained as a professional homoeopath herself she reflected back on her son's treatment by medically qualified homoeopaths and remarked at interview that "they were very allopathically based".

The remaining interviewees based their opinions mainly on reports from their own patients who had previous experience with medically qualified homoeopaths, or from other professional homoeopaths who might have had encounters with medically qualified homoeopaths.

It would not be unreasonable to propose that this criticism of medically qualified homoeopaths might be fuelled by a form of professional protectionism. Some professional homoeopaths may feel that they need to justify their existence, after all it is difficult to compete with medically qualified homoeopaths in terms of medical knowledge or access to National Health Service patients or resources. The only advantage to be gained by a patient from seeing a professional homoeopath would be if the professional homoeopath were a better homoeopath than the medically qualified homoeopath. One medically qualified homoeopath at interview summed this up by commenting that he could not understand why anyone would choose to see a professional homoeopath in preference to a medically qualified homoeopath if they were equally good homoeopaths. The medically qualified homoeopath, he said, had the advantage of being conventionally qualified in medicine also and would therefore be able to advise the patient in all aspects of their health and would then be able to utilise the best form of treatment for them, be it homoeopathy, conventional or a mixture of both.

When this scenario was put to professional homoeopaths at interview they all agreed that the medically qualified homoeopath should win 'hands down' if the two homoeopaths were equally good at homoeopathy, however, this scenario was

highly unlikely to occur, claimed the professional homoeopaths, as the professional homoeopath would be a better trained and better qualified homoeopath. The patient would choose the professional homoeopath if they wanted to be treated by homoeopathy and not a hybrid form of medicine.

One professional homoeopath, at interview, stated that the medically qualified homoeopaths that she had met were often very patronising and quite scathing about the abilities of professional homoeopaths, she put this behaviour down to fear and anger on the part of the medically qualified homoeopaths, the exclusivity of their 'club' was being threatened by outsiders.

Mixed with this criticism and suspicion of the manner of the medically qualified homoeopaths practice was respect for their training in conventional medicine which was perceived as giving them an advantage. There was often a tangible sense of regret that professional homoeopaths, who they suggested were so much better as homoeopaths, did not have this knowledge rather than it being in the possession of the, in their eyes, homoeopathically inferior medically qualified homoeopaths.

Although much of the criticism of medically qualified homoeopaths described so far was detected at interview, if the interview data is read in conjunction with some of the comments made in the free response sections of the questionnaire it becomes apparent that this critical stance was shared by many of the questionnaire respondents who were not interviewed. It would not be unreasonable, therefore, to suggest that many of the professional homoeopaths who responded to the questionnaires held similar views to the interviewees regarding medically qualified homoeopaths.

9.6 Medically qualified homoeopath's opinions of professional homoeopaths

Once again as with the professional homoeopath's opinions, the data in this section was mainly gathered from interviews and this reduces the reliability of the data as the number of medically qualified homoeopaths interviewed totalled three. However, as with the professional homoeopath's opinions of medically qualified homoeopaths, many of the questionnaire responses from medically qualified homoeopaths supported the opinions given at interview thereby enhancing the

validity and reliability of the data regarding the medically qualified homoeopath's opinions of professional homoeopaths.

The main point made by medically qualified homoeopaths regarding the practise of professional homoeopaths was that they should know their limits and work within them. As long as the professional homoeopaths were well trained and only practised homoeopathy, whilst recognising their own limitations, then the medically qualified homoeopaths were, on the whole, tolerant of their existence.

Regulation was mentioned by one medically qualified homoeopath who added that regulation meant all homoeopaths, not just professional homoeopaths. This medically qualified homoeopath agreed with many of the professional homoeopaths fears when he stated that the fact that someone is a doctor does not make them a homoeopath after they have attended two weekend courses. This would seem to suggest that the medically qualified homoeopaths who had undergone an extensive training in homoeopathy were equally as critical of medically qualified homoeopaths who attended the very minimum of training as the professional homoeopaths were. This is unsurprising really as it is reasonable to suggest that a doctor who has taken four years to achieve Membership of the Faculty of Homoeopathy should feel somewhat aggrieved that a doctor who has attended two weekend courses should also call themselves a homoeopath.

One medically qualified homoeopath was quite defensive of medical homoeopathy and denied the charges made against it by professional homoeopaths regarding the training and prescribing methods used by medically qualified homoeopaths. He in turn accused professional homoeopaths of being able to pick and choose their patients, of only seeing " nice, middle class white people who have got the money". This, he stated, was different from being a doctor, or a medically qualified homoeopath, in the National Health Service where you had to see every patient that is referred to the practice. This would seem to be an oversimplification of the situation of many professional homoeopaths who, because they are working on a fee for service basis, would be unlikely to turn away any patient who was able to pay. In addition there are currently a number of professional homoeopaths in the UK who have set up reduced fee, or no fee, special clinics for patients who are unemployed or are in receipt of state benefits. It would appear that the stereotyping of their counterparts is occurring in both forms of homoeopathy.

Both in the questionnaire data and in the interview data it was possible to detect a sense that the medically qualified homoeopaths felt that they were practising a science, a medical speciality, whilst they felt that the professional homoeopaths were practising a 'healing art'. One medically qualified homoeopath added a comment to the questionnaire stating that the professional homoeopaths lack of sciences led to them coming out with ;

“... ridiculous statements on the subject of patients health ie immunisation for instance”.

Medically qualified homoeopath 21.

The use of terminology such as 'vital force' by the professional homoeopaths was seen by some medically qualified homoeopaths as evidence of this, almost spiritual, healing art. One medically qualified homoeopath spoke of the way professional homoeopaths seemed to regard the practise of homoeopathy with an almost religious zeal;

“I think they want to make it mystical and I don't think it is mystical”

Medically qualified homoeopath 'X'.

9.7 The tensions within professional homoeopathy

The final tension that can be investigated is that which may be in place within professional homoeopathy only. This is the tension that may exist between the professionalisers in this group and those who are seen as anti-professionalisation, the group that have been referred to as the defenders of the faith.

In order to determine if differences existed between those who could be regarded as professionalisers and those who could be thought of as defenders, an analysis of their respective forms of discourse was made.

Using data from both the questionnaires and the interviews the defenders, those with a score of 5.5 or above on the potential dissent scale, were compared to the

professionalisers, those with a score of 2.0 or less. A number of themes emerged and these will be discussed in this section.

9.7.1 The use of 'mystical' discourse

Defenders frequently resorted to mystical discourse when describing homoeopathy and its workings. Descriptions of their work by defenders often included terms such as 'magic'. Here a defender talks about her work;

Because to work through an archetype is magic. You know, to have the power to heal, to feel it in yourself

One defender likened her use of homoeopathy to the way that Jesus healed the sick;

Jesus healed, using our medical analogy again, by love, by perceiving people so clearly and so well, that they got better. To see someone is to make an identity, it's the purest form of homoeopathy. Because we're not as good as that we need to have a discipline, rather like yoga I suppose, of meditating about the natures of different humans because we are not as good as Christ, we can't actually do that form of absolutely pure seeing. Which I think is the basis for all healing. I mean whether you call it love or whether you call it perception or energetics or whatever.

Spirituality and energy were also used to describe the healing power of homoeopathy;

... the spiritual dynamis, for me, speaks volumes. Because there's an energy in there and I feel that once we have the thing, the substance that we need, that has been potentised, then that enables us as individuals, for our own spiritual dynamis, to almost connect with it. Yes that's how I make sense of it. I don't think I fully understand it. But there's some sort of connection which for me, is not about a higher god or anything but simply to do with understanding the universe as a mixture of constantly changing and dynamic/spiritual material influences which resonate with how we each are, and I feel that if you have that connection which sort of comes into you, through a remedy or whatever, then that enables your own spiritual/dynamic self to resonate.

Defenders often made statements that suggested that homoeopathy was effective without the use of a remedy, the interaction between homoeopath and patient being sufficient to bring about a change in health;

And I know it works, whether or not I give a remedy, and it is true isn't it, lots of people say I felt so much better even before I got the remedy, in fact in the last week someone phoned up and said that, no two, one said she felt she didn't need to take the remedy she just wants to come back again in any case, and another woman who had some pretty clear cut pathology phoned two days after I saw her, I was working on her case at the time, and she said she feels fine, it's all changed. So for me that teaches me that actually with both of them, I was with them and I felt that I could experience what they experience to some extent, obviously not completely, and my intent with them was genuinely to heal and to understand more, and somehow that worked before even the remedy.

Another defender gave a similar opinion in the example below;

And I don't think you need the remedies. I use them because I'm superstitious too, and I would hate for someone not to get better, but I have had so many experiences, like we all have, of someone getting better the moment you put your letter [containing the tablet] in the letter-box, and the clarity of intention, once, if you're talking and listening and exchanging with somebody there comes a moment when something goes click. And there has been effected a change. And I think the remedy is ancillary to that. It backs it up perhaps but the healing has already begun. And I think it's about perception.

None of the professionalisers, however, stated that the remedy was ever unnecessary. In place of the 'mystical' descriptions of healing used by the defenders the professionalisers used the language of science, a quasi medical terminology being used to describe the method of treatment using homoeopathic remedies as in the following example;

You're still taking someone who is, for whatever reason, dysfunctional and you're working towards their functional abilities.

9.7.2 Homoeopathy as an intellectual puzzle or as a connection with the patient.

Professionalisers, when asked about the enjoyable elements of their work, tended to describe personal challenges rather than altruistic pleasures, centring the pleasurable aspects within themselves rather than in their interaction with the patient;

It's like having a big crossword and having to put it all together and find the name of the television programme in the middle.

Four professionalisers used the term 'detective' in their responses to the question 'What do you enjoy about your work as a homoeopath?';

To be a detective, finding the accurate remedy

The sheer detective work of seeing what is going on and what is the remedy

The detective work in finding the remedy to fit

I enjoy the process of consultation, and playing detective in order to find the right remedy to facilitate cure

The intellectual challenge of utilising data in a logical, scientific manner, of using a process of elimination to arrive at the correct remedy was often described by the professionalisers. None of these respondents stated that proof of the correctness of their remedy selection could only be gained through an improvement in the patient's condition, the intellectual pursuit rather than the positive outcome for the patient was the enjoyable aspect. This is not to state that these respondents did not enjoy seeing their patient's health improving, rather that the enjoyable aspect that came to mind when questioned was the intellectual puzzle.

Defenders, in contrast, rarely mentioned the puzzle-solving aspects of their role. The language used by defenders was often based upon the patient and interactions that took place between the homoeopath and the patient. Empowerment of patients and accompanying patients on their journey were often quoted as enjoyable aspects, terms such as 'rapport' and 'self awareness' were used as can be seen in the following examples;

Re-empowering people to take responsibility for their own health

The rapport with patients

The privilege of helping a fellow human being to a better understanding and enjoyment of better health

The satisfaction of seeing other people more able to fulfil themselves

Journeying with them through their life stories

9.7.3 How to describe non-homoeopathic therapies.

Defenders were seen to use the term 'allopathy' far more frequently than the professionalisers when describing orthodox medicine. The professionalisers preferred the terms 'orthodox' or 'conventional' to allopathy. When the defenders used 'allopathy' it appeared to be a pejorative term used to distance themselves, and their practice, from orthodox therapies.

This usage of the term was most apparent in the defenders remarks appended to the responses made to the questionnaire item asking if homoeopathy was 'alternative' or 'complementary'. For the defenders homoeopathy was frequently seen as an alternative and appended comments were often of the type seen in the following examples;

philosophically diametrically opposite allopathic medicine

in essence its philosophy is opposite to allopathy

alternative to allopathic due to side effects of drugs

usually works in the opposite way to allopathy

Not only was the term allopathic frequently used but the defenders were also eager to point out that, for many of them, 'alternative' should also be taken to represent the opposite of allopathy. The idea of an opposition between homoeopathy and allopathy was not seen in the remarks made by the professionalisers in response

to the same item on the questionnaire. The terms 'orthodox' and 'conventional' were utilised in preference to allopathy, and 'working alongside' or 'together with' such therapies was often described rather than opposition;

I am a homoeopath who will work alongside orthodox medics and orthodox medication

It complements many things well

It can also work in a complementary way where orthodox treatment is necessary to sustain life or where the patient is not confident enough to give up orthodox treatment

9.7.4 Animosity towards orthodox medicine

Defenders often made direct verbal attacks upon conventionally trained doctors, whether the doctor was working with orthodox therapies or as a medically qualified homoeopath as is shown in the following examples;

Aversion to invasive and mechanical style and power abuse of orthodox medicine

I felt unhappy, as a nurse, that the patients were often not 'cured', just given drugs, which ultimately pollute the body and make companies like ICI richer

Traditional doctors are frequently violently elitist & competitive & feel we threaten their status - if successful - and their patients if unsuccessful

Many patients have no trust in their GPs and are intimidated

Should doctors have legal limits on the number of iatrogenic diseases and deaths they can cause ?

When asked about medically qualified homoeopaths one defender started on an attack of their practice methods, wondered briefly if she was unfairly attacking them

through not understanding their methods, but then launched back into an angry attack of their methods of prescribing drugs in a way she considered to be dangerous;

I am shocked at the way they prescribe. Based on things I've heard things I've read, and this particular patient, and some relatives of patients I've treated, or still treat, who've been to, dare I say it, the Homoeopathic Hospital, and I can't believe the way they treat, but that's because I don't understand how to do it that way, perhaps. Well hang on, look I'm just being generous, I don't practice like that because I don't know how to but I also suspect, I'm doubtful, I'm doubtful of anyone's understanding of giving Carcinosa 1M to someone who's going to go into very acute stages, followed by Arsenicum daily, that, I doubt that and it makes me a bit cross actually. Because I don't want people to get sick.

Professionalisers would rarely make an explicit attack on orthodox medicine, except when responding to the question of whether orthodox medicine was holistic. When criticism was levelled at orthodox doctors it was often accompanied by an argument in defence of the individual doctors who had been socialised by the medical system and were constrained by a bureaucratic health care system;

But it's not their fault because of the pressure on them, and they are NHS mostly.

When describing medically qualified homoeopaths one professionaliser defended their practices both in terms of their socialisation as doctors and in terms of the validity of their treatment methods;

One thing is the philosophy is so completely different and if the medically qualified homoeopaths understand the philosophy of homoeopathy then fine, there's absolutely no hesitation. But more often than not the doctor homoeopaths actually get confused and prescribe symptomatically because their training has been in that way, and understandably so. That is really my concern. And if they treat symptomatically, occasionally I think that is valid. I think symptomatic treatment is absolutely valid in certain circumstances. I think in terms of terminal cases, symptomatic, palliative treatment is what you've got to go for. You cannot possibly go for the whole classical management.

The same professionaliser also admitted to holding a certain admiration for the medically qualified homoeopath's medical training;

They've had both training. They know how to diagnose. They have clinical experience which we don't have. I feel very privileged at the fact that I have been in hospitals for so long that I've picked up certain diagnostic skills. But there are some people who haven't got a baldy about it. And they wouldn't be able to diagnose shingles, which is a fairly easy one to do ...

Far from attacking orthodox doctors this is an example of a professionaliser defending them and their practices and admitting that they possess certain advantages over professional homoeopaths.

9.7.5 Why use different discourses ?

The two groups of professional homoeopaths whose discourses have been examined here have different potential target audiences that they address when they are talking about homoeopathy. Although all of the quotes here had the same audience, i.e. the interviewer / reader of the questionnaires, it is not an improbable assumption to make that the respondents would use these forms of language when they discuss homoeopathy with other audiences.

The professionalisers are those professional homoeopaths who are in favour of regulation of homoeopathy and who wish to see homoeopathy professionalised and working alongside conventional medicine. In order for these desired outcomes to become a plausible reality homoeopathy must be promoted as a scientific form of medicine and links must be forged between the Society of Homoeopaths and both the Faculty of Homoeopathy and the British Medical Association.

A scientific form of discourse that neither criticises conventional medicine, nor threatens it with an alternative model of therapy, is the form of discourse that will produce the highest probability of delivering the outcomes that the professionalisers desire. Use of the defender's mystical discourse might alienate the professionalisers target audience, the medical orthodoxy.

Some good organizational reasons for these differences might be suggested. Professionalisers are unlikely to use any language that may be construed as 'dissenting' because they want to work alongside conventional medicine and work with the same kinds of patients, while defenders have a different 'audience' in mind and therefore see fewer dangers in their more oppositional position. The defender's audience is made up of those patients who are seeking a form of health care other than conventional medicine. In order to attract any potential client who has become discouraged by their experiences with conventional medicine the defenders may find it useful to distance themselves from the conventional and advertise their alternativeness.

This could explain the scientific discourse of the professionalisers and the more mystical, patient oriented, discourse of the defenders. Perhaps the long term objectives of each group are sufficiently different to warrant these differences in discourse and target audiences. The professionalisers see their future source of patients as including referrals from conventional doctors who are more likely to refer patients to a highly professionalised, more 'scientific' and, therefore, more acceptable form of therapy. Hence the drive for professionalisation.

The defenders, however, see their future source of patients as being very similar to the present source, that is patients who seek another form of therapy either to complement conventional medicine or as an alternative to it. It does the defenders no harm to be seen to be attacking conventional medicine and its practitioners, to distance themselves from their form of therapy and to highlight the differences between conventional medicine and homoeopathy, or as they might put it, allopathy and homoeopathy.

A parallel that could be drawn here is with the work of Ashmore *et.al.* (1989) in which they examine the discourse of health economists. Ashmore *et.al.* (1989) divide health economists into 'insiders', those working within the National Health Service as salaried employees, and 'outsiders', usually full time academics in universities who work as paid consultants for the National Health Service.

Ashmore *et.al.* (1989) also identified two forms of discourse used when health economists were describing health economics and its use in the National Health Service. These two forms of discourse were labelled 'weak' and 'strong' forms.

The insiders, who are working alongside clinicians and other health care staff, tended to use the weak form of discourse in which health economics is described as a tool to be used to aid doctors in making decisions. In this weak form these decisions would be based upon a number of social and political factors as well as economic factors.

The outsiders, working outside of the National Health Service with, Ashmore *et.al.* (1989) argue, less experience of working with doctors, nurses and other health care workers, tended to prefer the strong form of discourse in which economics is described as a rather more radical solution to decision making. Social and political factors are seen as an interference in the preferred decision making strategy of using economic data as the base for problem solving in the National Health Service.

When the professional homoeopaths are considered the professionalisers are similar, in many respects, to the insider health economists. They wish to work alongside conventional doctors and therefore, in order to gain their co-operation, they offer the weak form of homoeopathic discourse - an additional tool to aid in the treatment of the patient, another option to be used in order to reach a successful conclusion. Homoeopathy is described as one part of a solution that may include other therapies as necessary.

The defender homoeopaths are more closely aligned to the outsider economists. They work outside of conventional medicine and do not wish to be influenced by it nor do they require any form of acceptance from it. Homoeopathic treatment is more often seen as a means to an end in itself, not part of an eclectic mixture of solutions. Both the outsider economists and the defender homoeopaths are willing to offer more radical solutions to problems, solutions that may not rest easily with the conventional medical profession.

This analysis has provided yet more evidence of the differences that exist within the professional homoeopathic community. Are these differences reconcilable or will they, eventually, lead to another schism within homoeopathy, similar to those which have occurred throughout its two hundred year history ? If the professionalisers and defenders differ in their practices as much as in their

discourse, and from data presented in other sections they do, there would seem to be an inevitability about a future split in homoeopathy.

9.8 A summary of the attitudes of homoeopaths

There would appear to be a competition in progress between professional homoeopaths and medically qualified homoeopaths for the proper use of the title 'homoeopath'. Both camps feel aggrieved at the use of the title by those with insufficient training, whether they are a doctor who has attended a two weekend course or the untrained lay homoeopath that one professional homoeopath referred to as quacks, and who Sharma's respondents referred to as 'cowboys' (Sharma 1992).

However, beyond this concerted effort to improve the image of homoeopathy there would appear to be a rivalry between medically qualified homoeopaths and professional homoeopaths. The medically qualified homoeopath's criticism of professional homoeopaths centres on their superficial knowledge of medicine, this they feel strengthens their claim to the homoeopathic title. The medically qualified homoeopath's perception of professional homoeopaths as unscientific, spiritual, alternative healers wishing to replace conventional medicine labels the professional homoeopaths as a threat to conventional medicine, to medically qualified homoeopaths and to patients. For these reasons it could be argued that the medically qualified homoeopaths might support a form of statutory registration with enforced medical training and scientific principles, this might be similar to the German system of Heilpraktikers.

The professional homoeopaths claim, however, that medically qualified homoeopaths have insufficient homoeopathic knowledge and, perhaps understandably, find it difficult to separate allopathic and homoeopathic practises leading to a hybridised form of medicine that is neither homoeopathy nor allopathy. The professional homoeopaths then add that this form of 'bastardised' homoeopathy is then used by medically qualified homoeopaths not as a complementary therapy, but as a supplementary therapy to their conventional prescribing. For these reasons the professional homoeopaths argue that they, and not the medically qualified homoeopaths have the right to claim the title of homoeopath.

If these strong feelings are indeed indicative of the way that grass-roots homoeopaths in both camps view each other then the discussions that are being held regularly between the Board of Directors of the Society of Homoeopaths, and other organisations representing professional homoeopathy, and the Council of the Faculty of Homoeopathy, with the aim of promoting statutory registration of homoeopaths in the UK may be to little avail if the membership of both camps make their feelings known.

However, this is not the entire story as the analysis of professional homoeopath's discourse suggests. The professional homoeopathic community is divided into those who support professionalisation and those who feel that homoeopathy does not require regulation, registration and professionalisation in order to survive. The professionalisers use a form of discourse that is intended to reduce the distance between the medically qualified homoeopaths and the professional homoeopaths. Bringing these two groups closer together is a necessary prerequisite for the introduction of any legally enforceable form of regulation and this would appear to be the aim of the professionalisers.

The discourse of the defenders shows them to equate more closely to the type of homoeopath that the medically qualified homoeopaths described when they were asked for their opinions on professional homoeopaths, unscientific and mystical.

A schism within the ranks of the professional homoeopaths would allow the professionalisers to distance themselves from the defenders and this might aid the professionalisers in their aims of building close links with the Faculty of Homoeopathy and achieving statutory regulation of homoeopaths through a General Homoeopathic Council.

However the defenders will always be a thorn in the side of the professionalisers, even after a schism, unless the professionalisers could prevent the admission of the defenders onto a register of homoeopaths and thereby prevent them from using the title 'homoeopath'.

10 THE CONTROL OF HOMOEOPATHY

10.1 The popularity of homoeopathy

There are a small number of themes that can be investigated when looking into the future of homoeopathy in the United Kingdom. The first of these concerns the current growth in the popularity of homoeopathy, will the growth continue in the near future ? It has been shown by many writers that the popularity of complementary and alternative medicines has grown quite rapidly over the past two decades. Private health insurance schemes are now recognising homoeopathy and other heterodox therapies and this will surely increase the numbers of potential clients wishing to try out a heterodox therapy, especially when their private health insurance scheme will foot the bill. At present it is difficult to envisage homoeopathy, or any other heterodox therapy, declining in popularity in the foreseeable future.

This growth in popularity has continued despite some concerted attacks being made on heterodox therapies by the medical orthodoxy and various consumer oriented popular media. It seems that with every new concern that is raised regarding a potential problem with the efficacy or safety of a conventional medical technique there emerges another set of new converts to heterodox medical practice.

In some respects conventional medicine has acted in a way that makes it its own worst enemy. The constant announcements made in the press and on the television describing newer and better technologies that have been developed in order to keep patients healthy have resulted in a public that expects modern medicine to be capable of helping with any instance of ill health, of being able to alleviate any symptoms, no matter what the cause. For many patients however, this is not the case and they must be informed that they have a health problem for which conventional medicine has no answer, there is no 'magic bullet' at present for their problem. These patients may have health problems as diverse as AIDS, rheumatoid arthritis or bronchial carcinoma and they may be attracted to homoeopathy, or any other heterodox therapy, if they feel that the 'promises' made to them by conventional medicine have not been kept and that orthodox medicine has failed them.

It seems fairly safe, at present, therefore to foresee a continued growth in the popularity of homoeopathy and this will undoubtedly be welcomed by those currently in homoeopathic practice, and those currently in training to practice homoeopathy, as it seems to suggest that there will be a steady supply of clients available for the foreseeable future.

Alongside the growing popularity of homoeopathy as a method of treatment for patients, there is a similar growth in the popularity of homoeopathy as a career. The numbers of homoeopaths applying for registration with the Society of Homoeopaths has increased quite sharply in recent years and there is always the danger that the supply of homoeopaths might outstrip the demand for them. It must be stated that although this does not seem to be the case at present, it is a consideration for the future if the numbers of practitioners continues to rise sharply and the popularity amongst clients does not match this increase. This scenario seems unlikely when the number of homoeopaths per head of population is compared to the number of general practitioners, however the client population is smaller for homoeopaths and there is a possibility of saturation being reached in some areas of the country where there are already many homoeopaths working.

10.2 The threat to orthodox medicine

The growth in popularity of all heterodox therapies, including homoeopathy, gives rise to the next question, will homoeopathy pose a threat to orthodox medicine in the near future ? The rise in the public's demand for homoeopathy could be interpreted as a threat to conventional medicine, especially if the move to homoeopathy is made due to a dissatisfaction with the service that conventional medicine can offer, as may be the case with many patients with chronic diseases to whom conventional medicine has little to offer.

There is evidence, however, that conventional medicine has made attempts to stem the dissatisfaction of their patients. Many orthodox practitioners now claim to work in an holistic fashion (Sharma 1992) just as the heterodox practitioners do. By decreasing the perceived differences in the ways in which orthodox and heterodox practitioners work the conventional doctors have attempted to demonstrate that there is no need to visit a heterodox therapist in order to receive holistic health care.

This claim to holism could be seen as an initial phase in an incorporationist strategy that may be used by the conventional medical practitioners. First take on the mantle of holistic practice and then start to use some of the therapeutic techniques of the heterodox therapists. This strategy of incorporationism was used by conventional doctors very successfully in the United States of America in the middle years of the 19th century (Coulter 1982 ; Cook and Naudé 1997) and could be successfully utilised again at the beginning of the twenty first century. There are already a growing number of doctors who are using acupuncture in their otherwise conventional practices, explaining its efficacy in terms of neuro immunological stimulation rather than using theories of balancing Yin and Yang in the patient's body. How long will it be before conventional doctors are incorporating homoeopathy into their practice ? The problem that conventional doctors have when considering incorporation of homoeopathy is in explaining its mode of action, at present there is no 'scientifically acceptable' explanation of the therapeutic actions of homoeopathy and this may well be a stumbling block for the incorporation of homoeopathy into the conventional practices of doctors within the United Kingdom. The attractions of incorporation, however, are many, not least of which is the financial benefit of the low cost of homoeopathic treatment compared with some modern drug therapies or surgery.

Despite the financial attractions of homoeopathy it seems unlikely that, with the present state of knowledge regarding a 'scientific' explanation of the mode of action, conventional doctors will apply a widespread strategy of incorporation of homoeopathy into conventional medical techniques. A different strategy is open to the conventional doctors that does not involve full incorporation, instead it involves control, this is the strategy of statutory regulation.

Before examining statutory regulation as a method of control, and of defusing the 'threat' of homoeopathy, it will be useful to examine other strategies that have been suggested. The first of these is general practitioner gatekeeping, that is only allowing patients to have access to homoeopathy via a general practitioner referral. The second strategy that has been suggested is that of imposing legally enforceable limits upon the conditions that professional homoeopaths may treat.

10.3 General practitioner referrals

The idea of patients only accessing homoeopathy through general practitioner referrals was met with an unenthusiastic response from 80% of professional homoeopaths and 77% of medically qualified homoeopaths, an almost universal negation of the idea. The question made no distinction between the type of homoeopath that the patient might be seeing, whether medically qualified or not.

Additional comments made by professional homoeopaths drew attention to doubts over whether general practitioners would have sufficient knowledge of homoeopathy, and what it was capable of, to make meaningful referrals. They also felt that general practitioners would preferentially refer to medically qualified homoeopaths. Many comments were made regarding the freedom of the patient to decide upon their own health care. Many other professional homoeopaths pointed out that a large number of their current patients preferred their general practitioner to be kept uninformed of their use of homoeopathy. If this was how patients reacted now, how would they ever ask to be referred for homoeopathy, these practitioners asked ?

One professional homoeopath pointed out that at present a general practitioner would not have any means of determining whether any given homoeopath was competent or not, a clear call for some form of registration of competent practitioners, which this respondent also made in other comments added to the questionnaire, stating that at present the Society of Homoeopaths and the United Kingdom Homoeopathic Medical Association were both failing in their duty to patients to provide this form of regulation of competence to practise.

A number of professional homoeopaths equated the concept of general practitioner referral to a disempowerment of patients and felt that, if anything, patients needed to be empowered as conventional medicine was not particularly good at empowering its patients. Homoeopathy was thought to empower patients and enable them to take responsibility for their own health care. Imposing general practitioner referrals, it was argued, would firstly disempower the patients and then prevent their subsequent empowerment from homoeopathy.

One medically qualified homoeopath made the comment that if he relied on general practitioner referrals to his private practice he would starve. Another comment from a medically qualified homoeopath agreed with the professional homoeopaths who argued that general practitioners did not possess the knowledge to make rational referrals. One further comment made by a medically qualified homoeopath was that a liaison between the homoeopath and the general practitioner should be established when a self-referral had occurred.

Of the twelve medically qualified homoeopaths that agreed with general practitioner referrals eight were working both with private patients and National Health Service patients and as the National Health Service patients may have been referred from their general practitioner their familiarity with this source of patients may have influenced their response somewhat. The remaining four medically qualified homoeopaths saw patients solely on a private basis and it is therefore possible that they thought that GPs would be more likely to refer to medically qualified homoeopaths than to professional homoeopaths. This might then remove a number of their professional competitors and open up the market for themselves.

It is possible that some respondents who agreed with the idea of general practitioner referrals may have misinterpreted the question. The question asked if patients should only be allowed access to homoeopathy via a general practitioner referral. It is possible that some respondents may have misread this as 'should patients be allowed via this route in addition to self referral', as some of the additional comments made by those respondents who answered the question in the affirmative showed that they did not agree with this as the only route for access to a homoeopath.

Others may have interpreted the question as meaning should homoeopathy be freely available on the National Health Service via the general practitioner, as a number of affirmative responses to the question were accompanied by comments stating that this would widen the availability of homoeopathy to those who could not afford to pay for it.

10.4 Imposition of legally enforced limitations on the treatment of certain disorders by professional homoeopaths

This concept was originally suggested by medically qualified homoeopaths during the course of interviews as a way of ensuring that homoeopaths without medical qualifications were not attempting to cure patients with malignant disease or other life threatening conditions, especially those with a good prognosis following conventional medical treatment. 'Professional homoeopaths should know their limitations' was a phrase used frequently by medically qualified homoeopaths during interviews and in additional comments made on questionnaires. The desire for enforcement of limits may be an indication that medically qualified homoeopaths do not trust professional homoeopaths to 'know their own limits' and stick to them.

The rejection of the notion of enforced limitations was almost universal amongst professional homoeopaths with 96% of them rejecting the idea. Medically qualified homoeopaths were rather more uncertain, one third did not answer this item on the questionnaire, of those who did answer 50% were in favour of limitations and 50% rejected them. This difference between the medically qualified homoeopaths and the professional homoeopaths was significant when the χ^2 test was applied to the data ($\chi^2 = 32.6$; $df = 2$; $p < 0.00001$).

Professional homoeopaths responded very negatively to this suggestion, the most frequently made comment was that as homoeopaths they treated people, not disorders, and this would make the imposition of limitations on disorders treated very difficult, if not impossible. Other comments were made regarding the patient's freedom of choice, just as with the general practitioner referral question, this imposition of limits was seen as a threat to the patient's freedom to choose which system of medicine to use, or to choose to use more than one system of medicine simultaneously.

As one professional homoeopath pointed out, in order to have a limitation imposed a conventional doctor would have had to have arrived at a diagnosis of a serious illness, the patient has, therefore, already been seen by the conventional medical system and would only wish to see a professional homoeopath if they wanted simultaneous conventional and homoeopathic treatment or were not satisfied with

the conventional therapy and wished to give something else a trial. Either way, imposing limitations upon professional homoeopaths would deny this patient these choices. This denial of choice, once the patient had been 'failed' by orthodox medicine, or had grown disillusioned with it, was given by many professional homoeopaths as a reason for their rejection of the imposition of such limits.

Self interest could also have been at the heart of such an overwhelming rejection of imposed limits. The more disorders that are added to the list of those forbidden to homoeopaths, the smaller the number of patients that professional homoeopaths will be able to see and the financial viability of practices could then be placed in jeopardy. Patients wishing to complement orthodox therapies, or who have been told that there is nothing that orthodox treatment can do, might often come into the categories of patients denied access to homoeopathy due to the seriousness of their disorder.

Self interest could also be at the core of the medically qualified homoeopaths suggestion that limits might be imposed on their professional homoeopathy counterparts. Although concerns regarding patient safety were often cited, it would also be of benefit to the medically qualified homoeopaths if patients in these categories of serious disease could only obtain homoeopathy through the services of a medically qualified homoeopath rather than through a professional homoeopath.

Of the medically qualified homoeopaths who rejected the imposition of limits for professional homoeopaths some rejections were on the grounds that it would be impossible to implement as so many patients of professional homoeopaths were self referrals and therefore there was no way for a conventional doctor to make a diagnosis. Some medically qualified homoeopaths felt that referral from a general practitioner as the only route for access to a professional homoeopath was the better answer as a diagnosis could then be made and a decision reached by the patient and the general practitioner together about the suitability of a referral to a professional homoeopath or not.

It is interesting to note that although, unsurprisingly, almost all professional homoeopaths rejected the idea, after all it was the professional homoeopaths who were having their abilities questioned and their practices interfered with, the

medically qualified homoeopaths were equally divided between those who promoted the idea (N = 19), those who rejected it (N = 19) and those who felt unable to answer the question (N = 19). Although the idea was originally suggested by a number of medically qualified homoeopaths, they did not receive universal support from their colleagues. The comments suggesting alternative strategies, such as extra training for professional homoeopaths, supervision of all patients attending a professional homoeopath by their general practitioner or a medically qualified homoeopath or the use of general practitioners as gatekeepers of access to professional homoeopaths, indicate that the rejecters of imposed limits are probably not rejecting the proposal because they feel it is not necessary to safeguard patients with serious disease, but because they feel that the imposition of such limits would not accomplish such safeguarding. These concerns from the medically qualified homoeopaths regarding the medical education of professional homoeopaths and the appropriateness of their freedom to practice without constraint, a situation unique to the UK as has already been shown (see Section 4.1), are investigated further in the next section (Section 10.5).

10.5 Statutory regulation of homoeopaths in the United Kingdom

The UK stands alone in Europe with regard to the freedom of non-medically qualified practitioners to practice heterodox therapies for the payment of a fee. In many other European countries such practice would be illegal. Germany's system of Heilpraktikers allows the practice of heterodox therapies by non medically qualified practitioners, however they must undergo a basic training in medical knowledge and pass a written examination to enable them to be licensed as a Heilpraktiker (Fisher and Ward 1994).

In the UK the osteopaths successfully steered a bill through parliament in 1993 that provides a General Osteopathic Council and a statutory register of osteopaths. The chiropractors in the UK had, at one point in their history, unsuccessfully applied for registration with the Council for Professions Supplementary to Medicine (Inglis 1985), this would have introduced a statutory register for chiropractors in the same way that it does for the radiographers, physiotherapists and other professions supplementary to medicine.

There have been suggestions made for many years that heterodox practitioners should be statutorily regulated, Inglis (1985) suggested the need for formal courses of education and assessment and the statutory registration of heterodox practitioners in the UK. Throughout the early 1990s various umbrella organisations attempted, mainly unsuccessfully, to bring together the many and varied heterodox practitioner's organisations to promote the passing of bills through parliament that would bring about such statutory registration (see for example the editorial of the *Journal of Alternative and Complementary Medicine* and the Newsletter of the Society of Homoeopaths during 1990-93 for what were often quite vitriolic accounts of these attempts by two umbrella organisations, the Institute for Complementary Medicine and the Council for Complementary and Alternative Medicine).

The British Medical Association added their voice to the calls for statutory registration in their 1993 report on complementary medicine and, in the same year, the then Shadow Health Minister, Dawn Primarolo, in a Labour Party consultation document (Primarolo 1993) called for registration of heterodox practitioners in order to provide consumer protection.

For the professional homoeopaths questioned statutory registration was a very contentious issue, 82% of them thought that statutory registration was necessary. For many of them this was an acceptance tempered by uncertainty and anxiety due to the unforeseen consequences that might accompany the benefits of registration. Many professional homoeopaths felt that this would lead to a 'watering down' of homoeopathic principles in order to curry favour with the British Medical Association to gain their support for such registration. Many added comments that indicated their uncertainty about the issue, of the 30 who made additional comments to this question seven were declaring their uncertainty regarding registration. This uncertainty seemed to be caused by a dilemma, on the one hand they could see the need to protect the patient from unscrupulous and underqualified practitioners, one of the 18 professional homoeopaths who was in favour of statutory registration made the comment "I am totally anti-quack", however it was also felt that much could be lost in the bureaucratisation that would follow statutory registration. For this reason self registration and regulation seemed to be a favoured option among many professional homoeopaths, this would place the control of homoeopathy in the hands of people who understood

homoeopathy rather than in the hands of the British Medical Association and the government.

The Society of Homoeopaths has been seen by many professional homoeopaths to be a supporter of statutory registration and it has worked closely with the Council for Complementary and Alternative Medicine to promote this option, both to the Faculty of Homoeopathy and the government of the day and also to its own membership through the pages of the Society's newsletter and its journal, *The Homoeopath*. This support seems to have added to some of the uncertainty amongst professional homoeopaths who can see drawbacks in the idea and question why their professional organisation seems to be supporting it. Letters have often been sent to the newsletter arguing against the Society's support for registration on several grounds, most frequently the feared exclusion of practitioners from the register or the equally feared dilution of homoeopathic practice at the hands of the conventional doctors in the Faculty of Homoeopathy and the British Medical Association.

It could be suggested that much of this opposition is linked to the desire of the professional homoeopaths to remain different to orthodox medicine, many may regard themselves as complementary to conventional medicine rather than as alternative, but they do not wish to be regarded as supplementary to medicine, working under the control or supervision of conventional medicine in a way prescribed by conventional doctors or medically qualified homoeopaths.

Professional homoeopaths prefer to see their practice as an additional option that patients can avail themselves of to receive something other than orthodox medical treatment. Bringing homoeopathy under the control of conventional medicine might make it seem less of an additional option for patients.

Ultimately, professional homoeopaths probably do not want to be structured, supervised and constricted in the way that they feel might occur under a statutory form of registration. As one interviewee stated, homoeopaths are very individualistic, and Sharma (1992) showed this to be the case with heterodox practitioners when she stated that the escape from bureaucratic restraints in order to work independently was one of the main motivations to practice. This

independence would mitigate against the bureaucratisation of homoeopathy that may be seen as inevitable with statutory regulation.

An effective form of self regulation is probably as far as many professional homoeopaths would feel comfortable with at present. Protection of the client, seen as highly desirable, would be provided by the existence of a single register of suitably educated, assessed, qualified practitioners but practitioners not wishing to join this register would not be prohibited from practising homoeopathy. Freedom of choice is therefore maintained both for the patient and the practitioner and no organisation would be able to dictate how homoeopathy should, or should not, be practised.

With regard to statutory registration of medically qualified homoeopaths the professional homoeopaths were marginally more in favour of this than they were for registration of themselves, 84% agreeing with registration of medically qualified homoeopaths - 2% more than agreed to registration of professional homoeopaths. For some this may have been a case of equality of treatment for all homoeopaths, 'if we have to do it so should they', for other professional homoeopaths this was seen as a means of addressing the suspicions that they had that many medically qualified homoeopaths only attended a minimal training and might not be practising homoeopathy 'properly', usually this meant not practising in a classical fashion. If medically qualified homoeopaths had to be assessed for registration then maybe some would not reach the required standard of homoeopathic knowledge and would be refused entry onto the register. Typical of this mode of thinking was a professional homoeopath who commented;

"Their ability to practise homoeopathy should be scrutinised by the governing body of homoeopathy and no assumption made that medical qualification exempts that need".

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Another professional homoeopath commented that they would not wish to share a register with medically qualified homoeopaths unless they could;

"demonstrate their ability to practise as holistically as professional homoeopaths".

These sentiments display quite graphically the deep suspicion that some professional homoeopaths hold about the way that medically qualified homoeopaths practise homoeopathy.

Medically qualified homoeopath's opinions regarding the registration of professional homoeopaths were quite definite, 92% (N= 50) were in favour, with only 4 medically qualified homoeopaths not in favour, one of whom felt it was unnecessary as professional homoeopaths should not even exist in the first place. The most frequent comment appended was that professional homoeopaths had received insufficient medical training. Statutory registration may have been seen by many of the medically qualified homoeopaths as a means of either completely preventing professional homoeopaths from practising at all, or of making a large core of medical knowledge compulsory before registration could be obtained.

Statutory registration may have been seen as the solution to a perceived problem that many medically qualified homoeopaths were anxious to solve. This was the problem of professional homoeopaths treating patients with serious disorders and therefore delaying conventional treatment for what might be a perfectly treatable condition that could prove to be fatal if not treated conventionally. For medically qualified homoeopaths statutory registration might be perceived as the answer as they feel that it would prevent untrained practitioners from working and would ensure a minimum level of medical knowledge in those who appeared on the register.

Medically qualified homoeopaths opinions on their own statutory registration were similar in some ways to the professional homoeopaths when considering their own registration. Self registration was seen as a better option, with membership of the Faculty of Homoeopathy being regarded by many as being a form of statutory registration anyway. Despite this preference for self registration 61% of medically qualified homoeopaths (N = 31) approved of some form of statutory registration. It is possible that many medically qualified homoeopaths felt that statutory registration should be with the Faculty of Homoeopathy and this was seen as being just as necessary in homoeopathy as in any other specialism. Just as obstetricians must be acknowledged by the Royal College of Obstetricians and Gynaecologists

following examination, so should homoeopaths be registered by the Faculty of Homoeopathy after appropriate assessment of their knowledge and skills.

10.6 Orthodox medicine and the regulation of homoeopathy

Statutory regulation of homoeopaths is perhaps the most hotly debated topic of the moment within the homoeopathic profession. The professional homoeopaths, under the guidance of the Society of Homoeopaths are, on the whole, in favour of statutory regulation, some more reluctantly in favour than others. Statutory regulation forms a major strand in the professionalisation strategy that is currently being promoted and pursued by the Society of Homoeopaths in order to gain wider recognition for its members and for their practice.

For many professional homoeopaths the issue of statutory regulation is the key issue for the next five or ten years. It is highly likely that there will be a concerted effort over the next five years, from the Society of Homoeopaths, to secure a Homoeopaths Bill, similar to the Osteopaths Bill and the Chiropractors Bill both already passed by parliament.

The osteopaths and the chiropractors enlisted the support of the British Medical Association in their attempts at obtaining statutory regulation and it is to be expected that the support of the elite of the medical orthodoxy, the British Medical Association, will be sought by the Society of Homoeopaths as parliament will, in all probability, seek the opinion of the British Medical Association on any new legislation that is proposed. Without the support of the British Medical Association any attempt by the professional homoeopaths to secure a Homoeopaths Bill would be far less likely to succeed.

Conventional medicine may perceive statutory regulation as a method of controlling homoeopathy without incorporation. Statutory regulation may be seen by both the British Medical Association and the Faculty of Homoeopathy, representing the medically qualified homoeopaths, as a means of controlling the activities of the professional homoeopaths thereby accruing the financial benefits of being able to refer patients to homoeopaths, without risking the danger of the threat to conventional medicine that homoeopathy may seem to pose. The enthusiasm for placing legal limits on the practice of professional homoeopaths and the perceived

need for general practitioner gatekeepers from some of the medically qualified homoeopaths are evidence of a desire to control the practice of homoeopathy by non medically qualified persons.

If the control of homoeopathy were to be desirable to the British Medical Association then there is the possibility that statutory regulation would be supported and a Homoeopaths Bill could be prepared within the next five years. However there is a certain antagonism towards professional homoeopaths on the part of the medically qualified homoeopaths, evident in statements made by medically qualified homoeopaths in response to the questionnaire and during interviews that show an impatience with the continuing adherence of many professional homoeopaths to dynamic or vitalist theories and their arguments against some of the basic techniques of conventional medicine that the medically qualified homoeopaths support, for example vaccination.

Before 'winning over' the British Medical Association the professional homoeopaths and the Society of Homoeopaths must first win over the Faculty of Homoeopathy and the medically qualified homoeopaths. Despite the talks that take place between the directors of these two bodies, it seems that there is much disquiet at grassroots level regarding the homoeopathic practice of each group's opposite numbers. This disquiet was most obviously displayed by the response from a medically qualified homoeopath regarding statutory regulation of professional homoeopaths 'This questions presumes that professional homoeopaths should even exist'.

Those professional homoeopaths most opposed to statutory regulation see it as a threat to the integrity of their homoeopathy practice, and many fear a 'watering down' of their principles in order to gain the support of the Faculty of Homoeopathy and the British Medical Association. The more sceptical of the professional homoeopaths view such support as highly unlikely to be forthcoming as the gap between the professional homoeopath's practices and the Faculty of Homoeopathy and the conventional doctors in the British Medical Association is too large to bridge. These professional homoeopaths see statutory regulation as highly unlikely to occur and highly undesirable.

If statutory regulation of homoeopaths has not been achieved in the next five years it will not be for want of trying on the part of the Society of Homoeopaths, the future

of such statutory regulation would seem to lie in the hands of the Faculty of Homoeopathy and the British Medical Association rather than in the hands of the professional homoeopaths.

10.7 Research into the efficacy of homoeopathy

Funding for homoeopathic research has always been scarce and this has frequently led to the production of what is often limited, small scale research studies on the efficacy of homoeopathic treatment.

It is only possible to speculate on the effects that might arise from the publication of a 'scientifically acceptable' proof of the action of homoeopathy, or indeed an acceptable explanation of how homoeopathy might act in such a highly diluted form. It is probable that such research would further the professional homoeopath's strategy for professionalisation and statutory regulation. It is highly probable that demand for homoeopathy would rise and that the number of doctors wishing to learn how to use homoeopathy would rise in order to try to meet this increase in demand. Homoeopathy would be legitimised and would therefore become a more readily accepted specialism within conventional medicine, with perhaps easier access to homoeopathy via the National Health Service.

Initially it might be assumed that homoeopathy might prove to be a greater threat to orthodox medicine, however, if homoeopathy were to be regarded as a legitimate field of study and practice for an orthodox physician the strategy of incorporation would almost certainly ensure that homoeopathy was no longer regarded as a heterodox therapy, but as a branch of orthodox medicine and, therefore, no longer a threat.

The results of such research being published in the next five years would be an unlikely event due to the current problems with funding of research. Research is currently being undertaken which is investigating some of the physical properties of water that might be able to act as a store for memory of a solute. This research might be able to offer an explanation of the high dilution effects that are seen in homoeopathy but, due to the nature of such knowledge, and the fact that it is not possible to explain such events using current theories of physics, it is difficult to obtain funding and difficult to find a means of disseminating the results of the

research. Benveniste's difficulties with publishing in the journal *Nature* when he claimed to have shown that highly dilute solutions could have a biochemical effect on cells *in vitro* (Davenas *et.al.* 1988) are testament to the difficulties encountered by the proponents of such research. Benveniste was subsequently labelled a scientific heretic for his work on high dilution effects and had his work investigated by a team from *Nature* that included a professional conjurer who would be able to uncover any fraud or 'sleight of hand' that might have been undertaken by Benveniste or any of his team.

It is the highly dilute nature of the homoeopathic remedies that appears to pose the greatest problem in explaining the actions of homoeopathic remedies and it is this problem that will tax the minds of scientists and will probably ensure that the theory of homoeopathy is seen as problematic by conventional science and conventional medicine for some time to come.

11 ARE HOMOEOPATHS HERETICS ?

Chapter 3 raised the topics of heresy, dissent and challenge and posed the question 'could homoeopaths be regarded as heretical ?'. This enquiry was recognised as being far more complex than this simply worded question due to the different nature and status of the two subgroups within homoeopathic practice in the UK. However, the basic question asked whether there was a challenge being mounted to medical orthodoxy by any homoeopaths currently practising in the UK.

Dissent and challenge were investigated using data from both questionnaires and interviews to propose a number of models of heresy culminating in a final, unique model proposing the relationship of various subgroups within UK homoeopathy with regard to dissent and challenge.

11.1 Measurement of dissent

From the results of the questionnaire and interview data collection exercises an attempt was made to determine the possible 'heretical status' of both medically qualified and professional homoeopaths.

11.1.1 Questionnaire data

From the questionnaire data it was possible to produce a 'dissent scale' which would identify those respondents whose answers indicated the possession of potentially heretical traits.

Following a factor analysis undertaken on SPSS, two factors were seen to emerge that related to dissent. The dissent scale was built from responses that indicated the following beliefs or attitudes all of which appeared as variables in the two dissent factors:

- dissatisfaction with conventional medicine
- homoeopathy is an alternative rather than a complementary therapy
- patients are largely responsible for any improvement in health
- conventional doctors have a negative opinion of homoeopathy
- the patient should be heavily involved in therapeutic decision making

Respondents could score between 0 and 12.5 on the resultant dissent scale. When this scale was applied to all homoeopaths who had returned questionnaires it was found that 16% (n = 16) of professional homoeopaths and 5% (n = 3) of medically qualified homoeopaths scored above 5.5 on the dissent scale and although this seemed a low score half of the respondents scored 2 or less. The group who scored 5.5 or more on the dissent scale were therefore regarded as 'potentially heretical'. This group formed 12% (n = 19) of all respondents.

The comparison of dissent scores for professional homoeopaths and medically qualified homoeopaths can be seen in Figure 11.1.

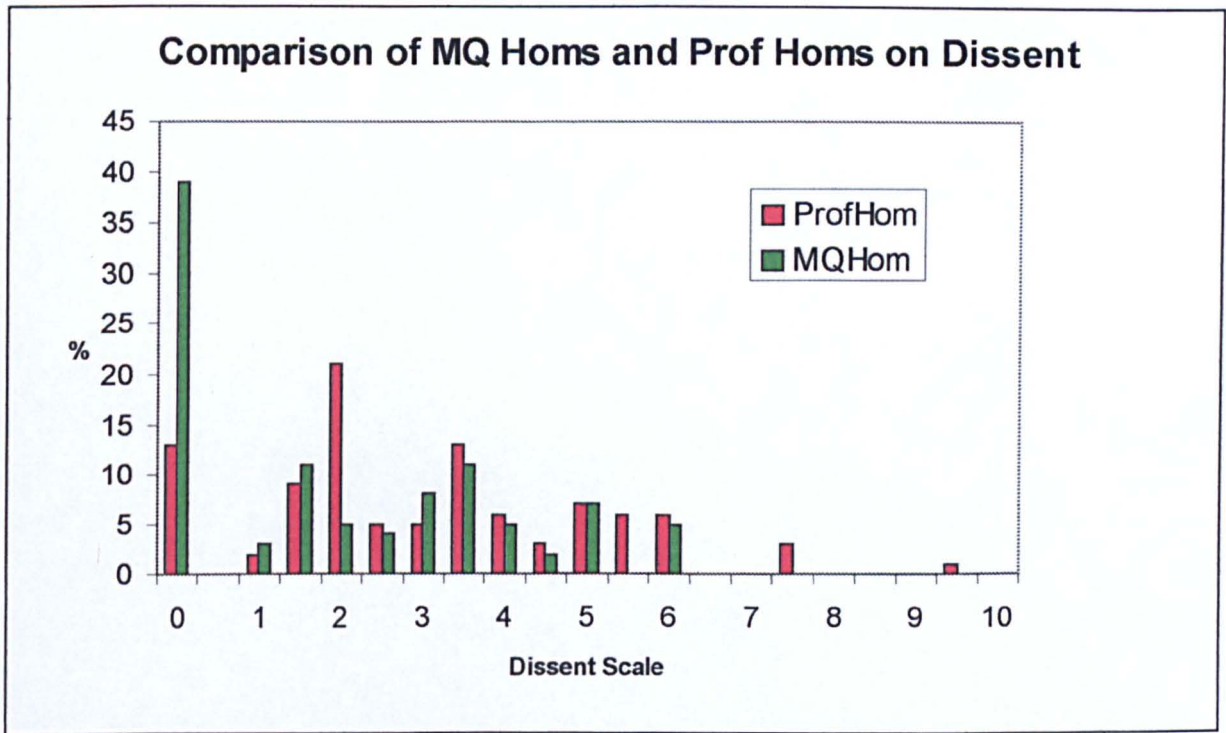


Figure 11.1 Comparison of medically qualified homoeopaths and professional homoeopaths on dissent

The highest score attained was 9.5, this was achieved by one professional homoeopath, and the lowest score was 0. The highest score for a medically qualified homoeopath was 6.0, with almost 40% of them scoring 0.

There were no significant differences found between the high scoring homoeopaths, those scoring 5.5 or above, and the lower scoring respondents with regard to their age, sex, years qualified as a homoeopath, duration of the

homoeopathy course they attended, number of patients seen per month or the duration of first or follow up appointments.

11.1.2 Interview data

Following the analysis of the questionnaire data three interviews were carried out with professional homoeopaths, all of whom were from the high dissent score group.

The greatest difference to be found between the high dissent score and the low dissent score professional homoeopaths at interview was in their use of homoeopathy as an alternative therapy. The low scorers stated that homoeopathy was complementary because:

“It could never replace, completely, allopathic medicine”

or

“I like to feel that the two work in tandem”

Two of the high scoring professional homoeopaths differed:

“Homoeopathy is genuinely another system, it is an alternative”

and

“I started out thinking it was an alternative, that clear cut, and I still think its an alternative”

In one other important aspect the two groups differed. Questionnaire respondents were asked whether statutory regulation should be introduced for professional homoeopaths. Only 12% of the low scoring professional homoeopaths felt that this was a bad idea, it was generally something that the professional homoeopaths wanted. This was backed up at interview:

“I think it’s overdue, I want it and I think it’s the way forward”

and

“I think it’s got to come and I think it will come, one way or the other”

However, 24% of high scoring professional homoeopaths did not want statutory regulation, and although this meant that the majority of them still wanted statutory regulation there was a difference in the way that the two groups perceived it. As one high scorer stated at interview:

“I’m not very interested in statutory regulation because again I feel that is coming from a mistaken place. I feel that that is coming from a place of anxiety and fear, about what the allopaths will think, or whether we are accepted and acceptable and whether we are credible or not. And I’m not interested in that.”

Professional Homoeopath H

The interviews therefore uncovered a difference between high and low dissent scorers in the way that homoeopathy was perceived and, perhaps, practised, as an alternative rather than a complementary therapy. A difference in the attitudes of professional homoeopaths towards the future regulation of homoeopathy was also found, however, leading to the possibility of conflict with the Board of Directors of the Society of Homoeopaths on future policy.

11.2 Could homoeopaths be heretics ?

Heterodoxy and heresy are, of course, not necessarily the same thing. Practitioners who are heterodox, that is not orthodox, are not necessarily heretical, it is only when heterodoxy is coupled with a challenge being mounted to the orthodoxy that heresy may be said to exist, and such a practitioner may be described as heretical. The use of the term heretic is, however, the preserve of the orthodoxy and only they may apply the title of heretic to a challenger.

As only the orthodoxy may confer the title heretic it was not the aim of the research to label any practitioners as heretics, what was attempted was to analyse the practitioner’s responses to determine if the actions of any of the homoeopaths could be described as mounting a challenge and therefore suitable for such a label to be applied by the orthodoxy. The medical orthodoxy must determine if ‘heretic’ is a suitable description of any of the homoeopaths currently practising in the UK, either medically qualified or not.

As has been stated above (section 5.2) heresy must come from within the orthodoxy. Sixteen professional homoeopaths scored 5.5 or above on the dissent scale and this score placed them in the potentially heretical group. However, the professional homoeopaths in the potentially heretical group are all from without the orthodoxy, none are medically qualified in the orthodox sense, and thus should not be properly labelled as heretics by the orthodoxy. Rather, these homoeopaths should be labelled as 'potential infidels', outsiders who are questioning the received wisdom of orthodox medicine, often using a different language of discourse from the orthodoxy, one which includes words like magic, healing, spirit and empowering.

The number of 'potential infidels' among the professional homoeopaths was quite small (16%, n=16) and superficially this might be considered a surprising result when the philosophical basis of homoeopathy is considered. The therapeutic models of homoeopathy and allopathy (a term coined by the homoeopaths to distinguish themselves from the practitioners of heroic medicine in the 18th and 19th centuries) are almost entirely at odds with each other, being based on the use of similars and opposites respectively. This fact alone might lead to the expectation that many professional homoeopaths would consider themselves to be opponents of conventional medicine and, in mounting such opposition, would meet the requirements to be included in the potential infidel group. This seemed not to be the case among the respondents.

Those professional homoeopaths who belonged to the 'potential infidel' group all regarded homoeopathy as an alternative rather than a complementary practice, and many felt that the patient's 'vital force', an internal dynamic energy, was almost entirely responsible for improvements in health, although not all used the term 'vital force'. Almost all felt that conventional doctors viewed homoeopathy negatively.

The medically qualified homoeopaths whose questionnaire scores placed them in the 'potentially heretical' category were only three in number and all felt that homoeopathy should be used in a complementary fashion rather than as an alternative. Their appearance in the potentially heretical group appeared to be mainly due to their stated dissatisfaction with conventional medicine as their chief motivation for initiating their use of homoeopathy. None of the medically qualified homoeopaths who responded to the questionnaire, including those in the

potentially heretical category, appeared to be a 'threat' by way of mounting a challenge to the orthodoxy and perhaps this is why, on the whole, medically qualified homoeopaths seem to be tolerated well within the orthodoxy. Indeed, in the seven years between its report on 'Alternative Therapy' (BMA 1986) and its report on 'Complementary Medicine' (BMA 1993), the British Medical Association moved away from its critical stance of disbelief in the efficacy of homoeopathy, to an interested, but wary, acceptance that a number of doctors do practice homoeopathy.

The relationship of these different groups of professional and medically qualified homoeopaths is shown in Figure 11.2. Those homoeopaths from inside the orthodoxy, the medically qualified homoeopaths, are either non heretics or potential heretics. The professional homoeopaths are outsiders and as such are either non infidels or potential infidels.

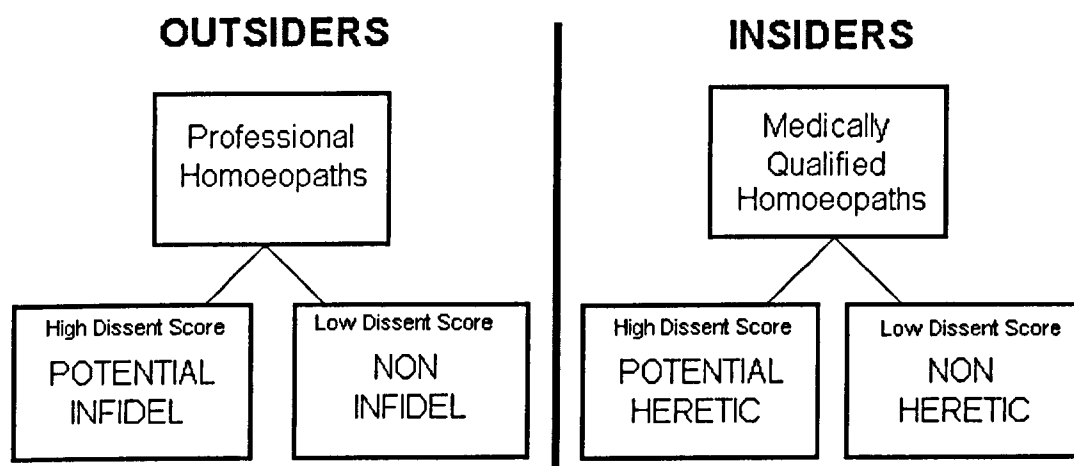


Figure 11.2 Heresy Model No.1

Perhaps it is not a surprise that the medically qualified homoeopaths do not appear to pose a threat to the orthodoxy with only 5% ($n = 3$) appearing in the potential heretic group. As conventionally qualified doctors, in addition to being medically qualified homoeopaths, many of them may practise a form of medicine that often combines conventional and homoeopathic techniques. They are all members of the Faculty of Homoeopathy and they no doubt perceive their power base as lying in their close connections with the medical orthodoxy. Mounting a challenge to the orthodoxy would probably be dangerous to them, jeopardising their continuing status as medical professionals. The British Medical Association tolerates the

medically qualified homoeopaths well due to their origins in conventional medicine with the addition of a later specialism. By challenging the orthodoxy these homoeopaths might risk incurring the wrath of the British Medical Association and thereby lose their cherished status as recognised medical practitioners.

The majority of medically qualified homoeopaths also seemed to use homoeopathy as a supplement to conventional medicine, as an 'additional tool', rather than as an alternative therapeutic philosophy. This being the case there was no reason to mount a challenge to the orthodoxy as there was no belief in homoeopathy as an alternative, better, system that should replace biomedicine.

This was not always the case with the professional homoeopaths however. None of the professional homoeopaths were medically qualified and therefore had no reason to believe that conventional medicine should not be challenged by an alternative therapeutic system originated two hundred years ago as a replacement for the 'heroic' form of conventional medicine then being practised. However, with only 16% of the professional homoeopaths gaining a sufficient score on the potential dissent scale to regard them as potential challengers it should probably be acknowledged that conventional medicine is now no longer seen by the majority of homoeopaths as a subordinate form of medicine that should be replaced by homoeopathy.

When interviews with professional homoeopaths were analysed there was found to be a difference between those in the potential infidel group and those in the non infidel group with regard to their use of homoeopathy as either a complementary or an alternative therapy. Non infidels stated that homoeopathy was a complementary system whereas the potential infidels were certain that homoeopathy was an alternative therapy. This difference would seem to be important in labelling practitioners as infidels, those mounting a challenge, or non infidels, where no challenge was being mounted. If homoeopathy is thought to complement conventional medicine then it is of no benefit to challenge the orthodoxy, the two systems work alongside one another and there is no perception of one as necessarily better than the other. If, however, homoeopathy is seen as an alternative to conventional medicine this might suggest that homoeopathy could, ostensibly, replace conventional medicine. There were many professional homoeopaths who stated that they felt that conventional medicine interfered with

their homoeopathic treatment and prevented it from fulfilling its true potential, this might be thought of as a plea for the replacement of conventional therapy with homoeopathy in these cases. With this plea in mind it is possible that the professional homoeopaths in the potential infidel group were indeed mounting a challenge to the orthodoxy and could properly be candidates for the term infidel, outsiders mounting a challenge to the orthodoxy, with the aim of replacing it with homoeopathy utilised in an alternative, rather than complementary or supplementary, fashion.

11.2.1 Homoeopathic heretics

Another important aspect of homoeopathic practise on which the two groups of professional homoeopaths differed was their acceptance of the introduction of statutory regulation of homoeopathy. Among non infidels 88% were in favour of statutory regulation and this was found to be the case at interview also. The potential infidels were, however, less in favour of statutory regulation with 72% in favour of its introduction. Although this is still a substantial majority in favour of regulation there were 28% of the potential infidels who saw regulation differently to the non infidels and this was shown in the interview data.

The fact that the non infidels were substantially in favour of regulation can possibly be explained by examining the reason for their support of such regulation. Regulation was seen by many professional homoeopaths not only as a means of protecting the patients but also as a means of protecting the interests of the homoeopath, through protection of title, and therefore a means of preventing the 'quacks' or 'cowboys' from entering the field and harming both the patients and the livelihoods of the professional homoeopaths. In order to achieve an acceptable form of statutory regulation many of the respondents thought it was necessary for the professional homoeopaths to gain the approval of both the Faculty of Homoeopathy and the British Medical Association. Neither of these bodies are likely to give their approval to such a scheme if professional homoeopaths are seen to be acting as alternative therapists who are mounting a challenge to conventional medicine and trying to replace it with homoeopathy. The desire to curry favour with the Faculty of Homoeopathy and the British Medical Association in order to obtain statutory regulation, and the ensuing protection for both the patients and the homoeopaths, is a strong candidate for explaining the complementary, non-

challenging stance taken by the majority of professional homoeopaths who responded.

The majority of potential infidels were also in favour of statutory regulation despite their alternative stance and this may be partially explained by their desire to have a register that only lists those practitioners with what are seen to be *bona fide* classical homoeopathic credentials, a method of improving the quality of both professional homoeopathy and medically qualified homoeopathy if the medically qualified homoeopaths are included on the register.

The group that are of especial interest are the 28% of potential infidels among the professional homoeopaths who are against the introduction of statutory regulation. This interest is due to the current drive from professional homoeopaths for the introduction of statutory regulation, in order to enhance their professional status (Cant and Sharma 1995 and 1996). This drive is being promoted strongly by the Society of Homoeopaths as can be deduced from the report of the Honorary Secretary of the Society of Homoeopaths in their Annual Report for 1996 in which he states;

"There is no doubt that we are moving towards full professional recognition, ... and we must be ready for this eventuality"

(Carlyon 1997)

In the same report the Director for Political Affairs states;

"Zofia Dymitr (the Chairwoman) and myself continued to attend meetings to discuss [unification and statutory regulation] with representatives of the Faculty of Homoeopathy and United Kingdom Homoeopathic Medical Association. Talks are set to continue into 1997 and have already succeeded in bringing about closer communication and co-operation."

(Gordon 1997a)

The Society of Homoeopaths is, arguably, the orthodoxy within professional, or lay, homoeopathy. They are certainly the largest organisation representing this professional group, with 1,227 probationary, licensed and registered members in

1998. They are also the most rapidly expanding organisation, registered membership having doubled to 480 in the five years from 1992 to 1997 (Society of Homoeopaths 1997). The Honorary Secretary states in his report for 1996 that;

“Increasingly we are the organisation representing professional homoeopaths that others turn to for advice and consultation concerning homoeopathy.”

(Carlyon 1997)

The other major organisation to which professional homoeopaths may belong is the UK Homoeopathic Medical Association, however their director has gone on record as saying that they see themselves solely as a registering body (Dymitr 1996).

If the Society of Homoeopaths is seen as the orthodoxy within professional homoeopathy then the 28% of potential infidels who do not favour regulation could be seen by the Society of Homoeopaths as heretics, due to their stated opposition to one of the Society's main aims. There has been much debate about the wisdom and the need for statutory regulation for professional homoeopaths, both in the Society's newsletter (see especially March and June 1997) and at the 'conferring session' at the 1995 Annual Conference. Much of this debate has been highly critical of the Society's drive for such regulation. This would indicate that within the potential infidels group of professional homoeopaths there is a smaller subgroup who are also dissenting from the homoeopathic orthodoxy's stated aims (Figure 11.3). Are these not only potential infidels but also possibly homoeopathic heretics ?

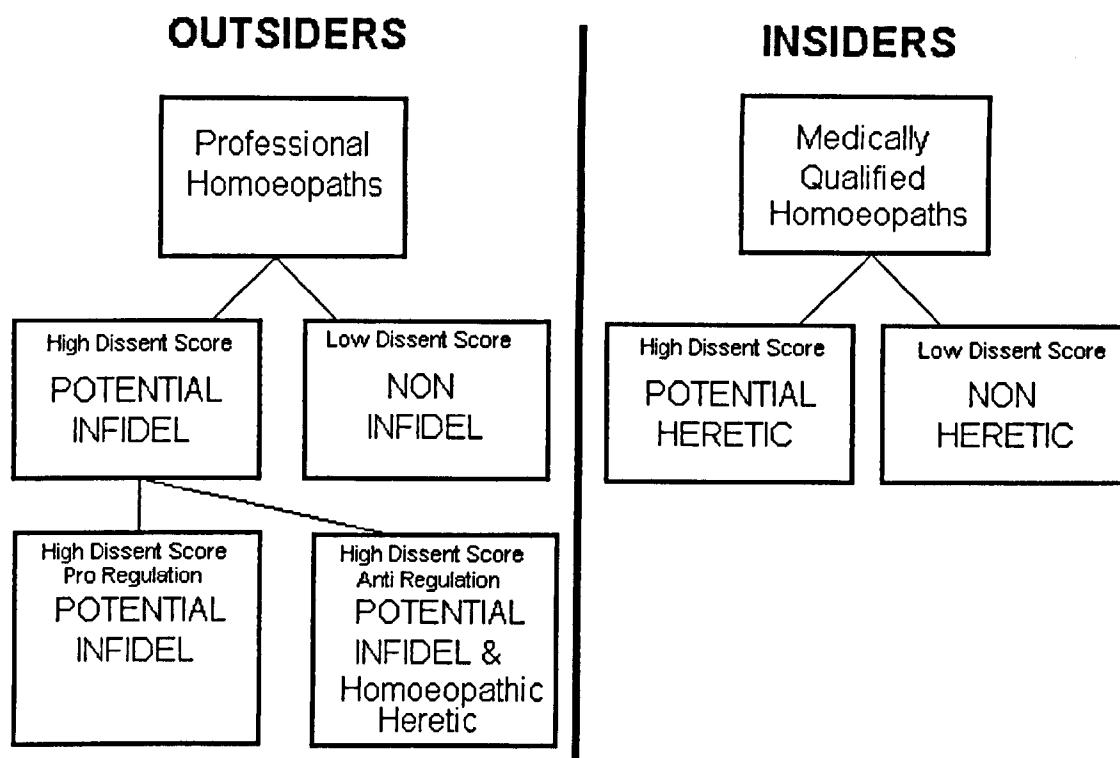


Figure 11.3 Heresy Model No.2

11.2.2 Are there any 'heretics' or 'infidels' in homoeopathy ?

As already stated the potential heretics in the medically qualified group should not be seen as challengers to the orthodoxy and as such they may be better described as dissenters. This small, and elusive, group do not appear to be heretical due to their use of homoeopathy in a complementary, non-challenging way, alongside conventional therapeutic regimes.

The 'potential infidels' amongst the professional homoeopaths all regarded homoeopathy as an alternative medicine and most felt that conventional doctors regarded them in a negative way. These facts, along with their stated dissatisfaction with conventional medicine as a major motivation for initially using homoeopathy, mean that it is right that they should be thought of as infidels rather than potential infidels, although of course only the medical orthodoxy could properly apply this term to them. This then leaves us with the small subgroup of 'infidels' who would appear to be dissenting from the Society of Homoeopaths' stated aim of introducing state registration and generally enhancing the professionalisation of homoeopathy.

11.2.3 Homoeopaths and pseudo-homoeopaths

The achievement of state registration and enhanced professionalism will be easier for the Society of Homoeopaths if they first gain the support of both the British Medical Association and The Faculty of Homoeopathy, with whom they have had a number of meetings. To further this cause the Society has been accused by some of its members of abandoning some of its philosophical tenets in recent years, for example their opposition to the vaccination of all children. This was seen, by those perhaps more cynical members of the Society, as 'getting into bed' with the allopaths in order to gain their support.

Cook and Naudé's assertion, referred to in Section 2.13, that pseudo-homoeopathy replaced homoeopathy in the late nineteenth century in America has been followed up by their assertion that this 'market-led' pseudo-homoeopathy is currently posing a new threat to homoeopathy, and that homoeopathy will be diluted with allopathic ideas.

Pseudo-homoeopathy, as it existed in America in the nineteenth century is described by Cook and Naudé as a 'mockery of medicine'. This is because it used whatever drugs were currently the most popular, hence it was often an eclectic mix of homoeopathic, allopathic and herbal medicines, all mixed in with old physic. Cook and Naudé also stated that this mixture of medicines would be prescribed according to the dominant therapeutic model of the time and - as they propose - this has always been the allopathic model.

The use of homoeopathy as a complementary, or supplementary, approach to conventional medicine, mixing the two in whatever way will, hopefully, benefit the patient could be perceived as pseudo-homoeopathic. Certainly any dilution of homoeopathic ideas regarding the nature of health and illness with conventional wisdom regarding vaccination and supporting the immune system would be denounced by Cook and Naudé as mere pseudo-homoeopathy. True homoeopathy is the form of homoeopathy practised by 'classical' homoeopaths. This is homoeopathy based upon the single dose of the single remedy which is most similar to the entirety of the patient's picture, not just presenting symptoms, but their personality, their likes and dislikes, the truly holistic picture of the person.

Cook and Naudé claim that the pseudo-homoeopathic threat to homoeopathy cannot be averted by either legislation or regulation. What is needed is:

“people of ideals, integrity and responsibility, whose love of homoeopathy and commitment to what is right cannot be compromised”

Cook and Naudé (1997)

And, they state, it will be these ‘lovers of homoeopathy’, who can be equated with the defenders of the faith as they have been referred to here, practising homoeopathy ‘properly’ who will avert the threat of pseudo-homoeopathy by the evidence of the results they achieve in curing their patients with ‘true’ homoeopathy.

The Society of Homoeopaths, representing the homoeopathic orthodoxy, are striving to bring about regulation and legislation, in order to enhance the professional standing of professional homoeopaths and gain greater acceptance of their practice by the medical profession and the public alike. If this process of professionalisation results in any further dilution of the homoeopathic system and an acceptance of the efficacy of allopathic therapy, it will be possible to apply Cook and Naudé’s term ‘pseudo-homoeopaths’ to these pro-regulation homoeopaths, who might be referred to as ‘professionalisers’. If this dilution of the homoeopathic system occurs as a result of the efforts of these professionalisers to gain greater acceptance, then it would seem that the professionalisers have the support of the vast majority of professional homoeopaths in Britain who are not heretical even by orthodox medicine’s standards. It would also appear that this majority of professional homoeopaths, along with the medically qualified homoeopaths, are actually the pseudo-homoeopaths that Cook and Naudé warn their readers about. This being the case, then the 28% of heretical homoeopaths who were found to disagree with regulation must surely be the ‘defenders of the faith’ (Figure 11.4).

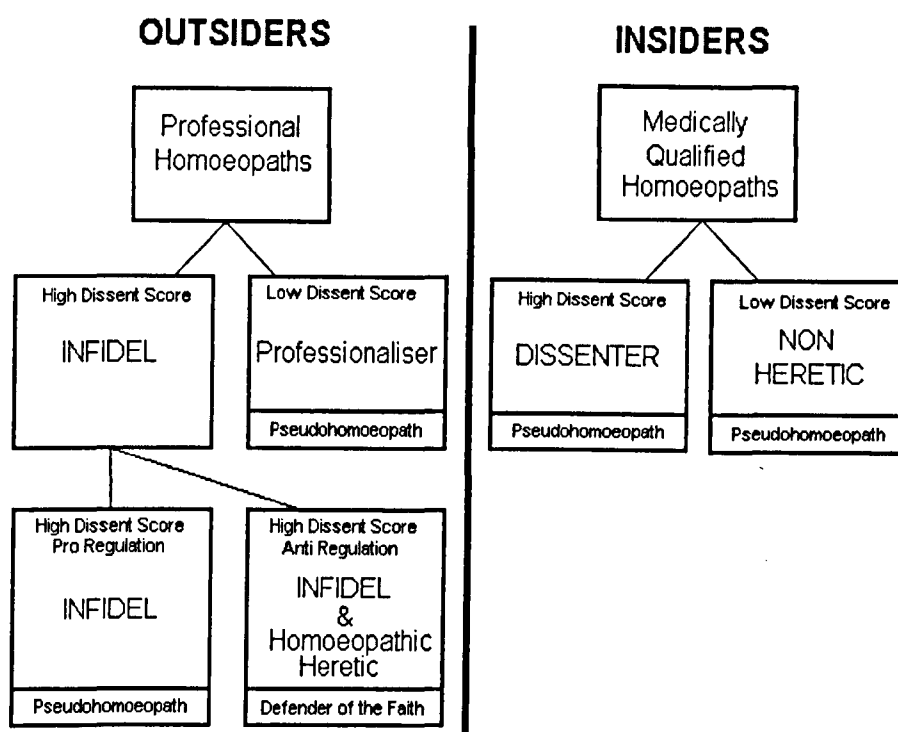


Figure 11.4 Heresy Model No.3

These few 'defenders of the faith' are therefore the only practitioners who could possibly be seen as heretical by all those concerned. According to the allopathic orthodoxy they would be infidels, and from the point of view of the homoeopathic orthodoxy they could be heretics. Unorthodox positions are recognised within professional homoeopathy. Recently the editor of *The Homoeopath*, the journal of the Society of Homeopaths, referred to 'an interesting trend in homoeopathy with the orthodox and the unconventional sitting side by side' (Logan 1997). This does not, of course, apply the title of 'heretic' to any group of professional homoeopaths but merely recognises that at least the editor of the Society of Homoeopaths' journal acknowledges that orthodoxies and unorthodoxies do exist within the body of professional homoeopathy. As yet, however, no labels have been applied by the orthodoxies, who are the only people with the power to append such a label.

It is not the role of researchers to label members of these professions as heretics or infidels, this is the prerogative of the professional orthodoxies. It is merely suggested here that these terms may be a useful metaphor to aid in the understanding of a complex situation that is currently fuelling debate within homoeopathy.

Homoeopaths, according to one of the heretical homoeopaths interviewed, tend to be strongly individualistic in nature and, she felt, the majority were being led along the route of professionalisation by a small, but organised, minority. As individualists, she felt, homoeopaths tended not to work together and this made it difficult to stop the professionalisers in their quest for statutory regulation.

11.2.4 Professionalisers

A voice still needs to be found for the professionalisers, to identify their opinions and attitudes. As well as the interviews carried out with low scorers on the potential dissent scale, the more public forum of the Society of Homoeopathy's journals was searched for evidence of the professionalisers statements over the years.

In the September 1988 Newsletter of the Society of Homoeopaths, Stephen Gordon wrote that homoeopaths needed to seek statutory recognition of their own accrediting body in much the same way that the osteopaths were doing (Gordon 1988a). He stated that this would be the model that would allow maximum independence in formulating their own affairs. He further warned that if homoeopaths did not do this their position as practitioners would be threatened by the medical profession in the UK and other European countries, and by the medically qualified homoeopaths in the UK who, he proposed, were 'slowly getting their act together, and who will seek with glee ... to try and establish theirs as the only right to practise homoeopathy in this country' (Gordon 1988a).

This statement in the September 1988 'Newsletter' appears to mark the beginning of a professionalisation campaign to enhance the status of professional homoeopathy through regulation and legislation. The impetus for this campaign was an attack of anxiety in the homoeopathic community brought about by the impending 'Single European Market' due to be initiated in January 1992. Many thought that this single market could result in the removal of the common-law right to practice homoeopathy in the UK. This would have dire consequences for professional homoeopaths in the UK.

A threat to the cause of professionalisation of homoeopathy then emerged in the same year in the shape of a prolonged debate in the pages of the Society of Homoeopathy Newsletter regarding the impending break-up of professional

homoeopathy by those who were rallying under the banner of 'classical' homoeopathy. Stephen Gordon launched an attack on the 'classical' group in the Newsletter (Gordon 1988b) stating that the formation of such a group was an implicit criticism of the Society of Homoeopaths and the standards of practice of its membership. He then stated that as Hahnemann was constantly changing the way he practised, and did not always stick to the 'classical rules', the classicists might be suggesting that he should be posthumously expelled from the ranks of homoeopathy (Gordon 1988b).

In response to Gordon's attack Weaver (1988) claimed that the basic truths of homoeopathy were being replaced by other philosophies which were being introduced as part of homoeopathy, he further claimed that the Society of Homoeopaths allowed practitioners of this non-Hahnemannian form of therapy onto its register of practitioners who, according to the Society of Homoeopaths 'practice according to the principles established by the founder of homoeopathy, Samuel Hahnemann'. The debate continued into the next issue of the quarterly Newsletter involving some seven other correspondents.

By 1990 the professionalisation debate had entered a phase where statutory regulation was becoming an imperative. Gordon (1990) stated that a process of 'infiltration and integration' would see homoeopathy as a 'central therapeutic tool in a national healthcare system'. In order for this to happen Gordon suggested that the medical profession and the professional homoeopaths should work together in an integrated way.

One year later the professionalisers, represented once again by Stephen Gordon, were promoting the joint goals of regulation and working within the National Health Service. Gordon (1991) stated that integration and regulation should not mean the dilution of homoeopathy into a 'disease-centred therapy using formulae' practised by 'large numbers of inadequately trained doctors'. Having said this Gordon further stated, in what could be interpreted as an attack on 'defenders', that homoeopathy was not the 'be-all and end-all' that many of, what he called, 'our evangelical brethren' seemed to believe. He then stated that other medical interventions were often necessary and, although homoeopathy merited a central role in a future evolved health care system, he acknowledged both his own limitations and the

limitations of the therapy. He summed up the professionaliser's desires quite succinctly when he wrote,

"I would like to work in much closer co-operation with members of the established medical profession whether within or outside the National Health Service on a basis of mutual understanding and respect for what we each have to contribute to the improved healthcare delivery to patients."

(Gordon 1991)

State registration for professional homoeopaths was once again raised in 1992. The spectre of the Single European Market had come and gone by the time that Dempster (1992) asked for views on state recognition. Once again summing up the position of the professionalisers he stated that if professional homoeopaths were to survive as a profession then they must become an 'integral part of a larger health care framework'. When he then posed the question 'how do we become part of the establishment ?' his answer was that this would occur only through professional and political recognition. The choice, for Dempster, was a simple one, do professional homoeopaths become 'legally recognised as a profession capable of providing homoeopathy, within the framework of a health service', or do they 'continue to exist in the uncertainties of a legal twilight zone where nothing is guaranteed'. For Dempster the choice was that of legislation and regulation, the path that was to be so heavily criticised five years later by Cook and Naudé (1997).

The main push from the Society of Homoeopaths towards statutory registration started in 1994 when Gordon (1994a) asked if state registration was necessary. The successful passing of the Osteopaths Act and the, then imminent, passing of the Chiropractors Bill were the models for the Society of Homoeopaths and prompted the push for registration. As Gordon pointed out, the aim of such registration was to require all persons calling themselves homoeopaths to register with a General Homoeopathic Council, which would lay down legally binding standards for conduct and education. These standards would lead to protection of title and to a defined and recognised profile and status for the homoeopathic profession (Gordon 1994a). A list of advantages that the professional homoeopaths would accrue was given by Gordon, but these could easily be summed up as 'an enhanced professional status in the eyes of physicians, patients and politicians'.

Inevitably the pages of the Newsletter of the Society of Homoeopaths carried arguments against the professionaliser's position, culminating in a conferring session at the Society's Annual Conference in September 1995. The professionaliser's response was to warn of the inevitability of regulatory legislation with, or without, the input of the professional homoeopaths. Gordon (1995) warned that the impending review of the Professions Supplementary to Medicine Act could result in all complementary medicines being included in, what was described as, an Act that would 'pin us down'. What was necessary, according to Gordon (1995), was a collective will from all those within the homoeopathic community to produce a process of professionalisation that would lead to a regulatory legislation devised by and for the homoeopaths. Meanwhile the Society of Homoeopaths was careful not to antagonise any of their members who were not so committed to regulation. The Newsletter of the Society of Homoeopaths contained a reassurance that the Society had not yet reached a decision about statutory regulation but was, in conjunction with the United Kingdom Homoeopathic Medical Association and the Faculty of Homoeopathy, considering the pros and cons for their members (Dymitr 1995). The goal of a united, self regulating profession was seen by the Society of Homoeopaths as highly desirable but, realistically, it was acknowledged that it would take a long time to achieve this.

The increasing likelihood of a Labour government being returned to parliament in May 1997 forced the issue somewhat and in early 1997 Stephen Gordon was pushing the cause of statutory self-regulation harder than ever before (Gordon 1997b). Gordon stated that the 'wishy-washy, common-law based situation in which we find ourselves at the moment [was] highly unsatisfactory'. Once again the 'threat' of the Professions Supplementary to Medicine Act was highlighted and the dire consequences of homoeopathy's inclusion in it was spelt out. Statutory self regulation would open doors and windows of opportunity, it would also 'send a resounding message and example out through Europe and to the rest of the World. The professional homoeopath is here and recognised' (Gordon 1997b).

11.2.5 The future of classical 'Hahnemannian' prescribing in the hands of the 'heretics'

The concept of homoeopathy as a heresy still needs some further discussion with regards the future of professional homoeopathy in the United Kingdom. It was shown in section 11.2 that medically qualified homoeopaths are very rarely, if ever,

heretical in their viewpoint and are probably more properly termed dissenters rather than heretics as no attack is made upon the medical orthodoxy.

Among professional homoeopaths the picture was slightly different with a three way split between 'professionalisers' those with a low dissent score and who were strongly in favour of statutory regulation, 'infidels' those with a high dissent score but who are also in favour of the introduction of statutory regulation and, finally, the homoeopathic heretics, those with a high dissent score who oppose the introduction of statutory regulation.

With the current drive for professionalisation, which includes the introduction of statutory regulation, being promoted strongly within the Society of Homoeopaths there is a possibility that the homoeopathic heretics, those who oppose statutory regulation, may wish to split from the Society of Homoeopaths. This split would be more likely to occur if the Society of Homoeopaths, and the 'professionalisers' were seen to be diluting classical homoeopathic philosophy and espousing conventional medical theories in order to further their drive for statutory regulation.

As was proposed in section 11.2.3 if this dilution strategy were to be employed by those in favour of statutory regulation then the term pseudo-homoeopath, coined by Cook and Naudé (1997), might be properly applied to them, and the 'homoeopathic heretics', claiming to be the only prescribers still adhering to classical philosophy might properly claim the title 'defenders of the faith'.

The result of such a split could see the 'heretical' homoeopaths claiming the Hahnemannian moral high ground from the massed ranks of the pseudo-homoeopaths. If the 'professionalisers' succeeded in their aim of obtaining a Homoeopaths Bill which introduced statutory regulation the outcome of such a split might see a small number of highly individualistic, 'heretical' homoeopaths unable to organise themselves effectively against a powerful, unified, professionalised and legally regulated 'pseudo-homoeopathic' profession.

Coulter (1982) described a split in homoeopathy which he claimed occurred in the late 19th century in the United States of America. This split was between the homoeopaths who favoured high dilution remedies and those who favoured low dilution remedies, a split from which homoeopathy took almost one hundred years

to recover. It is possible that another split could occur, with a similar outcome. The 'defenders' could be defeated and the 'pseudo-homoeopaths', the eclectic prescribers of a mixture of conventional medicine and homoeopathy, could triumph and dilute the teachings of Hahnemann to promote a form of therapy that Hahnemann might hardly recognise.

For the 'professionalisers' this outcome might be praised as progress. Hahnemann, they might claim, was constantly changing, refining and reforming his ideas throughout his life, why not continue his reformations into the twenty first century ? The classical prescribers might counter this claim with the claim that Hahnemann's formulation of the philosophy and practice of homoeopathy, that he left to posterity, works perfectly well if used properly and is not in need of any such reformation.

What of the future then, are we going to see the introduction of a Homoeopaths Bill that brings about the statutory regulation that so many professional homoeopaths desire and will this split the homoeopathic community ? This scenario is not entirely implausible, the Labour Party, when in opposition, were determined to introduce legislation to place heterodox therapies on a firmer footing, to introduce statutory regulation. With a Labour Party in government during the first few years of the new millennium, will there now be a stronger motivation to move the situation forward, are the next five years going to be crucial for homoeopathy in the United Kingdom ?

12 CONCLUSION

It has become clear that the two professional groups practising homoeopathy in the United Kingdom have many differences between them and yet there are moves being made to try to bring the two groups into a more harmonious relationship with each other in order that both may benefit, ostensibly from the introduction of some form of regulation that would safeguard both practitioners and patients in the future. In order to obtain this regulation there must be co-operation between the professional bodies which represent the professional homoeopaths and the medically qualified homoeopaths. This co-operation between the professional bodies would then, in theory, be followed by greater co-operation between the members of these organisations at the grass roots level. And yet, as has been previously shown, there is evidence of deep seated divisions, both between the two groups and within the groups themselves, as to what is the best course of action to follow. From where do these divisions originate ? Why are they in place ?

12.1 Divisions between professional homoeopaths and medically qualified homoeopaths

One explanation for these divisions may lie in the demographic differences between the memberships of the two groups. Alternatively the different ways in which homoeopathy is practised may provide an explanation. It has been shown that the professional homoeopaths are predominantly women, who are younger, on average, than the medically qualified homoeopaths and have been in practise for a shorter period of time. The majority of these professional homoeopaths have attended lengthy training courses at colleges where great emphasis is placed upon Hahnemannian and Kentian theory regarding how homoeopathy works and how it should be practised. The medically qualified homoeopaths are predominantly male with a higher average age, have been in practise longer, have all successfully undertaken conventional medical training and then a shorter, in most cases a very much shorter, period of training in homoeopathy where little, if any, Hahnemannian theory is taught. The two groups can therefore be seen to be substantially different in quite a number of ways.

When the clinics run by these homoeopaths were compared it was found that the medically qualified homoeopaths were seeing more patients per month than the

professional homoeopaths and, therefore, were giving less time on average to each individual patient than their professionally trained counterparts. These differences seem to be linked to differences in the ways in which homoeopaths feel that homoeopathy should be practised. The dynamic, or vitalist, elements of homoeopathy are still taught and used by professional homoeopaths while the medically qualified homoeopaths do not usually refer to vitalistic notions regarding the mode of action of homoeopathy, preferring to encompass their explanations of homoeopathy within their biomedical grand theory and explain its actions by reference to enhancement of the patients immunological status rather than the mysterious 'vital force' of the classical professional homoeopaths.

These differences led some respondents to disparage the beliefs or behaviours of their opposite numbers, with medically qualified homoeopaths deriding the vitalistic claims of the professional homoeopaths and declaring that there were dangers inherent in allowing non-medically qualified persons to practice any form of medicine. Professional homoeopaths were equally as scathing declaring that medically qualified homoeopaths were ill trained in homoeopathy and tended to practice an eclectic form of medicine that could not properly be termed homoeopathy nor could it be called allopathy. Rather, they claimed, it was a 'bastardised' medicine with elements of both homoeopathy and allopathy present.

There is therefore a struggle over the right to call these practises 'homoeopathy'. Is the term 'homoeopathy' only properly applied to the Hahnemannian form of medicine that classical professional homoeopaths claim to practise, or can it be properly applied to any practise that uses homoeopathically potentised remedies prescribed in a variety of ways, alongside conventional and other techniques, as many of the professional homoeopaths claim is the *modus operandi* of the medically qualified homoeopaths ?

It has been shown also that many medically qualified homoeopaths would like to see measures taken that would either restrict or retrain professional homoeopaths in order, ostensibly, to ensure the safety of their patients. These measures include the introduction of a system of general practitioner gatekeeping, limiting the medical conditions that professional homoeopaths may legally treat, retraining in conventional medical sciences and, finally, introducing a statutory register of

homoeopaths that would exclude those 'lay' practitioners who do not possess the necessary credentials for inclusion, the 'untrained quacks'.

The Society of Homoeopaths has also shown enthusiasm for moves aimed at the increased professionalisation of homoeopathy including the introduction of statutory regulation, along the lines of that already gained by the osteopaths and the chiropractors in the United Kingdom. A large proportion of the professional homoeopaths questioned, all of whom were members of the Society of Homoeopaths, were in favour of such moves, some with more reluctance than others, leading Cant and Sharma (1995) to dub the professional homoeopaths 'reluctant professionalisers'. A small minority of the professional homoeopaths were not in favour of statutory regulation and the Society of Homoeopaths' other moves towards enhancing the professional status of homoeopaths in the United Kingdom. This small group see these moves as a dilution of classical homoeopathy and evidence of a strategy of incorporation on the part of the medical profession and the medically qualified homoeopaths, with the more radical thinkers accusing the Society of Homoeopaths of 'selling out' to the Faculty of Homoeopathy.

With these differences between the two groups still very much in evidence it would seem that change must be wrought, especially at the grass roots level of professional homoeopathy, if there is to be any progress on building a united front to enable the introduction of statutory regulation of any kind. It seems increasingly probable that the only way in which the two groups will meet on common ground is after a schism in the ranks of the professional homoeopaths making up the membership of the Society of Homoeopaths.

This schism, not the first to split homoeopathy since its inception two hundred years ago, could be brought about by those who are more reluctant to bring about statutory regulation leaving the Society of Homoeopaths in protest. It is unlikely that this would take the form of an organised protest, homoeopaths tend to act as individuals and, as Sharma (1992) pointed out, they tend to dislike organisational bureaucracies, these characteristics would make an organised mass protest unlikely. A more probable scenario would be a number of homoeopaths, acting singly, registering their protest by resigning from the Society of Homoeopaths, this would

eventually lead to a split between the members and the past members of the Society.

A different scenario might involve the use of the strategy of credentialism that is currently in favour with the Society of Homoeopaths. The question could be asked 'who is practising homoeopathy correctly?'. With so many different opinions being voiced on the correct way of practising homoeopathy, the way would be open for questioning whether a practitioner was actually practising homoeopathy as it might be defined by a registering body. Would there be a case for de-registering those members who do not 'toe the line' by questioning their credentials and their practises? If they did not meet the minimum requirements for statutory registration then they could not properly appear on the register and would not, therefore, be allowed to practise using the title 'homoeopath'.

It is possible that any future splits in the ranks of the professional homoeopaths might play into the hands of the medically qualified homoeopaths who are interested in incorporationist strategies. We could be witnessing the demise of professional homoeopathy in the United Kingdom as we enter the twenty first century, just as was witnessed in the early years of the twentieth century.

12.2 Homoeopathy in a post modern society

How does post-modernism affect homoeopathy in the United Kingdom? As has already been stated, homoeopathy has its roots firmly planted in the modernist tradition. Has homoeopathy now moved on from its beginnings to embrace post modernism or is it still firmly grounded in its modernist origins? On the face of it the professional homoeopaths who continue to practice in the Hahnemannian tradition are still embracing the idea of an all encompassing, rationalistic explanation of ill health, the grand theory of the vital force.

However, as a group of practitioners the professional homoeopaths have always been subject to client control and therefore to consumerist pressures and it is these that have, arguably, led to the more intimate relationship that exists between homoeopath and client as has been shown by the data and also by Cant and Sharma (1995). This erosion of the existence of an expert authority, to be replaced by a therapist who is willing to enter into a relationship based on shared decision

making is, perhaps, the most compelling evidence of a post modern influence on homoeopathy, as on all heterodox therapies.

The emergence of professional homoeopaths who are willing to experiment with Hahnemann's original ideas, to negate his theories, to use their own experiences of clinical success and failure to inform alterations in their practices in order to increase their perceived success rates has given rise to groups of professional homoeopaths who refer to themselves as 'Not Just Classical' homoeopaths. The rise of the professionalisers within professional homoeopathy, those who some might say have been willing to dilute homoeopathic theory to further the cause of professionalisation, has brought about the existence of a further sub-group within professional homoeopathy. Are the professionalisers and the Not Just Classical groups further evidence of post modern influences on professional homoeopathy ? The negation of grand theory and the opening up of a pluralist narrative within homoeopathy that these groups have brought about show distinct post modern tendencies.

The fractionation of professional homoeopathy in recent years may be the result of post modernist tendencies. The move away from large scale professional authority to small scale, pluralistic and multi-narrative professions may be the shape of things to come, in which case what does the future hold for the champions of statutory regulation ? Is such regulation what is required in a post modern world or would it be preferable to dispense with the centralised authority of a 'General Homoeopathic Council', built along similar lines to the General Medical Council, in favour of pluralism ?

Pluralism in health care could be a contentious issue and it may be dangerous to dispense with centralised authority in favour of local plurality when that centralised authority is playing a role in safeguarding the health and welfare of consumers. For this reason Saks (1998) suggests that the government of Britain retains a consistent metanarrative which sets out the criteria against which both heterodox and orthodox health care can be evaluated. This centralising force, backed up by claims that it is in existence to protect and safeguard the public from 'unsafe' practitioners, could be a delaying influence on the possible development of effective post modern influences upon homoeopathy and the other heterodox health care practices.

12.3 Dissent and Heresy

It may be useful to begin this section with an examination of Wolpe's approach to the concepts of dissent and heresy before looking at how the homoeopaths in this study can be described in terms of dissent.

12.3.1 Wolpe's Model

Heresy, as a historical concept, carries negative connotations for most people. Heretics are seen as subversives who wish to challenge the orthodoxy, to replace it with their own ideas. The labelling of those who may not agree with the orthodox view in this way could be construed as damaging to those individuals and could even be regarded as ethically questionable.

Labelling does, however, seem to be the central purpose of Wolpe's framework. He rigidly defines the conditions that must be met before heresy can properly be said to exist, and the label applied, but then states that the term heretic is only properly applied by the orthodoxy, who often withhold it in their own best interests.

Furthermore, Wolpe (1994) himself states that just as he is resurrecting the idea of heresy it may be true to say that post modern influences are finally rendering the term *truly* obsolete. Modern life, he states, is being lived in a time without orthodoxies, it is characterised by heterodoxies above all else.

If, as Wolpe (1994) suggests, heterodoxy is not the opposite of orthodoxy but the plural of orthodoxy, and we are living in a time characterised by heterodoxy, it may be more useful to use Wolpe's framework as a starting point towards enlightenment regarding the plurality that exists rather than to negatively label groups as heretics due to their opposition to an orthodoxy that may be fast disappearing.

With the homoeopaths examined in this study the concept provided a starting point for a more individualised, 'tailor-made' model to be developed. This individualisation was not down to the level of the individual practitioner, but to the particular professional group under examination, that is, homoeopaths. This model, although initially using Wolpe's categories of heretic, infidel and dissenter,

eventually developed into a model that could more accurately reflect the current background and the socio-political environment that surrounded the practice of homoeopathy within the United Kingdom in the late 1990s.

The individualised model became necessary as Wolpe's concepts proved to be at once too restricting and yet too generalised when applied to homoeopaths. Restricting in the closely defined categories that not all homoeopaths fitted in to, yet too generalised when applying it to a small professional group made up of a number of distinct sub groups.

The utility of Wolpe's work is that it can initially trigger ideas and provide a broad framework which can then be adapted to the specific requirements of any particular groups, or sub-groups, under investigation.

12.3.2 Homoeopathy and dissent

When the history of the origins of homoeopathy is investigated it becomes apparent that Hahnemann was devising a system of medicine that was very different to the system in common usage at that time in Europe. His work was motivated by his disenchantment with the medical techniques he had seen and used. Homoeopathy was therefore devised as a challenge to the medical orthodoxy of the day. As a qualified doctor Hahnemann was an 'insider' mounting a challenge to the doctrines of conventional medicine and as such he was undoubtedly a potential candidate for the label 'heretic'. It is, of course, the privilege of the orthodoxy itself to append such a label to any challenger, an observer of past events does not have the right to do so. The literature, however, does show that the medical orthodoxy labelled Hahnemann as a heretic and he was often reported to the local magistrates by both the apothecaries and physicians as a dangerous heretic who should be stopped from practising, and proselytising, his heresies.

Hahnemann's homoeopathy can be regarded as a medical heresy for the entire duration of the nineteenth century, both in Europe and in the United States of America. It gained some degree of respectability when it was included in the services that could be dispensed under the aegis of the National Health Service but professional homoeopaths have always been excluded from working within the

National Health Service homoeopathic hospitals resulting in even this small degree of respectability being denied to the professional homoeopaths.

Many professional homoeopaths, unlike the majority of medically qualified homoeopaths, still learn and use homoeopathy in much the same way that Hahnemann would have used it, and yet by their own admission many professional homoeopaths could not be judged to be challenging conventional medicine at all, preferring to work alongside it, often in a complementary fashion rather than the alternative way in which homoeopathy was practised by Hahnemann and his early followers. In discarding the aspect of challenge to orthodox medicine, homoeopathy would appear to have rejected its heretical stance.

The practise of these 'classical' homoeopaths may be the same as that of Hahnemann, however the patients, and the general relationship of the patient to both homoeopathy and conventional medicine, has changed. If the patients wish to mix their medicines then the practitioners, both orthodox and heterodox, must accept that this is the patients choice and provide their services accordingly.

Are market forces therefore changing the practise of homoeopathy ? With all heterodox therapies enjoying a period of rapid growth in demand the greater number of consumers may be capable of exerting pressures for change on the professional homoeopaths who are under the influence of 'client control' far more than the orthodox physicians or the medically qualified homoeopaths.

Consumerism is not only concerned with choice but also with the perceived safety of the product or service and a heterodox therapy that is undergoing a process of professionalisation and statutory regulation is probably perceived as being safer than one which is regarded as of a heretical nature or one which is challenging the more familiar ideas of orthodox medicine. It will be interesting to see if market forces will push those professional homoeopaths who are less in favour of change into the background, allowing the professionalisers to complete their strategy of harmonisation with the medically qualified homoeopaths and the medical profession as a whole, leaving the 'heretics' to attract those clients who require a genuinely different alternative to conventional medicine.

Whatever the reasons, homoeopathy as practised in the United Kingdom by both doctors and professional homoeopaths does not, on the whole, present a challenge to orthodox medicine and cannot properly be thought of as a heretical form of medicine. The majority of homoeopaths seem very willing to work alongside their conventional colleagues, in a non challenging way, providing a complementary, or even supplementary, service for their clients.

12.4 Implications for the sociology of the professions

It is possible to divide the implications into two separate, yet related, fields. These are firstly the control of knowledge and secondly the access to, and use of, media to promote views.

12.4.1 Control of knowledge

Professionalisation is often concerned with control of knowledge. A group working to enhance their professional status must prove that they have a form of specialist knowledge which is not in the possession of any other professional group.

In homoeopathy there is certainly a specialist knowledge that may be possessed, however, there are a number of groups who all claim to be the rightful owners of this knowledge. The professional homoeopaths and the medically qualified homoeopaths have for a long time fought over who has the proper claim to this knowledge. Recently, however, perhaps in response to the drive for professionalisation from the Society of Homoeopaths there has emerged a third group who are making claims to be the sole rightful owners and users of this knowledge. This group is a sub-group of the professional homoeopaths and they claim to be the only practitioners using homoeopathic knowledge in its original format and are therefore the only rightful users. This group, called 'defenders of the faith' or 'defenders' in this work, are beginning to identify most other professional homoeopaths (i.e. those not in the 'defender' sub-group) with the medically qualified homoeopaths as those practitioners using homoeopathy in a less than traditional, and therefore, incorrect manner.

Unfortunately for these 'defenders', claims to knowledge may be insufficient to ensure their continued existence and the power of the Society of Homoeopaths to

use the media to promote their claims to professionalism may result in a marginalisation of the 'defenders'.

Professionalisation is not always a process of a coherent group of practitioners enhancing their professional status in a unified way. The homoeopaths are evidence that professionalisation can be a force for disunity as well as for unity.

12.4.2 Access to media for disseminating views

The view put forward by the elite of a profession may not always reflect the feelings at the level of the grass roots members. The practitioners on the 'shop floor' in both medically qualified and professional homoeopathy showed evidence of a strong sense of distrust of the other's practices. This distrust, however, was not always reflected in the statements made by the Board of Directors of the Society of Homoeopaths in their publications, where meetings between the Society of Homoeopaths and the Faculty of Homoeopathy were reported as enhancing and promoting future moves towards mutual acceptance and a unified form of registration for all homoeopaths.

It is unlikely that this discrepancy in the stated opinions of the elite and the grass roots membership of a profession uniquely affects homoeopathy in the United Kingdom and it can probably be concluded that such an environment exists within many other professional groups. It is therefore important to bear in mind that the elite of a profession have better access to more, and more powerful, media for disseminating their views than the grass-roots members. This inequality of access could result in a distorted picture being presented of the true state of affairs within a professional group.

This powerful use of the media to represent the views of the elite may also result in individual professionals mistakenly assuming that they are alone in dissenting from this published opinion, as the majority of the information that they are receiving may be from sources used by the elite to disseminate their view. In homoeopathy, especially, the highly individualistic nature of the practitioners, already referred to earlier, may preclude discussion with other members of the profession. This absence of discussion may preclude an individual practitioner from confirming that the views they hold are similar to those held by other practitioners.

It is possible that in the profession of homoeopathy, and in other professions, a calm and unified public face is covering up the turmoil experienced by a large number of individuals who feel betrayed by the entire profession. When studying professions it would be wise to bear in mind that there may be wide variations in opinions between those in the public eye, the elite of the profession, and those who make up the bulk of the membership. This difference is often not made public, as is the case with the homoeopaths, for public relations reasons.

12.5 Reflexive account of methods

This reflexive account will be written in the first person.

12.5.1 Reluctant Contacts

My initial plan for data collection was to interview many homoeopaths. Contacting them became a problem and it became apparent to me that a questionnaire with a space to provide contact details might yield a number of interviewees as well as collect some data. The questionnaires certainly revealed a lot of data but showed up two facts that were to compound my difficulties with making contacts.

Firstly the response rate to the questionnaire, although completely acceptable, was rather disappointing. Secondly, those who did respond were less likely to give contact details if they made more statements that could be construed as dissenting. Comments were often appended to the completed questionnaires giving reasons for not completing the contact details section, or wanting to know my motives for questioning them – the reasons stated in the accompanying letter were perhaps not believed by some. ‘Who is pulling your strings ?’ was asked by one respondent.

This gave me a picture of a profession that was constantly looking over its shoulder, why was someone interested in their work, who was he going to pass the information on to, and why ? I was accused of being funded by major drug companies who wanted to see how homoeopathy could be taken over by them in their search for more profits.

On the whole the homoeopaths in the study appeared to be a very non-dissenting group of practitioners and yet they reacted to my questioning as if they had something to hide. This may have had the effect of providing a false impression to

me as they may have hidden some details of their practices for fear of ridicule or disapproval from the media (as one respondent claimed to have experience of). It may be that a larger proportion of the professional and medically qualified homoeopaths were, in fact, dissenters but were reluctant to give me any evidence of it.

This reluctance to talk was highlighted by one prominent professional homoeopath who would have been important to interview with regards to the professionalisation issues within the Society of Homoeopaths. When personally introduced to this homoeopath at a social event it was made very clear to me that this person had no intention of speaking to me and I was completely ignored and left standing alone within seconds of the introduction. By this stage of the study I was quite used to the difficulties that could arise when trying to establish contacts with people, but on this occasion I was so expertly, and bluntly, avoided that I was quite astonished.

Once face to face contacts were made with homoeopaths they seemed to be happier to make responses of a more 'subversive' nature, this may be due to the fact that reassurances could be given in person about the nature of the research and the confidential nature of any responses that they made.

12.5.2 Possible Bias

I found the dissenters to be a particularly fascinating subgroup within the population of interest and, consequently, I found myself liking them as individuals even though I might not always find myself able to accept some of the statements that they often made. It may be possible that, although every effort was made to prevent or reduce it, an element of favourable bias towards this group has crept into the analyses made about them and their relationship with members of other groups.

Interestingly, this may of course be an element of the placebo effect that orthodox medicine claims is responsible for much of the effect of homoeopathy, these are a likeable group of people who can communicate very well.

12.5.3 Medically Qualified Homoeopaths

Initially I had expected to find the medically qualified homoeopaths very interesting, after all, this was a group of orthodox trained doctors utilising a heterodox practice

and I wanted to know why they would want to embrace such 'subversive' ways. The reality often proved to be that these doctors tended to use homoeopathy alongside orthodox techniques, and sometimes other heterodox techniques, in a way that was aimed at increasing the number of tools that they had at their disposal in order to carry out an eclectic form of medicine with homoeopathy as a supplementary technique.

This discovery may have produced an opportunity for a negative form of bias to be introduced with respect to this group, certainly the professional homoeopaths accused them of not practising homoeopathy correctly and I could see that they were using it as part of a repertoire rather than as the 'stand alone' therapy I was expecting. Once again biases will have been avoided if possible but this is not always possible, I hope they have been minimised if they exist at all.

12.6 Summing it all up

The practice of homoeopathy in the United Kingdom could be summed up as being riven by a number of factions. The division between medically qualified and non-medically qualified homoeopaths is an obvious one but within the ranks of professional homoeopathy there would also appear to be divisions. The moves by the directors of the Society of Homoeopaths, and many of its members, to enhance the professional status of homoeopathy through statutory regulation have proved unpopular with a sizeable minority of the membership. Divisions based on the 'proper and correct' way to practise homoeopathy are also present.

The drive for professionalisation is a drive to put in place a totalising metanarrative for homoeopathy, thus continuing its modernist traditions. It is possible that the developing splits within professional homoeopathy and the increasing suspicions that some professional homoeopaths hold regarding the practices of medically qualified homoeopaths may be symptomatic of the deconstructing influence of post-modernity on the practise of homoeopathy.

The professionalisers, in the guise of the Society of Homoeopaths representing the homoeopathic orthodoxy, may be attempting to change the practice of homoeopathy to make it more acceptable to the authorities that can confer

respectability upon it, in the form of statutory regulation. As 'elite' members of the orthodoxy this would not be seen as heresy, rather this change would be seen as 'revelation' (Wolpe 1994). Statutory regulation could control, or at least minimise, the schisms within homoeopathy in order to present a united, professional front to the world.

It is possible that under the influence of post modern pluralistic pressures, the professionalisers will be unsuccessful in their attempts to pull together the factions that exist within homoeopathy. If this were to be the case then statutory regulation would be unlikely to occur and a pluralistic homoeopathic community might be the result, leading to a broad range of practitioners for clients to choose from, all practising a form of therapy that they could quite properly call 'homoeopathy'. This could all lead to an increase in consumer choice, or an increase in consumer confusion.

13 APPENDIX A PROFESSIONAL QUESTIONNAIRE

Homoeopaths Questionnaire

1. Age
2. Sex.....
3. When did you start to practice homoeopathy ?
4. What homoeopathic training have you undertaken ?
 - a) Who ran the course(s) ?
.....
.....
.....
 - b) What was the duration of the course(s) ?
.....
.....
.....
5. Is homoeopathy your only form of paid employment ? (Please Tick)

Yes	No
6. If homoeopathy is not your only employment what other work do you do ?
.....
.....
.....
7. If you work part time in homoeopathy approximately what percentage of your time is spent practising homoeopathy ?.....%
8. What was your occupation before you started practising homoeopathy ?
.....
.....
.....
9. How many homoeopathic patients do you see per month ?
10. Do you ever see homoeopathic patients within the N.H.S ? i.e. NHS patients referred to you by GPs on their budget. (Please Tick)

Yes	No
11. How long is the homoeopathic patients appointment time ? (Please state in minutes)
..... minutes

12. Where do your patients come from ? (Please tick all that are appropriate)

Self referral	
Referred to you by GP for NHS funded treatment	
Referred to you by GP for private treatment	

13. What prompted you to start practising homoeopathy ?

.....

.....

.....

.....

.....

14. What do you enjoy most about your work as a homoeopath ?

.....

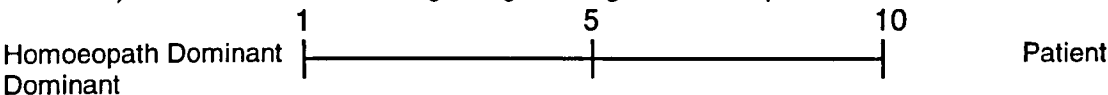
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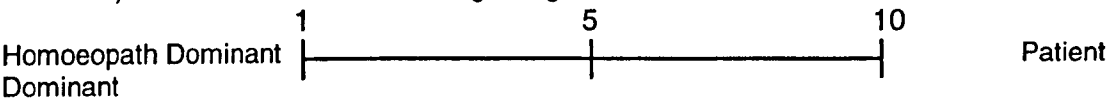
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15. I am interested in the interaction that takes place between the homoeopath and the client/patient. Please place a cross (X) on the line below that you feel indicates where you would place yourself on a scale of 1 - 10 on the topic indicated.

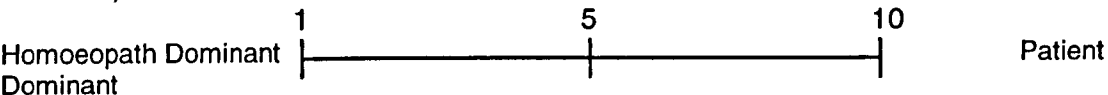
a) Who makes decisions regarding the diagnosis of the patient.



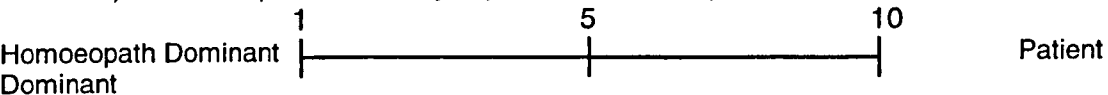
b) Who makes the decisions regarding what is to be treated



c) Who makes the decisions about the treatment to be used



d) Who is responsible for any improvements in the patients health ?



16. Do you consider homoeopathy to be (please tick)

an alternative medicine	
a complementary medicine	

Please comment further if you wish.

.....

.....

.....

17. Do you think homoeopathy is more holistic than conventional medicine ?

Yes	
No	

Please comment further if you wish.

.....

.....

.....

18. How do you feel homoeopathy is seen by doctors in conventional medicine ?
(Please Tick)

in a positive light	
in a negative light	
in a neutral light	

Please comment further if you wish

.....

.....

.....

19. Do you think patients should only be allowed access to homoeopathy by referral from their GP ?

Yes	
No	

Please comment further if you wish.

.....

.....

.....

20. Should professional homoeopaths (i.e. non medically qualified homoeopaths) be registered as homoeopaths in the same way as osteopaths and chiropractors must be ?

Yes	
No	

21. Should medically qualified homoeopaths be registered as homoeopaths in the same way as osteopaths and chiropractors must be ?

Yes	
No	

22. Should professional homoeopaths have legal limits placed upon the disorders they may treat ?

Yes	
No	

Thank you for your time and help in filling in this questionnaire. If you wish to enlarge on any of your answers please write the question number and any comments below.

Alternatively, if you would be willing to take part in an interview with me, either in person or on the telephone, please fill in your name address and telephone number and I will contact you in the strictest confidence

Name.

Tel No.

Address

14 APPENDIX B DOCTOR QUESTIONNAIRE

Homoeopaths Questionnaire

1. Age
2. Sex.....
3. When did you qualify from medical school ?.....
4. When did you start to use homoeopathy ?
5. What homoeopathic training have you undertaken ?
 a) Who ran the course(s) ?

 b) What was the duration of the course(s) ?

6. Do you work full time in homoeopathy or part time ? (Please Tick)

F/T	P/T
7. If you work part time in homoeopathy approximately what percentage of your time is spent using homoeopathy ?.....%
8. Please detail all posts held since qualifying from medical school, with dates if possible.

9. How many homoeopathic patients do you see per month ?
10. Do you see homoeopathic patients within the N.H.S ? (Please Tick)

Yes	No

11. Do you see homoeopathic patients privately ? (Please Tick)

Yes	No

12. How long is the homoeopathic patients appointment time ? (Please state in minutes)

Private	mins
N.H.S	mins

13. What prompted you to start using homoeopathy in your medical practice ?
(Please rank the top three reasons by writing 1,2 or 3 in the space.)

Felt that there was more than just conventional medicine		Wanted to do something different	
Allowed you to spend more time with patients		Felt dissatisfied with conventional therapy	
Felt that homoeopathy was an additional 'tool' I could use		Felt unsatisfied in the high pressure world of conventional medicine	

Any other reasons ?

.....
.....

14. Do you feel that homoeopathic consultations are (please tick)

more patient centred than conventional consultations	
less patient centred than conventional consultations	
equally as patient centred as conventional consultations	

Please comment further if you wish.

.....
.....
.....

15. Do you consider homoeopathy to be (please tick)

an alternative medicine	
a complementary medicine	

Please comment further if you wish.

.....
.....
.....

16. Do you think homoeopathy is more holistic than conventional medicine ?

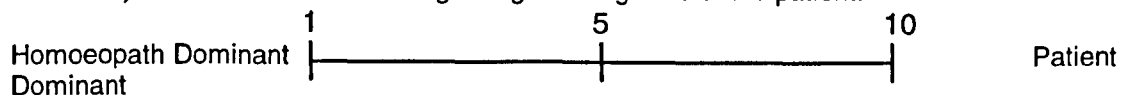
Yes	
No	

Please comment further if you wish.

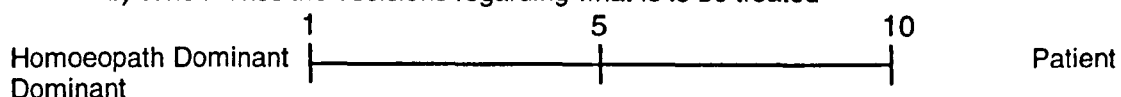
.....
.....
.....

17. I am interested in the interaction that takes place between the homoeopath and the client/patient. Please place a cross (X) on the line below that you feel indicates where you would place yourself on a scale of 1 - 10 on the topic indicated.

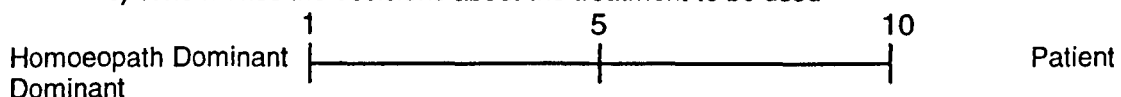
a) Who makes decisions regarding the diagnosis of the patient.



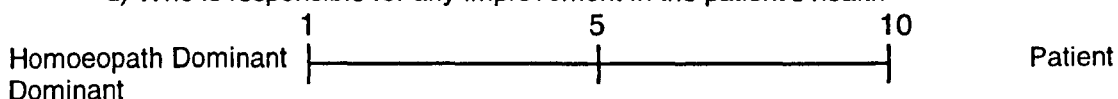
b) Who makes the decisions regarding what is to be treated



c) Who makes the decisions about the treatment to be used



d) Who is responsible for any improvement in the patient's health



18. How do you feel your homoeopathic practice affects your conventional colleagues opinion of you ? (Please Tick)

seen in a more positive way	
seen in a more negative way	
has no effect	

19. Do you think patients should only be allowed access to homoeopathy by referral from their GP ?

Yes	
No	

20. Should medically qualified homoeopaths be registered as homoeopaths, in the same way that osteopaths and chiropractors must be ?

Yes	
No	

21. Should non-medically qualified homoeopaths (professional homoeopaths) be registered as homoeopaths, in the same way that osteopaths and chiropractors must be ?

Yes	
No	

22. Should professional homoeopaths have legal limits placed upon the disorders they may treat ?

Yes	
No	

Thank you for your time and help in filling in this questionnaire. If you wish to enlarge on any of your answers please write the question number and any comments below.

Alternatively, if you would be willing to take part in an interview with me, either in person or on the telephone, please fill in your name address and telephone number and I will contact you in the strictest confidence

Name.

Tel No.

Address

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