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MEDICINE AND HEALTH

Edited by Michael Heap

CONTENTS

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EDITORIAL

Michael Heap

Most of this issue of the 'Skeptical Intelligencer' is taken up with a discussion, by a number of individuals, of the phenomenon of alternative or complementary medicine, and how it stands in relation to orthodox medicine. The practice of orthodox medicine is itself briefly discussed and some controversies are aired – such as the medicalisation or pathologising of personal difficulties and misfortunes that all humans have inevitably to face in their lives.

Related to the general subject matter is the increasing use of litigation to achieve financial compensation for misfortunes that were formerly, for most individuals, accepted as part of the normal 'slings and arrows' of life. Hence we now speak of the 'blame' or 'compensation' culture. A review is presented of 'Compensation Crazy', one of the two books reviewed in this issue that are part of a series edited by members of the Institute of Ideas.

The reader who intends to study all of the articles in this issue may find it helpful to do so in the sequence in which they appear, as there is some continuity within this. The papers on alternative medicine include a previously published article on the psychology of alternative medicine by a well-known expert, Professor Adrian Furnham of the Department of Psychology, University College London. Following this are two papers on the regulation of alternative medicine.

Before these papers, however, is one of my own in which, amongst other things, I attempt to establish what I believe is an essential backdrop against which socio-cultural phenomena such as alternative medicine, and as it happens, the 'medicalisation of personal misfortune' and the 'compensation culture' can be best understood. This paper includes material from an article that I wrote for the UK magazine *The Skeptic* some years ago.

ARTICLES

HEALING AND THERAPY IN THE AGE OF MASS AFFLUENCE

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PART I: THE POLITICAL, SOCIAL AND ECONOMIC CONTEXT OF HEALING AND THERAPY

Introduction

This paper is an updated version of an article that I wrote for the UK periodical *The Skeptic* ('Surely there is something in it: The social psychology of healing', *The Skeptic*, 9(4), 9-14). The paper begins as follows:

'This paper concerns the social psychology of healing and therapy. I am using these words more or less interchangeably and in a very broad sense. They refer to all aspects of the situation in which healing or therapy is intended to take place, regardless of whether it does so in reality. I am thus referring to the circumstances in which a person has some problem of mind or body and another person, the healer or therapist, attempts to alleviate that problem by means of some special knowledge or expertise.

'Defined as such, healing is a universal phenomenon, a significant activity in all societies at all ages of history. Indeed, if you survey healing throughout history and across contemporary cultures, and even within our own culture, you will encounter an extraordinary and fascinating range of human behaviour and beliefs, bounded only by the healer's own imagination and the compliance of those seeking to be healed, and therefore unbounded. I think this is more so than in any context other than religion. I am, moreover, challenged to understand why in our own society we have so many people involved in healing and therapy. I once visited an exhibition of alternative medicine and counted no less than thirty five distinct remedies being offered for someone complaining of headaches. Perhaps the more treatments there are for a problem the less likely any of them has a direct therapeutic effect. But my puzzlement in this regard is not confined to unorthodox medicine. In a recent critique of contemporary medical practices (Skrabanek & McCormick, 1989) I was astonished to read the following:

"Sir Douglas Black, a past president of the Royal College of Physicians, estimated that only about 10% of diseases are significantly influenced by modern treatment. This echoes the opinion of Sir George Pickering who guessed that in some 90% of patients seen by a general practitioner the effects of treatment

are unknown or there is no specific remedy which influences the course of the disease. Yet prescribing in general practice is the rule rather than the exception." (pp 10-11)

'In fact, I insist that if you put together mainstream public and private medicine, alternative or complementary medicine, commercially available, across-the-counter remedies, and so on, then you have a healing industry the collective scale of which vastly outstrips whatever it is really capable of achieving. In short, there seems to me to be far too much of it about. And yet the constant message that I am hearing is that we need *more* of it. Is it possible that there is another perverse law, namely that greater affluence brings less disease and better health but paradoxically the call for more healers? Indeed, I find little to restrain me if I speak of the 'Healing Classes' since healing involves the exercise of power over a disadvantaged population.'

I originally wrote these words over 12 years ago and since then have given further thought to the questions that were puzzling me. Puzzling me also was, and still is, the phenomenon of alternative medicine. The impetus for the previous paper and the present expanded version has arisen from my own dissatisfaction with narrow, health-focused explanations of alternative medicine and its growth in popularity as manifested by the increasing number of practices that are gathering under its umbrella; its promotion by celebrity figures and institutions including the House of Lords and the Royal Family; and growing demands for recognition, regulation, wider availability within our National Health Service; more research into its efficacy; more rigorous training of its practitioners; and so on. Explanations of these developments are usually based on assumptions about the needs of the consumer – the 'fight against illness' and the promotion of good health - as well as public demands for treatments that have a different philosophical basis to orthodox medicine, namely those that are 'natural', and 'treat the whole person'. It is also frequently stated that the growing popularity of alternative medicine arises from dissatisfaction with what orthodox medicine can offer, including time spent with a doctor or specialist.

These considerations fail to take into account certain glaring anomalies, namely that all of the developments listed above are taking place in the almost complete absence of any scientific evidence to support the foundations of alternative therapies and to demonstrate their clinical effectiveness over and above natural symptom remission and placebo responding (or, as I put it later, the failure to demonstrate objectively the authenticity of the practitioners). It is all the more surprising that these developments are occurring while research into orthodox medicine, unlike alternative medicine, continues to advance our knowledge of illness and its causes, amelioration, cure, and prevention, and promises much more in the future. Moreover, we have the growing awareness of the financial limitations of health service budgets and the insistence on the use of empirically validated methods of treatment ('evidence based practice').

I, and I dare say many sceptics, contend that the growth of the alterative medicine industry has little, if anything, to do with the health needs of the public or the remediation of illness. Moreover, factors such as the philosophical appeal of alternative medicine,

whilst they are not to be ignored, are probably of comparatively minor status in understanding the totality of the phenomenon.

How then are we to further our understanding of these developments? It appears to me that to arrive at satisfactory answers it is necessary to understand the political, economic and social context in which the healing industry is located. To take this claim further, however, requires me to enter fields of knowledge of which I have no particular expertise, and I caution the reader accordingly.

The Growth of Mass Affluence

It is undeniable that human beings are unique in the animal kingdom in possessing an extraordinary range of abilities and talents that are developed to a level well beyond that required simply for the survival of the individual and the species. How this has come about is not relevant to the present discussion. What is more important is that it is only relatively recently that the majority of people, at least in the Western world, have had the opportunity, in any significant measure, to reap the benefits of their inherent potentials as human beings as instead of merely struggling to survive . That this has been possible is due to the increasing affluence of the population and the economic and political freedoms that they enjoy. Associated with this are the relentless advance of knowledge and technology and the ever-widening range of choices available to each individual in virtually every aspect of his or her daily life.

The skills and talents and the ability to enjoy their products are not only represented by the rich array of material goods on offer, but also in the following: housing; transport and travel; the acquisition of knowledge for knowledge's sake; the arts; the sciences; cuisine; hobbies, sports and leisure activities; entertainment; and physical accomplishments and feats of endurance. In all of these areas and others, more and more is on offer to and attainable by, men and women in modern society.

It is not of course simply the case that a life rich in opportunity and fulfilment has only been realisable in the modern era. What is unique is not just the sheer scale of what is available to any individual in his or her daily existence (notwithstanding great disparities in wealth and opportunity amongst the population); of major significance is the fact that the range of benefits is available in varying degrees to all and not, as has been the case until recently, to just an elite minority.

The Three Components of Activity

As a rule, people will strive, individually and collectively, to avail themselves of as much of the benefits of modern life as possible, and to hold on to what they have. It is possible to conceive of at least three major components of social activity which, in combination, provide the means whereby these goals are achieved.

Component One is the procurement of the wealth whereby life's rich offerings may be purchased. The main source of most adult people's wealth is the income that they earn through their employment (and, in the case of retired people, at least nominally from the returns on the investment of a proportion of their earned income). There is also income through other investments and through welfare. Importantly, for many people, in addition to monetary reward, their work itself represents a life-enriching experience and a

fulfilling deployment of their knowledge and skills, however basic.

Component Two is the acquisition of knowledge and skills by people:

(a) to secure for them the means to obtain wealth, as above, usually by employment, and

(b) to enable them to engage in, and enjoy, the ever-increasing range of activities, amenities and assets available, as listed earlier.

Acquisition of the relevant knowledge and skills is mainly by formal education, training, and mass communication and, like employment, can be a rewarding end in itself.

Component Three is the prevention, removal, or minimisation of impediments:

(a) to directly accessing the opportunities on offer, and

(b) to indirectly accessing these by wealth acquisition (employment) and education and training

Here we are mainly concerned with misfortunes or adversities that occur in people's lives and cause suffering, not only directly, but also by preventing them from fully accessing what would otherwise be available. These misfortunes or adversities originate from a limited range of sources (often in combination) such as bacteria, viruses, etc; poisons; genetic irregularities; bodily malfunctions; ageing; human malevolence, negligence, incompetence and retribution; animals; and natural phenomena (the weather, earthquakes, etc). In human society, systems and agencies exist to prevent, remove or ameliorate these. Major examples are the medical services and, in the case of misfortunes due to human malevolence and negligence, the criminal and civil justice systems respectively. We may also include here insurance and welfare services.

Principles of the Three Components of Activity

Within each of the above three components of activity are systems, subsystems and agencies subserving the function of each, as well the general function of maximising human choice and potential. In the evolution of these, several important processes and trends may be discerned. It is important to stress that whilst these may not be successfully realised in every case, they are all driven by forces that are difficult to resist.

The principle of survival

Firstly, systems, sub-systems, agencies, and elements within them (e.g. occupations) that are associated with the above three components, once established tend to be difficult to disestablish. That is, forces exist that tend to maintain their survival, for their own sake if nothing else. At the most general level, societies and the people in them want to hold on to what they have, and this is evidence in the tendency for systems, institutions, and so on to promote their own survival.

The principle of expansion

Not only do they tend to survive: forces exist that promote their expansion. At the most general level, we see the never-ending growth of mass affluence and the range of products and amenities on offer and available to an

ever-widening section of the population. This growth is paralleled in manufacturing and service industries, educational, health and welfare services, the criminal and civil justice systems, and so on. Again this expansion serves the needs of these industries as well as those whom they supply and serve.

The principle of increasing diversity and specialisation

Within the systems, at every level we can usually detect an irresistible drive towards not just more of the same, but towards increasing technical and technological complexity, diversity and specialisation. Again this is evident generally when we consider the amenities, activities and assets that are available, but it is also evident in the evolution of activity at each of the three components summarised above.

Firstly, within Component One we see increasingly complex and specialised forms of legitimate employment and other forms of wealth acquisition. We also, incidentally, witness a parallel process in the illegal acquisition of wealth.

Secondly, and related to this, we note that the increasing complexity and diversity of (a) products and amenities and (b) employment make greater demands on the knowledge, abilities, and aptitudes of the population. Hence more complex and diverse must be the education and training that are delivered by the services concerned (Component Two).

Thirdly, this ever-increasing complexity is clearly evident in Component Three, notably in the health services, but also in the civil and criminal justice systems and in welfare and insurance services. Thus we witness the relentless advance of medical science in identifying and understanding illness, disease and injury, preventing their occurrence (as in the development of more and more vaccines) and treating them when they do occur. In association with this we have the ever-increasing diversification and specialisation of medical practice.

Here it is important to note how much more complex now are the *consequences* of illness and injury. In our early history, the main consequence of a non-fatal illness or accident was the loss of survival skills such as hunting, farming and defensive action. Now in our society, people who suffer disability do not die because they cannot fend for themselves; they very often do not even become totally dependent on others, and they can lead a very full life. However, the consequences of illness and disability are much more specialised and often more significant than in previous eras. They may be temporary, say when a holiday has to be cancelled, or activity in a favourite sport is suspended for a period, likewise the opportunity to socialise. Permanent consequences are, for example, the inability to undertake any sporting activity at all, to engage in many games and leisure activities, to drive a vehicle, and to enjoy music or the visual arts.

Very important are the consequences of illness and disability for activities related to Components One and Two. Again, these may be temporary – commonly a period off work or an interruption in education or training. However, an individual, because of a permanent disability, may be forever excluded from pursuing his or her career aspirations, including the relevant education and training. There is a multitude of obvious illustrations of

this, but here it is worth observing how some disorders and disabilities owe their prominence, and almost their recognition, to their consequences for the individual in modern society. A very good example of this is dyslexia. Being dyslexic may compromise the ability of an individual to participate in certain pleasures of life and to qualify in and undertake his or her desired trade or profession. However, not too long ago, being unable to read or write satisfactorily would have been of no consequence, and most people would never have had the opportunity to acquire such skills anyway. A similar story may be told about Attention Deficit-Hyperactive Disorder; one of the impetuses in diagnosing this disorder may well be the increasing requirement on children, from an early age to at least their mid-teens, to sit still and concentrate for long periods of time if they are to make their way in the world.

The principle of interdependence

It should be evident by now that the network of systems, subsystems and the elements comprising them (agencies and individuals) under the three components form an organic whole in which the structure and functioning of each, and their development according to the principles of survival, expansion and diversification, are intimately interwoven and dependent on every other. Once the conditions of political, social and economic freedom are in place, there is no simple line of dependency or causality amongst them, even between those subsystems and elements where a relationship of dependency or power is formally defined (e.g. hospital-patient, teacher-pupil, police-criminals). This will be discussed in more detail later; here let it be noted that the opportunity for any system or organisation to flourish and expand is greatly enhanced the more it enmeshes itself within this interdependent network across the three components.

The principle of inevitability

Once again, as long as the conditions of freedom and affluence are in place, the development of the systems associated with the three components, according to the principles of survival, expansion diversification, and interdependence, tends to occur in a relentless and irreversible fashion. This is directly parallel to increasing affluence, increasing range and diversity of available goods and opportunities, and the progress of human knowledge and science. Human nature dictates that this is very difficult to resist, for example, by religious and philosophical appeals to people to eschew the material trappings and comforts of modern civilisation or to adhere to strict rules and mores that demand honesty, fairness, unselfishness, tolerance, stoicism and so on. Likewise it would be very difficult to reverse the same trends in employment and wealth creation, medicine (in its widest sense), education, and the criminal and civil justice system. Even the growth in crime itself has proved difficult for governments to reverse. (There are other related social phenomena that also show great resistance to control, immigration and drug usage being two examples. Trade unionism, on the other hand, which in the UK peaked in the late 1970s, has declined in terms of activity and membership, but remains a significant presence).

This resistance to control of the systems and processes described here is probably in

significant measure due to their close interdependence, as discussed earlier.

The principle of over-promotion

Another difficult-to-resist consequence is that personal service industries such as medicine (not just orthodox practice, but also allied professional services, alternative medicine and commercial medicine), education, the social services, and the criminal and civil justice systems tend to over-promote themselves in terms of what they achieve and how much they are needed by the population (cf. the manufacturing industries). For reasons that will soon be apparent, another way of stating this is to say that they exaggerate their *authenticity*. Let us study this now in further detail.

Each of the above enterprises has a set of aims that can be simply stated. For example, the purpose of the medical services is to promote good health and prevent and either cure or ameliorate illness; the purpose of education and training is to equip people with the knowledge and skills required to lead a fulfilling and productive life and to pursue a trade or profession; and so on. The extent to which these services, and the myriad of activities that take place within each, are acknowledged as offering the best available means of achieving these aims can be said to indicate their *perceived authenticity*. However, these public services also exist to meet the needs of their employees and stakeholders (e.g. in the case of the health services, the pharmaceutical industry). Like any industry, they need to survive, but also to expand, diversify and specialise, and, as we have seen earlier, to be part of the interdependent network that exists across the three components of activity specified earlier. One major requirement whereby these needs can be safeguarded is for the service to be, if not completely authentic (according to the above use of this term), then at least to be perceived as such by the public.

One strain on their authenticity is increasing public demands and expectations about what can be delivered (see below), but this is reciprocated by the needs of these services for expansion and increasing diversity and specialisation. Clearly then, there are strong forces on these services, as with any industry, to promote their authenticity and hence, very likely to over-promote it, namely to overstate what they can achieve, how much people need them, what promises they are able to fulfil in the future, and so on.

Indeed, the services in question have, in collusion with politicians and the public, been extremely successful in promoting their authenticity – that is their perceived ability, over any other possible system, to achieve their implicit and explicit goals. This is most clearly evident in the relentless expansion of public and private money allocated to these services and the almost universal and constant demand for more.

However, perceived authenticity is not the same as genuine authenticity. The realisation that the huge investment in and expansion of these public services brings disappointing returns in the most fundamental ways (e.g. more healthy, informed, skilled and law-abiding citizens, in contrast to ‘sound-bite’ statistics, such as classroom sizes and waiting times for surgery) either provokes calls for more of the same or questions about efficiency and the mechanics of funding (e.g. whether there

should be more private sector involvement). The extent to which these megalithic institutions are embedded in the political and social structure of our nation precludes any effective challenge to their authenticity. This has become much more the case with the ever-growing tendency for governments to rely on the performance of public services as a measure of their own success (or in the terminology used here, their perceived authenticity) in the eyes of the electorate.

The principle of increasing demands and expectations

Yet another important aspect of mass affluence and the advance of science is the change in people's demands and expectations. People increasingly expect and demand more of the services that subserve the three components outlined earlier. This principle is also subject to the principles of over-promotion (i.e. over-extension of expectation and demand) and inevitability.

In the not-too-distant past, and sadly even now for a sizable proportion of humankind, most people could only expect a stunted life where illness, injury, deprivation and misfortune were always close at hand, to be accepted as fate or divine ordinance. For those who had faith, the real rewards would come in the life thereafter, provided they accepted their lot on earth with gratitude and humility. Now, as a result of economic and political freedom, mass affluence, and progress in human knowledge and its beneficial application, the common, and not too unreasonable, expectation for most people in our society is that life will be rich and varied, with an ever increasing range of opportunities and benefits to be sampled, and that obstructions to such (as listed earlier) have in many cases a reasonable chance of being prevented, minimised or removed. Inevitably then the attitude evolves that adversities and misfortunes *should not* occur and if they do there should be remedies for them. Hence when these expectations are not realised, a person's reaction is more likely to include a sense of injustice and unfairness and a demand for redress. Such attitudes are an inevitable consequence of the kinds of developments and progress in our society that I have discussed so far, which promote the expectation of a life that should not be free merely from disaster, but from even minor discomforts, annoyances and disappointments.

Diverse Implications

There are several aspects of modern life that are often the subject of sceptical commentary that can be understood from the present analysis as being an inevitable consequence of political, economic and social freedom and the advance of scientific knowledge and its application. One of these is the tendency to pathologise and medicalise problems and misfortunes that until recently were implicitly acknowledged as the responsibility of the individual to accept or cope with, with the support of his or her family, friends and spiritual advisors. That is, more and more of these problems are now regarded as the province of experts in medicine (conventional or otherwise) and related disciplines who are perceived as the best equipped (i.e. the most authentic) at understanding them and prescribing or delivering the remedies for them. This theme of the 'over-pathologising' or 'medicalising' of human problems (or 'the colonisation of discontent') is taken up later in the current issue of the *Skeptical Intelligencer*.

Two more phenomena of interest that are predictable from the present analysis are 'NIMBYism' (the attitude of 'not in my back yard') and 'the compensation culture'. These topics are also discussed later in this issue.

Yet another topic of relevance here is the 'nanny state', that is, what some perceive as an excessive tendency for our government to be involved in many major aspects of our lives. This is not a topic for the present discussion. It is sufficient to point out here that, despite their best efforts, governments are subject to the same difficult-to-reverse tendencies to survive, expand and diversify in their activities and functions and to overextend themselves in what they offer for the present and what they promise for the future in the most basic aspects of daily life. Inevitably, public expectations about what governments can actual achieve also become overextended, placing considerable strain on the government's perceived authenticity. Nor is it possible for the current opposition party to resist these trends. In the 2001 General Election, the huge scale of the Conservative Party's defeat was ascribed to their campaigning on the ideological issue of whether the UK should in the future exchange the pound for the Euro as its national currency. Now the obligatory political mantra for both the government and opposition is 'better public services'.

The Importance of Perceived Authenticity

The idea of authenticity of roles, agencies (and professional practices) is very important for the analysis of healing practices and will be studied in greater depth here. Firstly, however, since we are interested in healing in the modern age, it is useful to be aware of one important context in which the evolution of the healing industry has taken place in recent years, namely employment (or more broadly personal wealth creation or Component One activities).

Modern trends in employment

As was stated earlier, the prime means whereby people acquire wealth is by their employment. It is important here to make a note of recent demographic changes in employment statistics (Labour Market and Skill Trends, 2000). Firstly, although there have been fluctuations over the last 50 years, employment levels in the UK are currently at record levels. (It is also noteworthy that, at the time of writing, the government is suggesting that people should stay in work longer and therefore retire – say at 70 years. This is partly because the returns on their accumulated investments in their pension schemes may not be sufficient to support them in the long retirement period that people these days enjoy, owing to their greater longevity.) Secondly there is proportionately more part-time, temporary, contractual and home-based employment. Thirdly, and very significantly, the expansion and diversification of employment has occurred much more in the service sector, including personal and protective occupations, than in production industries (manufacturing, agriculture, fisheries, etc.). In 1978 the largest employment sector (30% of the market) was manufacturing industry; in 1998 it was public administration, education, health and other services (28%, with manufacturing down to 17%). Skill requirements have become more demanding, with a corresponding increase of young people in higher education and training. Finally, the move to a service-based economy

is matched by the rise in the proportion of women in employment (47.1% of those of working age in 1960, compared with 69.4% in 2001, the corresponding rates for men being 96.1% and 79.6%).

The symbiotic nature of supply and demand

It would be incorrect to state that all of these changes *only* reflect the expanding and increasing diversification of the needs and demands of the consumer and the growing ability of human knowledge and expertise to meet these needs. Classical economics acknowledges that there is a reciprocal relationship between those who supply goods and services and those who demand them. That is, it is not the case the activities of the former are simply motivated by the requirement of ensuring that the needs of the latter are completely satisfied. The prime motivation of suppliers is, in fact, the satisfaction of their own needs. This principle is summarised by the great Scottish economist Adam Smith who wrote:

'It is not from the benevolence of the butcher, or the brewer, or the baker, that we expect our dinner, but from their regard to their own interests (The Wealth of Nations, 1759).

In other words it serves well the needs of, for example, the butcher (e.g. the need to earn a living, to have job satisfaction, to enjoy status in the community, and so on) to ensure that he is perceived by the consumer as occupying the role best placed to provide them with the meat that they desire. In this respect we can say that the butcher has a strong need to be perceived as *authentic*. Remember, however, that *perceived* authenticity is not the same as *actual* authenticity. For example, it may be better for people to obtain the meat they desire at the best possible price from some source other than a butcher. Thus the butcher is not authentic in this respect. (Note that the idea of 'authenticity' is best applied to the *role* that the person occupies, not the person himself or herself. So, Fred Jones, for example, may be 'authentic' as a butcher – qualified, well trained, honest, and dedicated - but this does not mean that the activities prescribed by the role defined as 'butcher' are themselves authentic.)

Putting it another way, a job itself is like a commodity or service; it addresses a range of needs on the part of the role-occupier. This fact in itself indicates that the distinction of supply and demand is not simply one way; those who supply may also be said to demand and those who demand may also be said to supply. In other words the relationship between the two can be said to be *symbiotic*, and underlying this is the need of the person or agency to be perceived as authentic in his, her or its designated role. (In fact, if we pursue the argument further according to role theory, we may assert that in many formal reciprocal role relationships, such as doctor-patient, pupil-teacher, complainant-lawyer, there is also a need for the other member (the 'client') to be perceived as authentic. We need not, however, concern ourselves with this here.)

I believe that this issue of the need for perceived authenticity is especially salient in service industries, in particular the agencies and professional roles associated with personal services such as in education and training, health and illness, and welfare, safety and personal protection (in the main those come under Components Two and Three as

described earlier). Moreover, the need to expand the personal service sector, not merely to meet demand but also to meet employment needs, increases the strain on these services to demonstrate the authenticity of their activities and practices.

PART II: THE NEED FOR AUTHENTICATION IN HEALING AND THERAPY

Authenticity and Power in Healing and Therapy

I shall now confine the discussion to healing services (i.e. orthodox medicine, alternative medicine, commercial medicine, counselling, etc.) although this analysis may be adapted to other personal services such as education and the law.

Healing usually involves a practitioner as an expert doing something to someone - treating or assessing him or her in some way and, most notably, interpreting on behalf of that person what is right or wrong with his or her body, mind or personal circumstances and what are the necessary remedies**.** Consequently they are about *power* and one thing that sustains such practices is the power relationship - the practitioner's need for power and the recipient's need for someone with that power. (I am not necessarily using the term 'power' in a pejorative sense; in fact it is an essential feature of everyday life.) Hence the crucial need is for the practitioner to be perceived as authentic in his or her role and anything that challenges the authenticity of his or her ideas and practices challenges the authenticity and power of the practitioner. (Recall that 'authenticity' is best applied to the *role* occupied by the practitioner; we are not so much concerned with whether the particular individual is, good or bad at being, say, a homeopath or has the proper qualifications and training; much more relevant is the authenticity of the activities prescribed by the role of 'homeopath' itself.)

The Purpose of Healing and Therapy

In our own society the role of healer or therapist has a certain permanency; that is, it is usually a profession or occupation from which the person derives his or her livelihood and social identity. In consequence the question of the authenticity or legitimacy of his or her power is all the more significant. In fact this combination of firstly the importance to the therapist of his or her perceived authenticity and secondly the power imbalance between therapist and patient seems to me to be of such significance that I am persuaded to make the following assertion. Normally we would define the purpose of healing or therapy as, say, 'to alleviate the sufferings of the patient'. I propose the following definition:

The purpose of therapy is to authenticate the therapist

...that is, to legitimise his or her power and his or her beliefs and practices. It is apposite to emphasise that we are always speaking of the therapist's *perceived* authenticity.

I am here referring to what determines the behaviours and beliefs of both the therapist *and* the patient. In most instances, the crucial issue to which therapist and patient or client apply themselves is the authenticity of the

therapist (*see Note 1*). But because of the power imbalance the practitioner has greater control over defining the needs of the patient, the remedies to prescribe, the range of legitimate outcomes, and so on, and will tend to do so in ways which are self-authenticating.

The Means of Authentication

In what ways can a healer or therapist promote the perceived authenticity of his or her role? One obvious way is by adherence to the traditional healing ceremony, which fulfils the expectations of the person wishing to be healed. This includes taking a history, performing an examination, administering tests, providing a diagnosis, preferably based on a rationale acceptable to the patient, administration of a remedy, monitoring progress and outcome, and so on. But adherence to a ceremony is not in itself sufficient for a practitioner to be perceived as authentic.

Authentication by scientific validation

Clearly the most effective way of authenticating the healer's role is by the patient's getting better, or at least being perceived to do so. One way of increasing the likelihood of this is by accountability to scientific knowledge and enquiry. Firstly, diagnoses and treatments should be based upon scientifically established finding in the fields of human physiology, biochemistry, pathology, and so on. Thus we have therapies that are authenticated by being 'process based' according to scientific knowledge. However, this is now recognised as insufficient. These treatments should also be scientifically demonstrated to have a specific remedial effect on the disease or condition to which they are applied. Thus the treatments are authenticated or otherwise by the 'evidence-based' (or 'outcome based') approach.

Here we have the principle that the ideas and practices must have a *clear derivation* based upon careful and objective observation, experimentation, and logical and mathematical deductions made therefrom. They must also be accountable to the *self-correcting process* of scientific enquiry, as a result of which they may be left intact, modified, or abandoned altogether. Historical examples of the last category are trepanning and phrenology. More recent treatments that have been subjected to the evidence-based approach are provided by Sackett & Rosenberg (1995) who observe that certain drugs that suppress unstable cardiac rhythms in patients who have suffered myocardial infarction have now been found to *increase* rather than decrease the risk of death; likewise many process-based manoeuvres that have been used in obstetrics and childbirth have now been found to be of doubtful value or harmless.

However, this alone is now considered insufficient to establish the authenticity of a treatment. The clinical benefits of the treatment should be demonstrated to be worth the time, effort and money spent, particularly when weighed against considerations such as the cost effectiveness of other treatments, the patient's quality of life, and adverse side effects. The UK government, which is responsible for the distribution of finite resources, recognises the importance of this, as demonstrated by the establishment of the National Institute for Clinical Excellence, whose brief it is to decide upon the availability of treatments in the Health Service according to these criteria.

Even all of this, however, ought not to be regarded as sufficient for establishing the authenticity of any treatment. More radical challenges to the authenticity of any curative approach to illness may be made by asking whether resources should be diverted to, say, preventative measures. For example in recent years we have witnessed the dramatic rise in the incidence of asthma, notably in children, and it may be argued that the most authentic way of addressing this is by researching the causes of this epidemic and remedying these, rather than trying to find ever more effective treatments. Similarly we have seen an alarming increase in the proportion of overweight and obese people in the population, again particularly children, with enormous implications for their future health. Effective remedies may be available to treat obesity and the diseases that are thereby caused, but it may be that the most authentic specialists are those who are promoting appropriate lifestyle changes and to whom priority should be given in allocating resources. There may some justification for the claim that the current prejudice is to perceive the curative medical practitioners (and the pharmaceutical industry) as more authentic (because their practices are 'evidence-based') than those advocating preventative measures such as changes in lifestyle and government action on social and environmental issues *(see Note 2)*.

Authentication by validation through scientific enquiry is only one way that a therapy promotes its perceived authenticity. In fact, when attempts have been made to authenticate unconventional therapies in this way, little scientific support has emerged for the processes on which they are presumed to be based, and despite sometimes extraordinary claims for their efficacy, clinical measures of outcome appear to be vanishingly small the more rigorous the procedures used to test them (e.g. NHS Centre for Reviews and Dissemination, 2001, 2002). This reminds me of an amusing graph (Figure 1) presented by Henri Broch (2000) on changes over time in alleged psychokinetic power. This originally entailed the movement of massive constructions, but these days, under controlled experimental conditions, the phenomenon is only seriously claimed for subatomic particles.

Figure 1: The decrease – by a factor of a million – of the reputed psychokinetic power "intensity" (the displaced masses) with time. This trend can be found in any other type of psychic phenomenon. (Reproduced from Broch (2000), page 36, by kind permission of the author and the Editor of the *Skeptical Inquirer*.)

Authentication by authority

Power should always come with accountability, but this has not always been so in medicine. It is generally accepted that until relatively recently physicians and their treatments tended on balance to make their patients worse rather than better. Indeed, some treatments would, out of the medical context, have involved the physician and patient in roles hardly different from that of torturer and victim: viz., trepanning, purging and bleeding, (which were used for hundreds and even thousands of years) and procedures used up

to the last century on mentally ill people, such as beatings, cold-water treatment and 'spin therapy' (whereby the patient was spun round at great speed).

Despite all this, the perceived authenticity of medical doctors was upheld and the medical profession survived. And today the same is true of alternative therapists, whose treatments have not been authenticated in the ways described earlier, and whose adherents often reject this form of authentication. Are there other means of authentication at their disposal? Consider this claim: ‘The fact that these practices have been used by people for hundreds of years proves that they work’. Or ‘We don't need to test whether or not our procedures are effective - we know they are from our own experience’ or ‘our patients tell us so’. This is *authentication by authority*.

It sounds very reasonable; but we should bear in mind that many patients have problems and conditions that are variable over time and not infrequently have a tendency to change for the better regardless of their therapist's ministrations. Add to this the fact that when we judge the validity of our own valued beliefs, we attach greater weighting to confirming as opposed to disconfirming evidence and the consequences are obvious.

Consider also this cumbersome piece of advice: ‘Maximise the range of conceivable positive outcomes’. For example, if your patient improves, obviously your therapy is working. If your patient gets worse, your treatment is starting to show some effect. (Some alternative therapists inform their patients that their condition may worsen at the start of treatment before it gets better.) Finally, if your patient is unchanged, any further deterioration has been halted. In this regard I was interested in the reactions of the staff at a well-known alternative cancer treatment clinic when they received some adverse publicity concerning their therapy regime and hence their authenticity. In interviews given by the personnel involved it seemed to become increasingly obscure what defining qualities would distinguish a satisfactory and an unsatisfactory response to their programme.

Authentication by mystique

As I have implied, in most of the kinds of practices under discussion the knowledge and ideas underlying them are fixed and unchallenged; we may describe them as ‘dogma’. We therefore need some impressive answers to the question 'How were they derived?' 'Many thousands of years ago by Chinese physicians, philosophers or astronomers' may be one answer; or 'By Amazonian Indians long before the invasion of white men'. Similar reasons could also be used to support the practices of trepanning, purging and bleeding.

Authentication by magic and religion

The appeal of magic for those seeking power - albeit the power to do good - and those seeking relief from suffering and unhappiness should not be underestimated. I mean magic in a very broad everyday sense. We invest things and ideas with magical properties when we do not understand them, when they have an intangible and ethereal quality, and when in some way they appear to have the potential for some unusually powerful or supernormal properties. Some magical concepts are of course nonentities such as animal magnetism

or ghosts. Of course the magic is in the mind of the beholder, not in the thing itself.

One of the most convincing ways of persuading anyone of the authenticity of some procedure or phenomenon (say a healing ritual or even a religious faith) is that it has magical or miraculous properties. In India, for example, many healers and gurus owe their power over their followers to their apparent ability to perform miracles such as materialising jewels and holy powder out of thin air. Some of them even attract the attention of politicians, either because it gives the latter credit to be seen consorting with them, or perhaps they need a miracle or two to keep them in public favour. Enter the Indian Science and Rationalist Association, a group dedicated to eliminating this kind of religious fraud and superstition. The rationalists show how they themselves can pluck precious stones from the air without recourse to divine powers. But of greater interest are the extraordinary physical feats accomplished by devotees of the gurus. They are able, through 'trance states', prayer and devotion, to walk on red hot coals without being burnt, have spikes thrust through their cheeks and tongue; be spun around on ropes with metal hooks skewered in their flesh; and have their heads buried in the ground without suffocating.

What is the answer of the rationalists to all this? They call for volunteers from the onlookers and, with a little persuasion, have them performing all of the above acts without any kind of religious indoctrination or even any indication of their entering into a 'trance state'. Are the gurus and healers happy to have this kind of attention and rational insight into their practices? Their reactions would suggest otherwise (Eagle, 1995).

Sometimes the magical phenomenon is a special gift the person has: 'I have an energy flowing from my hands' I once heard a healer say. Consider three interesting aspects of this assertion, which I have also heard from other religious healers.

'I have an energy flowing from my hands.' Note the attraction of the idea of *an invisible force or energy* that has fluid properties. This is a very common theme in the history of healing; recall the activities of Anton Mesmer in the eighteenth century and the extraordinary carryings-on at his Paris salon, which he ascribed to an invisible fluid force, animal magnetism. You may also be reminded of the theories and practices of Wilhelm Reich in the last century, and the ideas behind acupuncture.

When a concept or entity is invested with magical properties, it acquires the capacity to evoke an almost boundless range of behaviours and beliefs, but only amongst those people who accept those magical properties, which they tend to do in a *dogmatic* fashion. A concept in psychotherapy that elicits much magical thinking is the 'unconscious mind' (*see Note 3*). Another one, fashionable in alternative therapy is the 'aura', the presumed field of energy that radiates from the bodies of living things, including humans.

Some years ago I attended a training course in therapeutic massage at a well-known centre in West London. One thing we had to practise was massaging the aura. This involved passing the hands up and down the client's reclining body without touching it, thus supposedly clearing congested areas of 'negative energy'. Various hand movements were employed; for example, now and again

while ‘massaging the aura’, one was instructed to shake one’s hands away from the person's body in the manner one does when dispelling droplets of water. When massaging around the head one used twirling movements as though gathering the energy up, and then one slowly drew it backwards away from the head in the manner of pulling on the reins of a horse. This was especially recommended if the patient needed to resolve a past trauma; the more distant in time the trauma, the further one pulled back the ‘energy’, so that in a small consulting room this might necessitate making a gradual backward exit out of the door. We were also urged to wash our hands on completion of the massage lest the client's ‘negative energy’ adhere to us and leave us with bad feelings.

Apart from these behaviours I found interesting the reactions of the teacher and group to the lone questioning voice. I shall not say whose this was and I shall leave it to the reader to imagine the nature of these reactions. My point is this: that were the aura a more visible or tangible entity and more rationally understood then one would see a much more restricted range of beliefs and behaviours, and a greater tolerance of divergent opinion.

‘I have an energy flowing from my hands’. The second point to note is that in any other context such an assertion would invite not mere disbelief, but some harsh questions about the claimant's motives and even mental stability. But place him or her in a context of healing - in this case a hospice for the terminally ill - legitimise this with religion, and merely to raise an eyebrow becomes an act of profanity. So we have *authentication by religion*.

Thirdly, note the lure of the *cheap source of power*. It is not only physicists who are looking for this - it appeals to us all. Why bother with the toils of six years' full-time study when the power to heal is literally there at your fingertips? Take a set of simple techniques, endow them with magical properties by some quasi-scientific, mystical or spiritual theory, make extravagant claims about their healing properties, and you have a common formula in the market place of unorthodox therapies.

Authentication by mystery

‘Nobody knows how it works’ is an oft-used paradoxical means of authenticating an unusual practice, the implication being that it *does* work but by some means that presently outstrips human knowledge. Consider the reply of a Kirlian photographer to my question ‘What exactly is the `aura'?’ ‘It's a form of electromagnetic radiation, but it's not recognised by scientists.’ Better variations on this authenticating theme are ‘not *yet* recognised by scientists’, ‘scientists still don't understand how...’, and so on.

Yet science itself carries its own aura of magic and mystery. Most of us do not understand science, and the achievements of science astonish us. People therefore inevitably attribute to science, and to modern medicine itself, magical properties in the manner described earlier. Not surprisingly, therefore, certain concepts elucidated by science have been appropriated by alternative therapists, invested with magic, and presented as authentic ideas and practices. So we have:

Authentication by pseudo-science

As we have seen, these concepts include force, energy, magnetism, and electromagnetic waves. More recent ones are vitamins and minerals, hormones, toxins, allergy, biological rhythms, brain waves - particularly the alpha rhythm (which has given rise to the magical ‘alpha state’) - subliminal perception, and left-right brain differences, the right cerebral hemisphere having now become a magical entity.

The same fate has now befallen endorphins; these are neuropeptides that ameliorate our experience of pain and are related to certain pleasurable experiences. I have seen several unorthodox therapies authenticated by the assertion that they ‘cause the brain to produce endorphins’ for which magical claims are then made.

I earlier suggested that magical therapeutic properties are often conferred upon phenomena which, having an ethereal and intangible quality and not being fully understood, somehow hold out the promise of an accessible source of unusual power. Acquisition of this power provides the main motivation for this process, but it is in fact difficult to predict with any exactitude which phenomena may be selected. Half seriously, I believe that one great attraction of the alpha rhythm is simply its name. When alpha biofeedback was a fad in the USA in the 1970s, group sessions of alpha training used to be held in special places called 'alpha temples'. Would any of this have happened had the phenomenon been labelled 'Higginbottom's rhythm'? I very much doubt it. However, I lately read an interesting account of the ways in which no less a mundane substance than water is marketed as a panacea (Gardner,1993). Clearly my portrayal of magical remedies as 'ethereal and intangible' is in need of further elaboration.

Another relevant attribute for a phenomenon to be endowed with magical healing properties is that, at least in our own culture, it must be without harmful side effects. This would be an unusual characteristic for any treatment of scientifically proven efficacy, since most organically active interventions can't help but carry some risk of compromising healthy functions as well as ameliorating diseased ones. The key point is this: the administration of any substance or procedure that may have harmful effects is usually subject to legal restriction and it is thereby unavailable for recruitment as a magical nostrum. So something like X-ray radiation, which would appear to be eminently eligible for endowment with magical healing properties, is not promoted as a remedy in the marketplace of alternative therapies *only* because its cumulative harmful effects restrict its accessibility. But there was a time when these harmful effects were not recognised and X rays were advertised as a cure for all manner of medical and psychological complaints. No doubt they still would be had not their harmful effects been discovered.

Authentication by charisma

The ideas and discoveries were made by some extraordinary and inspired individual - viz. homeopathy, osteopathy, chiropractic, iridology, biorhythms, and so on.

As I have described them, unlike orthodox practices, these systems of ideas tend to form rather static structures; we do not hear, for

example, of any discoveries or breakthroughs by alternative medical practitioners. My impression is that rather than gradual change, transformation or decay by the process of self-regulation, there is a kind of grafting of ideas often related to some impressive or charismatic figure who introduces his or her own version of the practice in question and creates a following - the Bach Flower Remedies, the Alexander Technique, the Feldenkrais Method, Rolfing, and so on.

Authentication by celebrity

It is by no means uncommon for the popular media to feature stories of famous individuals who subscribe to some unusual and unorthodox treatment. More often than not these people are film or television stars, but in the UK, two of the most prominent are the Prince of Wales and the wife of the Prime Minister. It would be of no interest to readers of the newspapers to hear that now and again Mrs. Blair takes a Paracetamol for tension headaches that must be an inevitable consequence of the kind of life she leads. However, it is certainly newsworthy when her choice of treatment is, say, Indian head massage. Why there is such media interest in celebrities' choice of alternative medicine is, mercifully, beyond the scope of this paper.

Authentication by labelling

One of the simplest ways that we endow any activity with legitimacy and authenticity is to give that activity a label. 'What is this?' we bemusedly ask a woman who is vigorously massaging the soles of the feet of another woman. 'I'm a *reflexologist*; I'm doing *reflexology* on a *patient* with *myalgic encephalomyopathy* is the answer.

In fact a most impressive array of interventions present themselves to the patient in question. She may be administered various potions (synthetic, herbal or whatever); she may have her head massaged, her feet pummelled, her whole body rubbed with exotic smelling oils; electric appliances may be attached to her, pendulums swung around her, prayers said for her, needles stuck into her, crystals passed over her and so on. However extraordinary the practice, the therapist's assigning a label to it (and to himself or herself as a practitioner of that therapy) is a first start to authenticating his or her claim to power. The same can be said for his or her labelling of the patient's problem; however anyone seeking treatment also needs authentication in his or her role as a patient (cf. 'I'm not making this up, there is definitely something wrong with me'), hence the dual role of the diagnostic label.

I once received through my door a leaflet advertising a 'hypnotherapist'. Hypno-therapists have some problems authenticating themselves, as the expectations of the hypnotic subject are very often not confirmed by the experience (cf. 'I could hear everything you said'). The hypnotherapist in question got round this by labelling his therapy as a type of hypnosis as 'conscious hypnosis'.

Finally on this theme is the subtle switch in the UK in the re-labelling of unorthodox medicine from 'alternative' to 'complementary'. 'My treatment is complementary *not* alternative' was the insistent headline of a local newspaper article concerning a fringe therapist. There may be a number of reasons for this change but the most important one in my opinion money is the more flexible arrangements within the National Health Service that allow unorthodox practitioners

greater access to this lucrative market. Co-operation rather than conflict with the health care establishment is thus indicated. And so, 'alternative', at one time assertive and uncompromising, the proud boast of unorthodox medicine, now lies abandoned and forlorn, while 'complementary', at least when it manages to get itself spelt properly, joins its comrades-in-arms, 'natural' and 'holistic', on that ever increasing pile of convenience vocabulary - meaning anything, everything and nothing at all.

Authentication by splitting

I have borrowed this term from Melanie Klein's theories. 'There are authentic practitioners and there are inauthentic practitioners; the former are properly trained and do a good job; any challenges to authenticity apply to the latter group (the 'cowboys'), the ones who aren't properly trained.

Authentication by qualification, professionalisation and legislation

'What we need are regulations and laws limiting practice to properly qualified individuals ..... in order to protect the public'. Here I should emphasise that I am not challenging the validity or desirability of this assertion. I am saying that to understand the behaviour and attitudes of those who make them we would do better to interpret their intention as to authenticate themselves and not simply to benefit their patients and clients. As was argued earlier in this article, once a system of activities becomes institutionalised within the interdependent network of employment, education and, in this case, medicine there it tends to remain and flourish.

Summary

In a modern free and prosperous society the intimate collusive nature of the processes of supply and demand in seeking to fulfil the needs of each party ensures that both what is offered and what is demanded of them will expand and become increasingly diverse and specialised. Consequently, by mutual consent, more and more areas of human distress, disappointment and discontent become colonised by assumed experts, especially those in the healing industry. Likewise, what is promised and what is expected become more detached from what is achievable. Yet, the major underlining requirement on both sides is that the roles of those who supply these services are authentic.

Conventional practitioners in the healing industry have become progressively more accountable to scientific knowledge and enquiry as a means of authentication, both for the hypothesised basis of the diagnoses and remedies they offer and for the efficacy of their remedies. Yet we can still challenge their authenticity by asking questions about the broader costs and benefits (not just financial but also physical, emotional, spiritual, and so on), other possible approaches such as prevention and a focus on ecological and lifestyle factors, and personal freedom and responsibility.

Practitioners of alternative medicine are not authenticated by science. Instead, authentication is sought by appeals to authority, mystery, magic and pseudo-science. There is no doubt that belief in the power and magic of a treatment may promote some form of healing. Also, unlike the typical general medical practitioner, many alternative

therapists have the advantage that they are able to devote sufficient time to the entire healing ceremony, notably a thorough examination and the nurturing of a close healer-patient relationship. Furthermore, whereas a brief visit to one's general practitioner is often seen as an obligation when one is ill, likewise taking the pills that the doctor prescribes, consulting, say, a homeopath or reflexologist is more the personal choice of the individual, who can therefore claim some ownership of the solution to his or her problem. This and the payment of an unremunerated fee may encourage greater personal commitment to and belief in the therapy, no mean consideration.

It comes, then, as no surprise that surveys have revealed very high levels of consumer satisfaction (i.e. perceived authenticity) with alternative practitioners. Why, therefore, try to fix something that isn't broken? I suggest that there is considerable merit in having a clear and rational distinction between orthodox and alternative practitioners and preserving public access to the latter. I therefore make the following suggestions.

(i) It is unproductive and wasteful to teach medical students and trainee and qualified doctors about alternative medicine.

(ii) No Health Service funds should be allocated to therapeutic practices whose foundations are contradicted by existing scientific knowledge.

(iii) Research into such practices is a waste of resources and will bring no significant returns for public health or the amelioration of illness.

(iv) Practitioners of alternative medicine should be allowed to work with the minimum of government regulation.

I doubt whether any but a small minority would endorse this package in its entirety, and the reasons for this are, I hope, not too difficult to locate in this paper.

Notes

1. Perhaps we can define 'placebo' here as 'the readiness of the patient to authenticate the therapist'; in psychotherapy at least, the opposite could define 'resistance'.

2. Some years ago the then Health Secretary Frank Dobson was featured on local television opening a general medical practice in an inner city 'sink' estate. To universal acclaim, he announced that this would be a great help in improving the health of the people on the estate. Nobody was heard to ask whether, in this instance, priority was being given to the most authentic means of achieving this aim.

3. '*The sovereign means for believing what one likes in psychology and of turning what might become a science into a tumbling ground for whimsies.'* William James (1890, p 163)

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COMPLEMENTARY AND ALTERNATIVE MEDICINE

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Research and royals, patients and politicians, counsellors and clinicians – all have recently taken a considerable interest in complementary and alternative medicine (CAM). Fringe, unconventional, unorthodox, natural and folk medicine have come in from the cold, and CAM is now big business under this new label (Ernst & Furnham, 2000). CAM seems to be favourably perceived by many general practitioners (Easthope *et al*., 2000). Indeed the rise of CAM has led to a House of Lords inquiry into six aspects of CAM: evidence, information, research, training, regulation and risk, and NHS provision (Ernst, 2000). In recent years the increasing public interest in CAM (see Table I) has been reflected in academic books (e.g. Abbot *et a*l., 1996; Vincent & Furnham, 1999) and journal articles (e.g. the 'theme issue' of the *Journal of the American Medical Associatio*n, 1998, 280, No.18). So what answers has this research provided? Why is CAM so popular? Does it actually work? And what role can psychology play in understanding the phenomenon?

Unity and diversity in CAM

Aakster (1986) described three main models of medical thinking. The *pharmaceutical* model is a demonstrable deviation of function or structure that can be diagnosed by careful observation. The causes of disease are mainly germ-like, and the application of therapeutic technology is all-important. The *integrational* model resulted from technicians attempting to 'reintegrate' the body. This approach is not afraid of allowing for

psychological and social causes to be specified in the aetiology of illness. The third model has been labelled *holistic* and does not distinguish between soma, psyche and social. It stresses total therapy and holds up the idea of a natural way of living. The wide scope of CAM makes it difficult to pigeonhole within one of these models, or to identify what unites CAM in the face of the considerable diversity of theories, philosophies and therapies. Yet there *are* common themes within the philosophies of CAM. Aakster (1986) believes that they differ from orthodox medicine in five ways:

- *Health:* Whereas conventional medicine sees health as an absence of disease, alternative medicine frequently mentions a balance of opposing forces (both external and internal).
- *Disease:* The conventional medicinal interpretation sees disease as a specific, locally defined deviation in organ or tissue structure. CAM practitioners stress wide signs, such as body language indicating disruptive forces and restorative processes.
- *Diagnosis:* Regular medicine stresses morphological classification based on location and aetiology, while alternative interpretations often consider problems of functionality (e.g. in dressing or feeding oneself) as diagnostically useful.
- *Therapy:* Conventional medicine often claims to destroy, demolish or suppress the forces that make people ill, while alternative therapies often aim to strengthen the vitalising, health-promoting forces. CAM therapies seem particularly hostile to chemical therapies and surgery.
- *Patient:* In much conventional medicine the patient is the passive recipient of external solutions – in CAM the patient is an active participant in regaining health.

TABLE I

The Rise and Rise of CAM

USA

- In 1993, 34 per cent of the population visited a CAM therapist, more than visited primary care physicians. Expenditure was estimated at $13.7 billion a year (Eisenberg *et a*l., 1993).
- By 1998, 47.3 per cent of all Americans were estimated to visit a CAM practitioner. Annual visits rose from 427 million in 1990 to 629 million in 1997 (Eisenberg *et a*l., 1998).

France

- Use of homoeopathy (the most popular CAM) rose from 16 per cent of the population in 1982 to 29 per cent in 1987, and to 36 per cent in 1992 (Fisher & Ward, 1994).

The Netherlands

- In 1981, 6.4 per cent visited a CAM therapist – rising to 15.7 per cent in 1990 (Fisher & Ward, 1994).

UK

- Around 25 per cent of the British population have used some form of CAM.
- Around 80 per cent of the public who use it are satisfied with CAM therapies compared with 60 per cent with 'orthodox medicine'.
- Around 65 per cent of British hospital doctors believe that CAM has a place in mainstream medicine.
- About 93 per cent of GPs have suggested a referral to CAM (Ernst & Kaptchuk, 1996). Nearly 67 per cent of local health authorities in the UK are purchasing at least one form of CAM (White & Ernst, 2000).
- Individuals spend £1.6 million per annum on CAM therapies, the NHS about £40 million; and £500 million is spent on CAM products (Ernst & Furnham, 2000).

One way of classifying the many different CAM therapies is by 'emphasis' (structural,

biochemical, energetic and mind-spirit) and by their methods of care and treatment (Turner, 1998). Using factor analysis, I set out to see how 589 members of the public classified 39 different types of CAM, depending on whether they had heard of it, knew how it works, whether they had tried it, and whether they believed it works or not (Furnham, 2000). A pattern emerged with art therapies (e.g. music, dance), talk therapies (i.e. counselling), and 'foreign techniques' (e.g. Reiki, Shiatsu) all classified distinctly. The 'big six' therapies – acupuncture, chiropractic, homoeopathy, medical herbalism, naturopathy (a belief in the healing power of nature) and osteopathy – are often grouped together by lay people, presumably because they see them as most established and regulated – despite the fact the they are based on very different methods and philosophies. In fact it is this diversity in the field of CAM that can lead to problems in regulation. While there have been calls to find regulatory bodies to oversee all CAM practices, this has proved very difficult because of the theoretical, historical and political differences between the various CAM specialities. Given this lack of an official regulatory body, scientific research into the effectiveness of CAM becomes even more crucial. Fortunately, the popular interest in CAM has indeed been matched by a relatively sudden and dramatic increase in research on the two central questions in this area: do CAM therapies actually work, and why do people choose them?

Does it Work?

Is there good evidence from double-blind, placebo-controlled, randomised studies that a particular therapy 'cures illness' as it says it does? Properly designed and executed studies are complex and very expensive, and similar to the research effort to determine the efficacy of psychotherapy. Indeed, it is the extensive research into the placebo effect that makes psychological input particularly valuable (Vincent & Furnham, 1997). The answer to the question is either very little or no good evidence is available for the therapeutic success of most CAM, possibly with the exception of herbalism (Vincent & Furnham, 1999). This is because there has not been a concerted scientific research effort to investigate the claims of many of the specialities of CAM until recently. However, as more sophisticated meta-analyses are published it does seem to be the case that there is clear, incontrovertible evidence for small but robust positive effects of specific CAM treatments (e.g. Ernst & Pittler, 1998).

Why Choose It?

If the evidence is limited and equivocal, and indeed often points to lack of efficiency, the central question must be why patients choose (at their own expense) to visit a CAM practitioner. What do they get from the treatment? Why do they persist? This is where there have been many psychological studies (Furnham & Kirkcaldy, 1996; Vincent & Furnham, 1999) concerning the often mixed motives that patients have in shopping for health treatments. Results from various studies (reported by Vincent & Furnham, 1997) show several key factors.

People shop for health. They want to use all possible (and affordable) options in health care. People are not 'brand loyal' to orthodox medicine or any particular therapy. They experiment, and CAM is to many just another product or service. The question is how the

brand offers something quite different that no other product service offers. This raises the question – as yet to be answered – of what makes an individual brand loyal to a therapy, a therapist or indeed a place of treatment.

People want a cure without side-effects or pain. This may in fact distinguish different CAM therapies, offering a very strong, unique selling point for homoeopathy over either herbalism or acupuncture, because of the scare stories about poisoning in the former and pain and infection in the latter. It is for instance the 'gentleness' of homoeopathy and its dilutions that may be particularly attractive to people.

CAM is seen as a 'last hope' for chronic illnesses. Many sufferers of chronic painful conditions or addictions have tried many other cures, and turn to CAM as a last hope. Some treatments have a powerful psychological component particularly those associated with touch (i.e. massage, reflexology). Equally the emphasis may need to move from cure to effective management of such chronic conditions, just as it does in clinical psychology.

Disappointment with the traditional orthodox consultation. GPs all too often have little time, may seem patronising, or may not fully examine the patient or touch them. Further, patients are often not asked the full set of questions they expect to answer for a 'full' diagnosis. In short, they are not treated like a modern adult consumer. There is a strong departure point for many CAM practitioners who have much longer consultations, and appreciate patients' need to talk or be examined. The question is how the traditional or average CAM consultation is different from both traditional orthodox consultation and that of other (competitor) CAM therapies. It is possible to compare and contrast across a number of variables (history-taking approach, language used, patient role, decision-making process, bedside manner) to show how different they are, which may account for the popularity of CAM.

People want an emphasis on 'wellness', not 'illness'. Because many people want to learn more about self-care, fitness (wellness and preventive measures) orthodox medicine may be seen as a narrow, restorative, disease-(complaint-) oriented approach that aims to destroy, demolish or suppress illness-inducing forces through such things as chemical therapies and surgery. What many people want is an emphasis on natural restorative processes. The emphasis is quite different – illness vs. wellness. Psychologists have long recognised this as a valid and useful approach. CAM is often seen as restorative, balanced, natural and preventive, fitting in with the particular zeitgeist.

Many people believe in the 'holistic' message. It seems obvious to most that lifestyle, personal relationships and work operate all together and simultaneously have an impact on health. Equally they believe that there are many and manifold signs of wellness and illness from digestion, sleep patterns and body appearance to more subtle nonverbal signs associated with gait, balance, body odour, and so on. The implication is that the diagnostic interview may need to include questions about all aspects of the person's life, not only their physical symptoms.

Is There a CAM 'Type'?

Comparisons of users and non-users of CAM have shown evidence of different beliefs about health and disease in general (Vincent & Furnham, 1997). There is some evidence that frequent CAM users are more health conscious and believe more strongly that people can influence their own state of health, both by lifestyle and through maintaining a psychological equilibrium. Users of CAM appear to have less faith in 'provider control' – the ability of medicine (specifically orthodox doctors) to resolve problems of ill health. Some studies of cancer patients using CAM have found that they were more likely than those not using CAM to believe cancer was preventable through diet, stress reduction and environmental changes and to believe that patients should take an active role in their own health (Cassileth, 1988). Many CAM users seem to be sympathetic with green issues, ideas and understanding. These include environmentalism, anti-materialism and a belief in 'one world'. Pro-CAM beliefs may also include issues around inequality, alienation, and social exclusion. CAM patients also seem to be interested in general consumer affair issues and may even belong to bodies that attempt to lobby in favour of a certain position. They appear to be sensitive to consumer rights, bad practice and poor treatment. CAM patients appear to be particularly interested in the 'life of the mind'. They certainly believe the maxim of 'a healthy mind and a healthy body'. CAM patients are, because of their own medical condition, likely to be very empathic to the plight of others, and hostile to the 'uncaring' attitude of certain specialists (e.g. surgeons). However, despite these suggested differences in beliefs and values, there is little to support the widely held view that those who use CAM are especially gullible or naive, or have unusual (neurotic) personalities or bizarre values or belief systems. In terms of demography, those who use CAM are more likely to be women, aged 30–40, middle rather than working class, educated above average levels, and to live in urban rather than rural areas. Their medical history is more likely to feature chronic problems than acute, often non-specific or with a heavy psychological (i.e. have a 'thick file' in the sense that their interest in health issues has led them to seek out various remedies from many different sources. However, despite some differences in beliefs, it is dangerous and foolhardy to talk about the 'typical' user. CAM rejoices in differences and individuality and the uniqueness of people's lives.

The Role of Psychology in CAM Research

Psychological research can substantially help medical and sociological research into CAM through both methodological and theoretical contributions. Psychologists' expertise in evaluative research and methodology, their understanding of placebo effects and their emphasis on evidence-based methodology means that they are ideally suited to join multidisciplinary research teams interested in CAM. More sophisticated, longitudinal research is needed to explore differences in orthodox medicine and CAM patients. Further, key elements in the CAM consultation that make them popular, including the explanations that they provide, merits good research. Social psychological expertise in questionnaire design and analysis, as well as discourse analysis, can be (and indeed has been) very useful in trying to understand patient motives and satisfactions. Research psychologists interested in experimental design and meta-

analysis may assist in evaluating the quality of the experimental evidence, as well as assist CAM practitioners and those less experienced in research design so as to reduce artefacts and confounds. Recent studies on efficacy research into psychotherapy, perhaps even harder to evaluate than CAM therapies, has helped psychologists address some of the issues concerned with evaluating the ingredients of therapeutic efficacy (Bergin & Garfield, 1994). From a theoretical perspective psychology may be particularly useful in helping understand patient pathways to CAM; the knowledge, attitudes and beliefs of patients as well as the dynamics of the GP and CAM consultation. Indeed this knowledge may prevent the growth of CAP – complementary and alternative psychotherapy with all the problems of unregulated practitioners of very dubious practices. Psychological theories may also be applied to, and tested in, the CAM context. Thus Furnham and Lovett (2001) showed that the theories of reasoned action and the theory of planned behaviour could be used successfully to investigate factors underlying intentions and actual use of homoeopathy over a one-month period. Similarly, Furnham and Lovett (in press) demonstrated how attribution theory could understand patient perceptions of risk. There are many other psychological theories and models in the health and medical psychology literature (e.g. the health beliefs model) that may go a long way to answering some of the fundamental questions in this comparatively new, multidisciplinary area of research. Psychology and CAM may have a healthy and fruitful relationship for many years to come.

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TRENDS IN THE REGULATION OF COMPLEMENTARY MEDICINE

This article is based on a talk given by the author at a meeting of the Hypnosis & Psychosomatic Medicine Section of the Royal Society of Medicine on May 31st 2002, entitled 'Hypnosis - Princess or Handmaiden?'

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Introduction

Complementary therapies are "those which can work alongside and in conjunction with conventional medicine" (British Medical Association, 1993). Some of you may be surprised at the title of this presentation for I suspect that the majority in this Society consider hypnosis to be an integral part of professional practice not complementary to it. But the outside world most certainly does view hypnotherapy as such, and all of complementary therapy (CAM) is in a rapid state of change. We need to consider that change because it will have consequences for our practice whether we like it or not.

The forces driving and influencing this change are many but there is only time to mention a few.

House of Lords Select Committee on Science and Technology

This considered written and verbal evidence before producing its report. The British Society of Medical and Dental Hypnosis and the Hypnotherapy Society submitted evidence on hypnotherapy to their lordships.

Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary

This report may well prove to be extremely influential in all aspects of health care provision including complementary medicine. At first glance it seemingly has little to do with either hypnotherapy or complementary therapy, since it was an enquiry into failure of care in paediatric cardiology, but precisely because it was looking at how to prevent other such failures its recommendations are more likely to be acted upon. Recommendations made here deal with issues of cultural change, education and training, competency, regulation, effectiveness, consent, etc.

The Prince of Wales's Foundation for Integrated Health (FIH) formerly the Foundation for Integrated Medicine)

This is a registered charity whose aim is to promote the development and integrated delivery of safe, effective and efficient forms of healthcare, through encouraging greater collaboration between all healthcare practitioners. The foundation acts as a forum,

actively promoting and supporting discussion, and facilitating development and action. Their objectives span these key areas: Delivery, Education, Information, Regulation, Research and Development

TABLE I
Grouping of therapies as recommended by The House of Lords Scientific Review Committee

<table>
<tr><td>Group 1
Professionally organised disciplines, with their own diagnostic approach. They have some scientific evidence of effectiveness and recognised systems of training for practitioners.

Acupuncture
Chiropractic
Herbal medicine
Homoeopathy
Osteopathy</td><td>Group 2
Complementary therapies that lack a firm scientific basis and are not regulated to protect the public, but which give help and comfort to many people.

Alexander technique
Aromatherapy
Bach flower remedies
Bodywork therapies, including massage
Counselling stress therapy
Healing
Hypnotherapy
Maharishi Ayurvedic Medicine
Meditation
Nutritional medicine
Reflexology
Shiatsu
Yoga</td></tr>
<tr><td colspan="2">Group 3
Alternative disciplines which offer diagnostic information as well as treatment but for which the Committee did not find convincing evidence of efficacy</td></tr>
<tr><td>3A
Long established and traditional disciplines with very specific philosophies

Anthroposophical medicine
Ayurvedic medicine
Chinese herbal medicine
Eastern medicine (Tibb)
Naturopathy
Traditional Chinese medicine</td><td>3B
Other alternative disciplines

Crystal therapy
Dowsing
Iridology
Kinesiology
Radionics</td></tr>
</table>

The All-Parliamentary Group for Integrated and Complementary Health Care

This Is a group, led by the MP David Tredinnick, which meets every two months at Portcullis House. Many of those lay practitioners who are trying to bring about change attend, along with interested professionals. At their next meeting they will be discussing regulation, the promotion of excellence in standards, integrated healthcare, and the challenges ahead. Their invited speaker is Mr Nigel Clarke, Chairman of the General Osteopathic Council.

The House of Lords Report

It may help to look a little more closely at the House of Lords report. Table I gives the groupings of the various CAMs recommend by their lordships.

Recommendations of The House of Lords Scientific Review Committee

- The development of a single regulatory body for each therapy to protect public interests
- The development by the General Medical Council (GMC) and the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC) of clear guidelines on competencies and training for their members
- Several recommendations concerned with education and training
- Pump-priming funding with the establishment of a number of centres of excellence for conducting CAM research
- Greater integration of CAM in the National Health Service (NHS), but only those therapies that are statutorily regulated or have a powerful mechanism of voluntary regulation should be available through the NHS

In March 2001 the Government published its response to this keenly awaited report and in essence accepted all of the recommendations.

Developments Arising out of the House of Lords Report

NICE (National Institute for Clinical Excellence) has been commissioned to draw up guidelines for supportive care. It should report by next year.

The FIH is working to establish safe competent practice in the lay sector and to integrate therapies into orthodox health care. Their lordships named this body as the one both conventional and complementary therapy should turn to for advice. Of their many sections, three are of particular interest to our debate.

1. *Complementary Therapies* Project team leader Marianne Tavares is working with National Council for Hospices and the Specialist Palliative Care Services to produce best practice guidelines for the provision of complementary therapies within palliative care. Hypnotherapy is included in the list of therapies they are seeking to integrate into the palliative and hospice care setting.

2. *Regulation* This team is currently working with 20 complementary therapies with a view to statutory or voluntary self-regulation. They are meeting with certain lay societies who are keen to follow the

House of Lords recommendation for a single regulatory body for hypnosis. The team is well aware of the gulf between medical and lay hypnosis bodies but medicine might influence key elements of a single lay body through the foundation. At the moment the work is focused on encouraging working together to look at aspects of regulation. The current area of focus is National Occupational Standards, with the input of Healthworks UK as recommended by their lordships.

3. *Education* Project manager Lorraine Williams is working with the Special Interest Group of The Royal College of Nursing to develop education and training courses in complementary therapies for nurses and midwives. I am not aware if either the GMC or UKCC is as yet following this lead.

All at the Foundation would welcome and appreciate an input from those engaged in the medical use of hypnosis.

A Proposal as to how the Future for Hypnosis *Could* Look

Hypnotherapy: the word is in the public domain, well accepted and understood by all except those of us concerned with its use in medicine. This word will not go away.

Two distinct and clearly defined arms for hypnosis (clearly defined, that is, for public understanding) are:

1. Medical hypnosis

The proposal is for **a single body encompassing all of the current societies**, with **a name that makes clear who and what it represents.** It may be that the terminology 'medical hypnosis' should be used, but it should be given much greater public recognition.

It is important to encourage a much higher public profile than is presently the case. I think that all complementary therapies have entered into orthodox health care from the lay sector. Massage and acupuncture are in many pain clinics now. We have aromatherapy and reflexology in lots of settings, particularly in oncology. We do have the potential to develop from within having already established some research evidence of efficacy. Whether we go on to build on our existing base or not, this second arm will I think come into being

2. Lay hypnosis

The term ‘lay’ is more respectful than ‘fringe’ and encompasses those practitioners who do not fit well in either arm, such as psychotherapists.

The proposal is again for **a single body that is statutorily regulated**. Such a body will need a minimum educational standard for acceptance to training and have clearly defined training. programmes. I accept that before you can apply for statutory regulation you need to have a robust system of voluntary regulation in place first so this is a long way off; but neither are we, in medicine, one single body despite the efforts of many within the societies to draw us closer together. Only through statutory regulation will we see the demise of those ill-trained and inept practitioners who put the vulnerable users at risk. Again the name of the body **should make clear who and what it represents,** so that no one is in any doubt as who belongs to what. There should be **a reduction in unethical and unsubstantiated claims that are given great publicity.**

It may be worth reminding ourselves of what a voluntary system of regulation would provide (source: Budd & Mills (2000)).

An effective voluntary self-regulating professional body:

- maintains a register of individual members or member organisations
- sets educational standards and runs an accreditation system for training establishments
- maintains professional competence among its members with an adequate programme of continuing professional development
- provides codes of conduct, ethics and practice
- has in place a complaints mechanism for members of the public
- has in place a disciplinary procedure that is accessible to the public
- requires members to have adequate professional indemnity insurance
- has the capacity to represent the whole profession
- includes external representation on executive councils to represent patients or clients and the wider public interest

Benefits of this proposal

This model would, I believe, allow much greater respect for, and acceptance of, the use of hypnosis in medical settings. There would be scope in such a model for medical hypnosis to influence lay hypnotherapy. It would also give the public access to safe and competent therapy for the myriad of legitimate problems that currently are rarely dealt with in medical environments, problems such as smoking, slimming, and fears of, for example, flying, public speaking, and spiders; likewise performance enhancement in the arts and sport or corporate affairs and certain professions.

Such a model would also, I believe, lead to greater opportunities for research evidence to satisfy the demand for evidence-based practice that we have come to expect in health care. It would also provide the opportunity to help create a safer, more equitable health care system for the use of hypnosis.

Now is the time for those of us in orthodox health care to look long and hard not only at ourselves and our practices but also at the lay sector, those that provide it and those that use it. We *can choose* to acknowledge what is happening in the field of complementary therapy provision and grasp this opportunity to influence change. To do so we have first to put our own house in order. For, in the words of the song 'The times they are a changin', and it doesn't matter what model of change you turn to in order to have an effect on the outcome of change: you have to be engaged in the process.

One thing is certain: if we do nothing, we may find change imposed upon us. To ignore these powerful moves towards change is to bury our heads in the sand. We do have a golden opportunity to help create a safer, more equitable health care system in respect of the use of hypnosis. Some may even consider that we have a responsibility to do so.

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APPENDIX

Foundation for Integrated Medicine *(Extract taken directly from its literature, 2000)*

To achieve our aim of having complementary medicine available to all who need it, integrated with conventional healthcare, we have an extensive programme of work in the areas of delivery, education, information, regulation and research and development, as indicated in our objectives.

Objectives

***Delivery*:** To promote the development of a range of integrated models of provision which offer choice, including access to complementary and alternative healthcare when appropriate.

Education: To promote the development of a common basis for all healthcare education and training across all healthcare professions together with programmes of continuing professional development for all practitioners.

Information: To encourage and facilitate the distribution *of* clear and reliable information on orthodox; complementary and alternative methods of healthcare to patients, practitioners and the public.

Regulation: To encourage the establishment, maintenance and development of systems of regulation including audit for complementary and alternative healthcare, either on a statutory or voluntary basis.

***Research and Development*:** To encourage the development of high quality and appropriate research into the safety, effectiveness and efficacy of all forms of healthcare, particularly those regarded as complementary and alternative.

Five key values underpin our work

***Patient centred*:** the needs of individuals and their families come first.

***Comprehensive*:** patients should be treated as whole individuals with equal recognition given to their physical, mental and spiritual health.

***Effective*:** any treatment given should be supported by objective research evidence wherever it exists.

***Accessible*:** all appropriate and effective forms of healthcare, including complementary and alternative approaches, should be available to those who need them.

***Safe*:** treatment must be safe and appropriate.

Extracts from the House of Lords Report that are relevant to the debate 'Hypnosis - Princess or Handmaiden?' on Friday 31st May, 2002, at the Royal Society of Medicine

SUMMARY

IV. The interests of the public in their use of CAM will be best served by improved regulatory structures for many of the professions concerned. Although there is evidence of progress across many fronts, the Committee found considerable diversity of standards, with an unacceptable fragmentation in some therapies, especially in Groups 2 and 3. In the best interests of their patients such therapies must each strive to unite under a single voluntary regulatory body with the features we highlight (Chapter 5).

Page 32: 4.18……Those therapies in our Group 2 which aim to operate as an adjunct to conventional medicine and mainly make claims in the area of relaxation and stress management are in lesser need of proof of treatment-specific effects but should control their claims according to the evidence available to them.

Page 35: 4.37…… we recommend that if a therapy whose mechanism of action is unclear does gain sufficient evidence to support its efficacy, then the NHS and the medical profession should ensure that the public have access to it and its potential benefits.

Page 39: *Hypnotherapy* - Professional organisation of hypnotherapists is complicated, partly because there is an overlap with the organisations representing psychotherapists who do not consider themselves complementary or alternative and so were not included in Mills and Budd's survey. They identified seventeen bodies representing hypnotherapists; five of these are members of the relatively new umbrella body, the UK Confederation of Hypnotherapy Organisations. Mills and Budd suggest hypnotherapy is an area where consensus has been 'particularly elusive' and there is a wide variation of educational standards and practice in the area. They hope the UK Confederation of Hypnotherapy Organisations will be a more successful initiative. And there are some doctors and dentists who practise hypnotherapy: many are members of the Society of Medical and Dental Hypnosis.

Page 41: 5.12……The public cannot have full confidence in those therapies where there is considerable professional fragmentation, We recommend that, in order to protect the public, professions with more than one regulatory body make a concerted effort to bring their various bodies together and to develop a clear professional structure.

Page 54: 5.79 We recommend that each existing regulatory body in the healthcare professions should develop clear guidelines on competency and training for their members on the position they take in relation to their members' activities in well organised CAM disciplines; as well as guidelines on appropriate training courses and other relevant issues. In drawing up such guidelines the conventional regulatory bodies should communicate with the relevant complementary regulatory bodies and the Foundation for

Integrated Medicine to obtain advice on training and best practice and to encourage integrated practice.

RECOGNITION OF UNPROVEN THERAPIES IN EUROPE: THE NEVER-ENDING STORY

Willem Betz

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Unproven therapies go under many names such as un- or non-conventional, alternative, complementary and supplementary. I shall use the abbreviation CAM here, unless in citations.

One of the original goals that the European Union (EU) wished to achieve was the elimination of barriers at national borders. As a result, all citizens would be able to travel or settle freely in any member state, and goods could be freely exported and imported between them. For consumer goods and private persons this goal was rather easily achieved, but for medicine and medical professionals, the problem was complicated by the diversity of practices and traditions in the individual states.

Licence to Practice Medicine

One of the first steps was to obtain agreement on the minimal criteria for the training and certification of medical doctors. These criteria are now established for doctors and several categories of allied professionals and they can travel and settle in any country of the EU. There is a list of 28 officially recognised medical specialities. None of them is CAM but as we shall see, the pro-CAM lobbies want to change this.

Licence to Practice CAM

Most countries strictly limit all diagnostic and therapeutic practices to registered doctors or (but only on referral by a doctor) allied professionals. Some countries (e.g. the UK and the Netherlands) do not impose the rules. They publish lists of medical activities that can only be undertaken by registered doctors or paramedics. Also, in most countries doctors have freedom of choice of diagnostic and therapeutic methods. Nowhere is it forbidden by law for a doctor to practise CAM; the national disciplinary bodies can impose sanctions but that does not happen very often and mostly only after a formal complaint by a patient who thinks that he or she has been harmed or deprived of the proper care. Some kinds of non-medical CAM practitioners are recognised in some EU countries but are only tolerated or are totally illegal in others (e.g. chiropractors are legal in some Scandinavian states and in the UK, likewise heilpraktiker in Germany). Several initiatives in the EU to

oblige the member states to accept them have failed, mainly because of the lack of standards of quality or uniformity in their training. A professional title that takes several years of study in one country can be obtained in a few weekends in another. The CAM lobbies have recognised this problem and are trying to unite on an international scale and to obtain monopolies for some groups.

Payment of CAM by Health Insurance

All EU countries have some form of mandatory national health insurance system, but most of them totally exclude CAM from reimbursement, though there are some minor exceptions. On the other hand, if registered medical doctors practise CAM, then these actions are usually covered by the insurance, though their prescriptions for non-registered therapies or medications may not be.

Medication

In most EU member states the sale of medication with health claims is regulated and restricted to pharmacies. The list of registered medications was the result more of historical evolution than scientific evaluation. Some medications had been on the market for so long and once registered, this was forever. Some products were based on very old formulae produced by a small family enterprise or even a monastery and still qualified as over-the-counter products for self-medication. Others were homeopathic or herbal preparations. In Germany, for example, the number of registered medicines came close to an incredible 100,000 many of them so-called 'combination products'.

In the past, the demands on efficacy or safety were not very strict. Now doctors have learned that many of them are either ineffective or dangerous or both, but this does not stop people from buying them.

In 1965 the first efforts were made by the EU to overhaul the existing situation. Perhaps the Thalidomide (Softenon) drama accelerated this. (This drug was not allowed in the USA by the Food and Drug Administration (FDA), some say because of keen insight, others say because of slow processing by the FDA. Consequently there were no malformed babies in that country). Several EU directives were issued (footnote i), imposing on the member states very strict rules for the testing of any medication for efficacy and safety before allowing them to be sold to the public. These directives allowed a very long time limit to put the matter in order. One of the important rules was that all those previously registered had to re-apply.

This was decades ago and the deadlines are long since past, but even today the situation is still not resolved; several states are not applying them and they are threatened with high fines. Though there is now a European agency situated in London, all countries continued registering medications on a national scale, and some do it in a very peculiar way.

Though the new system is still far from watertight, it has had serious consequences. Immediately after the publication of the first directives, they caused quite a panic amongst producers, mainly those responsible for very outmoded and unscrutinised patent medicines. They realised that they could not meet criteria for quality and either closed shop or withdrew some of their products. In some cases the

profits of selling the products could not match the expenses of preparing a report of clinical tests to substantiate the therapeutic claims that they had been making. For other products, the claims were clearly untrue and could not be substantiated. The result was that in several countries the number of listed medications dropped to 20%-50% of the figures of 1965. The reaction from the CAM industry was different. They also must have realised that their chances of meeting the efficacy criteria were close to zero. It appears that in the first years after the issuing of the directives, they completely ignored them, or perhaps thought that the storm would blow over. However, later, when it became clear that the states could not escape the directives, they started a series of political actions to avoid or to change the rules.

Tactics and Arguments used to Change the Rules for Efficacy and Safety

The first efforts attempted to use the free commerce and trade treaties, by claiming that since all persons and goods should be able to travel freely in the EU, the same should apply to homeopathic products, and that the directives for medication were impeding the free commerce of the said products. The first serious action for the recognition of homeopathic medicine (HM) started in 1990 under the leadership of the Belgian European Parliament (EP) member Mr. Chanterie. His group maintained that a review of the directives should be ordered by the Council.

Citations from 'Considerations, Explanations and Justifications'

- 'Alternative medicine is widely prescribed and used in all member states, even if not always officially recognised'.

Comment: One could say the same about any other commercialised potion or even gambling.

- 'A survey in 1987 for the EU in 9 countries showed that between 7% and 25% of the population seek the advice of an alternative therapist at least once a year'. (In another document they mention 18%-75%).

Comment: This is a misrepresentation intended to make CAM look more important than it is and perhaps to seduce EP members into believing they will gain votes if they endorse this recognition. The cited figures on the use of CAM vary between 7% and 80% depending on how the questions on its usage are put. 'Did you ever use it?' gives different answers to 'Did you use it during the last 12 months?' Some surveys even counted dieting, praying and jogging as CAM. The number of regular users is near 7%, most of them also regular consumers of normal medicine. The exclusive users of CAM are less than 1%. However, whatever the numbers are, this should not be an argument to drop the criteria for quality.

- 'Conventional statistical methods for clinical trials are scarcely applicable to homeopathy'.

Comment: We are still waiting for the first publication of homeopathic mathematics or statistics.

- 'One of the causes of the controversy between allopathic and homeopathic medicine is precisely that classical medicine does not wish to follow the 'proofs' given by homeopathic doctors. Scientific articles about homeopathy are

rarely accepted by mainstream publications'.

Comment 1: The conspiracy theory has been refuted many times, to no available (e.g. the chapter on 'Constraints' in the COSB4 Report).

Comment 2. The use of the term 'allopathic medicine' must be rejected. It is a term invented by the founder of homeopathy who wanted to distinguish his system from the medicine that was practised 200 years ago. The latter is based on the concept of the four humours or 'life fluids' and has no relation at all to scientific medicine of today. The use of the terms 'allo-' and 'homeo-' gives the impression that they are two equally valuable systems.

Comment 3. CAM practitioners can be roughly divided into three groups. One group totally rejects any reference to scientific proof, claiming that this is not possible or not necessary. The other faction accepts the need for randomised controlled trials (RCTs). However they claim that sufficient proof has already been obtained but the stubborn academic medical community refuses to accept it and is involved in a conspiracy against them, declining to publish their work. The third group also accepts the RCT as standard and concedes that existing evidence is not sufficient because of lack of funding and the inexperience of CAM researchers.

- 'There exist very extensive lists of publications that prove the efficacy of homeopathy as well as anthroposophic medicine.'

Comment: That this is definitely not true has been demonstrated in several meta-analyses. This is the 'conspiracy' again. Where is this list?

- 'It is in complete contradiction to the philosophy behind these methods to engage in measurement as is done in allopathic medicine.'

Comment: They are not concerned about their own contradictions. 'We have the evidence but they refuse to see' and 'We cannot provide the evidence because we are different'. So what do they propose as an alternative method of measuring?

- 'Methods of testing the remedies should be those currently used in homeopathic institutions.'

Comment: This could be acceptable, on condition that they explain how it is done, so it can be replicated and eventually falsified. The homeopathic method of 'proving' by 8 volunteers is a statistical nonsense.

- *'The fact that classical medicine cannot understand the workings of CAM, including homeopathy, does not mean that they don't work.'*

Comment: This is an oft-repeated misrepresentation that has been refuted many times to no avail. Classical medicine has many precedents for accepting that a treatment works before the mechanism has been understood. Before worrying our heads trying to 'understand' we would first like to see proof that it works.

- 'Tens of thousands of homeopathic and anthroposophic doctors and millions of patients are more than sufficient proof of the effectiveness of their treatments'.

Comment: The same reasoning could be applied to any absurd or even dangerous habit

or medieval remedy. If we accept the fact that anything that sells well must be good, the consequences could be extreme.

- 'The right to practise homeopathy and other CAM should be regulated to prevent non-experts taking a share in the market.'

Comment: This is an oft-recurring theme. The CAM pressure groups want to secure a monopoly for themselves. The club they represent is the only good one, because they say so. Once they obtain a monopoly they will conduct their own internal recognition and internal regulation. The German, Dutch and USA experiences have shown that this leads to uncritical promotion by the industry, not to critical quality assurance.

- 'For commercial homeopathic medicine in very low concentrations, a simplified method of registration should be adopted without any mention of the therapeutic indications.'

Comment: This seems reasonable. Homeopathy does not recognise the concept 'disease', so why not allow the marketing of non-dangerous solutions, the label only mentioning the contents and not the indications. Who wants to forbid the distribution of holy water? If people would like to buy it, why not? The market is abundant in other products such as cosmetics for wrinkles or hair loss, which do not work either. Recent experience has shown that it is not sufficient to forbid false claims on the labels, since these are also publicised by other means, such as books or the Internet.

- 'Even for homeopathic medicines that mention a therapeutic indication, registration has to be granted.

Comment: Can the reader understand that this contradicts the previous assertion? The 'simplified registration' could be granted since the preparations do not carry any claims of therapeutic effectiveness for a specific disease or symptom. The unicist, or classical homeopath claims that all patients are individuals. If such practitioners want to mention a therapeutic indication then they abandon the homeopathic notion that every patient is different and should be treated as such. This clearly demonstrates the dishonest attitude of the producers who definitely do sell products with medical indications and want to continue doing so without delivering honest proof.

- 'Freedom of choice of therapy has to be guaranteed'.

Comment: Agreed, if the choice can be based on honest information.

- 'Allopathy, anthroposophy and homeopathy are to be considered as different approaches, each having its own merits, and in many cases they are complementary'.

Comment: The term allopathy again! If there are merits, honesty prescribes that those merits should be specified and open to critical appraisal.

- Anthroposophic medicines registered in official pharmacopoeiae should be treated on the same basis as allopathic medications.

Comment: these pharmacopoeiae are no more than cookbooks that describe how to prepare the product (e.g. how to kill and grind the cochroach), but give no proof as to efficacy.

The anthroposophs jump on the same bandwagon as the homeopaths, although the systems are very different.

- To give homeopathic and anthroposophic medicines the same opportunities as those of allopathic medicine, and to guarantee freedom of choice of therapy, the health insurance schemes should not be allowed to show preference in their funding arrangements.

Comment: The CAM practitioners refuse equal treatment since they want to be registered without proof. This is another example of their trying to have their cake and eat it. Equal treatment should be accorded after equal meeting of the requirements.

The Chanterie proposal was partially approved by the EP, and resulted in a new directive that corrected and amended the original. This result was celebrated as a great victory in CAM circles, though some were disappointed by the restrictions.

The Results: Directives 92/73/EEC and 92/74/EEC

Homeopathic medications can apply for a 'simplified registration'; but this can only be accorded under certain conditions such as:

- Only very low concentrations (high dilutions) so as to exclude any toxic risk (specified)
- Only for oral or external use
- The label can only mention the composition and dilution
- The label has to mention: 'homeopathic medication without approved (proven) therapeutic indication' (the wording differs a little in the different languages)
- The label has to mention 'If the complaints persist, go and see a doctor'
- No therapeutic indication can be given

What was rejected:

- All injectable substances
- All concentrations that might be dangerous for the patient
- Instructions that the states have to provide payment by health insurance of homeopathic procedures and products
- The mandatory organisation of an official training and education programme in CAM
- All mention of medical practice, medical education, and reimbursement of medication (because they surpassed the limits of the mandate of the committee: free traffic)
- The proposed label 'If the symptoms persist, seek the advice of a competent (licensed) homeopath
- 'Fantasy' or brand names, as well as leaflets that mention indications

Comments

The private homeopathic practitioners initially said they were very happy with this resolution. It complied completely with their doctrine that for every patient the medication selected depends on an individualised assessment. Standard medication for a specific disease or symptom does not fit in with the homeopathic way of thinking since homeopaths do not recognise 'allopathic reductionist' diagnoses. The banning of commercial preparations with 'fantasy' names and specific indications was for them a welcome measure against self-medication.

All of this is not without a degree of hypocrisy or contradiction since many homeopaths confess that for 'simple cases' they also make use of industrial standard preparations or so called 'complexes' (e.g. for urinary infections and ear infections).

Less happy were the 'water-shaking' companies. They were the main sponsors of these EP initiatives and feared a very strong setback for marketing their patent formulae.

As was to be expected, a new offensive was launched soon after. Most of the same arguments were used again, some were rephrased, and some new tactics were introduced.

The Second Offensive 1994 (The Lannoye Resolution that became the Collins Resolution)

The chairperson of this second working group was another Belgian, Mr. Lannoye. The following motion for resolution B4-0024/94 15 was presented by his working group to the EP in 1994.

Excerpts from the Considerations

- 'Whereas it is important to ensure that patients have the broadest possible choice ….and are protected against unqualified individuals'.

Comment: The quest for a monopoly again!

- 'Whereas, in order to protect the health of his own patients to the full, a doctor may use all resources and knowledge in any field of medicine in accordance with his own judgment and conscience'.

Comment: This is a new approach. The statement that a doctor has to use his judgment and conscience sounds honourable, but in most countries the doctor is also obliged to make his choice according to the present state of medical science. The way it is formulated here relieves a doctor of the obligation of scientifically justifying his choice of therapy. This could give a free rein to, for example,. cancer therapy with coffee enemas; only his peers will judge, and if he used the right brand of coffee, well brewed and in the correct concentration, then nothing can be held against him.

- 'Chiropractic, homeopathy, anthropo-sophical medicine, Chinese traditional medicine (including acupuncture), shiatsu, naturopathy, osteopathy, phytotherapy, etc. are recognised in some member states and have self-regulatory mechanisms'.

Comment 1: This is not true for most of the cited systems and it is again the strategy of leveling to the lowest: if any state allows it, all others should follow. One could wonder how the public would react if the same arguments were applied to the death penalty, pyramid schemes, the selling of illegal drugs, etc.

Comment 2: Self-regulation again. Medical doctors know nothing about our concepts. Let us arrange our own affairs.

- 'Evaluation must be carried out according to the appropriate methodologies for the various disciplines'.

Comment: This should not be rejected out of hand, since it is defendable that trials have to take into account the specificity of a method, but cannot be approved unless the researchers clearly specify how they intend to

do this evaluation. If the method is falsifiable and reproducible, it could be accepted. Let us hope it will not be done with a divining rod or pendulum. Repeatedly I have asked prominent homeopaths to explain their method of 'proving', but they say it is impossible to understand without many years of study.

- '…qualifications *(should)* be harmonised at a high level as a result of a rigorous self-regulatory process within the profession itself, ….leading to the award of a state diploma'.

Comment: First give us a monopoly, then we arrange our own affairs and then later we will lobby to become a recognised medical specialty. Who wants to become a specialist doctor in coffee enema treatment? The study takes years and will not be cheap in my school.

- 'Whereas a transition phase will be necessary …. to meet the requirements of the new legislation'.

Comment: This means: since we were already in business, let us continue. This cannot be accepted without specific guarantees for criteria.

Their demands (some excerpts)

- '….calls on the Commission to immediately launch a process of recognising non-conventional medicine and, to this end, to take the necessary steps to encourage the establishment of appropriate committees.'

Comment: Self recognition again - guess whom they want to seat in those committees. This was accepted by the EP, <u>but the condition 'if the results of the study allow it' was added</u> during the plenary discussion. It is said that this made Mr. Lannoye so angry that he refused to see his name attached to the resolution. (It is a tradition to name a resolution after the chairman of the preparatory commission, so it became the 'Collins Resolution' after the name of the chairman of that EP session.)

- '….calls on the Commission to carry out a thorough study into the safety, effectiveness …..to promote the development of research programmes in the field of non-conventional medicines taking into account …specific characteristics of non-conventional medical disciplines … to submit a report as soon as possible….'

Comments: Since 1994 (Budget B7142), millions have been allocated and spent on this research without any clinically relevant result. This is very similar to the US National Council of CAM that has also spent $100 millions of dollars on research without any clinical results, yet 'more studies are needed' so the budget is raised to $100 million per year.

- 'Remove trade barriers between member states by giving manufacturers of health products free access to all the markets in the EU'.

Comment: This sounds fair if the Directives are honestly applied, but the Dutch example (see later) gives cause for distrust.

The above text was approved by the EP in May 1997. It is interesting to note that out of the 22 physicians in the EP, none of them voted for the recognition. Mr. Lannoye later stated in a speech to homeopaths (Monaco)

that this is proof of how the medical establishment obstructs change.

The Third Offensive, 1998

Since the results of 1997 were not enough for the CAM lobby, they immediately started to organise a new offensive in the spring of 1998. Most of the old arguments were used again, albeit somewhat rephrased to cover more than homeopathy alone. The offensive was also aimed at trying to keep the advantages of the simplified registration but loosening up the restrictions on those products.

Arguments

- 'In countries for which statistics are available, non-conventional medicine is used by 20 to 50% of the population'.

Comment: This has been refuted many times to no avail, but once more: the correct figure of regular users is around 7% (Belgian National Health Survey). Most of them are also heavy users of normal medicine.

- 'There is disaffection with conventional medicine.'

Comment: strange logic: normal medicine is bad, so CAM must be good. This is suggested by the dualistic terminology CAM advocates try to promote – 'conventional versus non-conventional', 'allopathy versus homeopathy', etc - as if there are two equal roads to health.

- 'Conventional medicine is …certainly effective, but it attacks symptoms above all, and often has undesirable side effects'.

Comments: It is suggested that CAM cures the fundamental causes and has no adverse effects. This is unproven and/or false.

- '….a growing trend to seek out medicine with a more human face, medicine which deals with human beings and not just their pathologies'.

Comment: As said before, in other words all normal doctors are bullies and all CAM practitioners are sweet and understanding. It is a mean insult to all caring doctors and especially to general medical practice, which pays so much attention to the holistic and psychosomatic aspects of the patient.

- 'CAM remedies seek not so much to destroy pathogens as to restore the human body's capacity to resist them'.

Comment: The old fable of the boosting of the self-curing capacities again, but where is the proof of this?

- 'Alternative medicine questions the irrational scientific prejudice which it has attracted.'

Comment: The straw man tactics and name-calling. The others are irrational and prejudiced. It is not lack of evidence but the old conspiracy again.

- 'We may quite legitimately conclude that the interests of the pharmaceutical industry have prevailed over those of European citizens'

Comment: Obviously everybody who does not believe in CAM has been bribed by the industry. One may also wonder how they can explain that giving an uncontrolled free hand to the homeopathic industry is in the interest of the consumer'.

- 'For those disciplines which already enjoy some form of legal recognition in one or more member states and/or some form of professional organisation at European level the guarantee as regards safety may be taken as read'.

- *Comment: False. It is not that because a treatment exists for a period of time that it can be assumed to be safe. Sometimes the adverse effects come later. CAM has no system for recording them. It reminds one of the Belgian Chinese herbs drama where 100 (mostly young) women lost their kidneys and are now developing cancers, all this being due to a very old, and therefore 'safe', Chinese herb. Similar cases have been registered all over the world. The accidents caused by chiropractic neck manipulations are far more frequent than initially thought.*

- 'As regards their effectiveness, studies, admittedly not very numerous, do exist, and are generally conclusive, provided it is accepted that we will not limit assessment of effectiveness to the methodology and criteria used for conventional medicine.'

Comment: There is no conclusive evidence from repeated studies or reviews. As Mr. Goebbels said: 'Keep on lying, something will stick.

- Chiropractic is, on this basis, now scientifically demonstrated …. following several studies carried out… in the UK'

Comment: Definitely not true, but it is difficult to counter this statement when they do not give the references.

- Conclusive proof of the effectiveness of homeopathy is piling up, even if the orthodox scientific community is not yet convinced. We could go on giving examples involving acupuncture, Chinese traditional medicine, osteopathy and many other methods of treatment.

Comment: All published meta-analyses and the Cochrane reports say the opposite, but they keep on lying.

- Proof of therapeutic effectiveness 'is not possible using generally recognised scientific methods'.

Comment: I thought, from what they were saying a few lines above, that they do have proof.

The Considerations (some excerpts)

- 'Whereas it is important to ensure that patients have the broadest possible choice of therapy, guaranteeing them the maximum level of safety and the most accurate information possible on the safety, quality, effectiveness and possible risks of so-called non-conventional medicines, and that they are protected against unqualified individuals…'

Comment: Here is the monopoly again, but now also the domino principle: Mr. Lannoye argues now that since homeopathic medication is recognised, it is a scandal that homeopathy is not recognised as a medical specialty (footnote ii).

- 'Whereas there is a broad range of non-conventional medical disciplines, and some of them enjoy some form of legal recognition in certain member states

and/or possess an organisational structure at European level (common basic training, deontological code, etc.) in particular chiropractic, homeopathy, anthro-posophical medicine, Chinese traditional medicine (including acupuncture), shiatsu, naturopathy, osteopathy, phytotherapy, etc…..'

Comment: This could give the impression that all the cited systems are organised or recognised, and this is definitely not so. In several countries they have fiercely competing organizations, each striving for a monopoly and viciously attacking its competitors.

- 'Whereas the freedom to exercise their profession, which certain health practitioners currently enjoy in their countries should under no circumstances be limited by modifying the status or the degree of recognition enjoyed by these disciplines at European level, nor by limiting the freedom of choice of therapy enjoyed by patients….'

Question: Even if they should be proven to be dangerous or inefficient, must they remain untouched? The trick here is that in contrast to normal medicine they do not want to have recognition for a specific procedure or product for a specific disease but for the whole system. One could as well claim medications are good, so all that is sold in a pharmacy is good. This kind of statements paralyses all attempts at evaluation and criticism.

- 'Whereas there are already clear signs of developments …. in the form of national legislation in certain member states, liberalising the practice of non-conventional medicine while reserving certain specific activities for authorised practitioners (the Dutch BIG 1994)…….'

Comment: The Dutch are reconsidering this law that gave the' quacks' a free hand. Several dramatic cases are in court now.

- '…..that qualifications be harmonised at a high level as a result of a rigorous self-regulatory process within the profession itself, subsequently leading to the award of a state diploma'.

Comment: This so-called rigorous self-regulation is far from rigorous. The German and Dutch experience proves that they are more like propaganda instruments.

- 'Whereas the training of conventional medical practitioners should include an introduction to certain non-conventional medical disciplines.'

Comment: No problem, provided it entails an objective and critical study.

- 'The European Pharmacopoeia should include the full range of pharmaceutical and herbal products used in non-conventional medicine.'

Comment: Once more: instructions how to cook and grind are not the same as proof of efficacy, but we know from past experience that later this will be used as an instrument to claim legality.

- '…..introduction where possible of non-conventional medicines in the livestock farming sector.'

Question: How do they think they will promote this? How does one take an in-depth interview with a cow? Or determine its life energy by taking its pulses in a dozen different places? If

they plan to introduce medications with a disease indication, then they should provide proof of efficacy.

Their demands

For the "simplified registration of products to stop the discrimination":

- Permission to use 'fantasy names'
- Permission for more concentrated products
- Permission to sell the concentrated mother tincture
- Permission to sell injectable forms and nose sprays
- To do their own testing (without specifying how)
- Abolition of the label 'homeopathic product without proven efficacy'
- Anthroposophy to be treated in the same way as homeopathy
- Uniformity to the lowest level (permitted in one country, therefore …)

And all this without any kind of proof!

Note: The EP voted positively on the proposals in 1998. The European Commission is charged to bring them into effect. As yet it has taken no action.

What has Happened?

The CAM industry has already devised several ways to circumvent, bend or just ignore the rules laid down by the EU. The Dutch example is very illustrative: they have created a new category of homeopathic medicines - those who do not have to comply with the EU rules. The Council Directive 92/73/EEC of 22 September 1992 allows the 'simplified registration' of homeopathic products (i.e. without the usual requirements of proof or efficacy and safety as required for all medications) only if they are extremely diluted and do not mention any indications:-

Article 7 of the EU Directive

1. Only homeopathic medicinal products which satisfy all of the following conditions may be subject to a special, simplified registration procedure:- they are administered orally of externally, and no specific therapeutic indication appears on the labelling of the medicinal product or in any information relating thereto,…'

If those two conditions are not fulfilled, the medications have to provide the requirements as for any other medication, a costly but essential procedure as described in 65/65/EEC and 75/319/EEC.

The Dutch law on homeopathy (footnote iii) has a very peculiar way of interpreting this directive: They apparently accept the EU regulations for homeopathic products without any claim to indications. However, they created a new category of homeopathic products with indications, (so-called Article 6 products) that include composite products, injectable products, mother tinctures (i.e. concentrated solutions!) and low-potency products (i.e. concentrated), al those in contradiction with the EU directive. Those Article 6 products can mention indications *'if they can present literature that make it acceptable that the product can be used with success for the mentioned indication'* (my translation). In Article 3.2 it is stated that as reference for the indication it can suffice *'for it to be mentioned in a 'homeopathic book that is often used by a homeopathic doctors' organisation'.*

It is clear that those rules make a farce out of the EU directives and allow all kinds of abuses. It is also interesting to notice that in the explanatory notes of the Dutch law it is mentioned that this law has been elaborated at the specific request of NEHOMA (the union of Dutch homeopathic industry) for export reasons (sic!).

In December 1999 the first homeopathic product manufactured by Biohorma was registered for the indications 'fever' and 'nerve pain' without any valid proof. Several other products have followed and the registration is still going on. The other member countries will have to allow the import of this unfair competition. I have written several complaints to the EU against this outright fraud, but without any result.

Less subtle tactics by the CAM peddlers

In 2002 there was a proposition in the EP to regulate the labeling and the correct composition of food supplements such as vitamins and minerals that are marketed in the form of tablets, capsules and powders. The complete texts of the proposals and the debates can be found on the website of the EP (footnote iv), and are very interesting reading, especially with regard to what some EP members dare to say in defence of the quacks.

The chairwoman of the working group, Mrs Emilia Müller, who had to prepare and present the working document to the EP has been threatened in her personal life, as has her family by the CAM food supplement lobby. I shall simply let some excerpts speak for themselves:

MP1: 'However, may I say also that Emilia Müller has suffered one of the worst assaults by people outside this Parliament that any Member has had to put up with. It is one thing to be e-mailed; it is one thing to be lobbied; it is one thing to be mass-lobbied; but to endure threats of violence, bullying and harassment as she and her family have is something which this Parliament will not accept'.

MP2: 'Many of us have been pestered and obstructed to an unreasonable degree by those who have masqueraded as philanthropists and defenders of the sick'.

MP3: 'Mr. President, it is not every day we have to congratulate a rapporteur for sheer civil courage in standing up to one of the most unscrupulous lobbies of our time'.

Those actions do not exactly conform to the image of the gentle, tree-hugging, all-natural people CAM advocates try to sell us.

General Conclusions and Recommendations

- There should not be different rules for recognition or ethics of so-called alterative medicine.

- Any attempt to obtain monopolies on recognition and inside regulation are very dangerous for public health because the they allow the organization to escape effective control.

- We must caution our EP members against the dangers of recognising a whole system as a kind of black box that could place it above all scrutiny.

- 'Alternative medicine' does not exist. There are medical procedures that have been proven to be effective for some

indications, and there is the rest. The term 'alternative' is no more than a sales trick to peddle unproven methods.

Footnotes

[i] Directives 65/65/EEC and 75/319/EEC, and 89/341/EEC

[ii] Speech at the Monaco AltMed congress 28 November 1999

[iii] http://www3.europarl.eu.int/omk/omnsapir.so/debats?APP=DEBATS&PRG=COD&DIR=0080&LANGUE=EN&DOC=20000080(COD)E2-en.doc

[iv] Dutch Government Paper (Staatsblad) 1995 publication number 654, http://overheid-op.sdu.nl/cgi/showdoc/pdf/dv:7713/1/3/STB2280.pdf

THE MEDICALISATION OF MISFORTUNE

Michael Heap (with comments by Dr. Trevor Jordan, Dr. Gerry Kent and Dr. David Tombs)

It is often noted how nowadays it seems that there is a growing tendency for personal difficulties, disappointments, frustrations and misfortunes in everyday life to be construed as the business of experts who are equipped with the knowledge and skills to diagnose what is wrong, how the problems came about, and how they can be cured or at least ameliorated. One way of describing this process is to talk about the increasing 'pathologising' or 'medicalising' of difficulties and misfortunes and the progressive 'colonising' of these areas of life by presumed experts from the healing industries. Such statements are usually made by people who bemoan this trend and would like something to be done to reverse it.

For example, in a recent article in the 'Sunday Times' ('Stop taking the alternative medicine'). GP Michael Fitzpatrick wrote:

'The redefinition of illness as disease has become the dominant medical response to unexplained physical symptoms which are given labels such as ME, fibromyalgia, irritable bowel syndrome. The expansion of psychiatric diagnoses, from depression and anxiety to attention deficit disorder, hyperactivity disorder and post-traumatic stress disorder, now takes in a substantial section of the population. The effect of these labels is often to intensify and prolong the incapacity.'

(Dr. Fitzpatrick also has a chapter in the book *Alternative Medicine: Should we Swallow it?* which is reviewed in this issue by Sandro G. Masoni.)

Dr. Fitzpatrick mentions post-traumatic stress disorder and I shall return to this shortly. Another common target for critics who are concerned about this trend for 'over-pathologising' is 'stress'. This term is very commonly used in a very broad and ill-defined way, often to cover a wide range of states of mind and body in which the person regularly

experiences unpleasant feelings such as anxiety, low mood, tiredness, and irritability, apparently due to the demands of his or her daily life. Nowadays people may consult experts in stress management and receive counselling and therapy. Large employers frequently arrange stress management courses for their staff, and books and audio and video cassette tapes on stress management proliferate. It is not incorrect therefore to speak of the 'stress management industry'.

Some critics, such as Dr. Fitzpatrick, feel that all of this, far from being helpful, is exploitative; it encourages people to regard themselves as victims in need of the ministrations of experts who know much more about their problems than they do. Some critics question whether the experts do indeed have anything more to offer than their clients can achieve for themselves.

All of this may indeed by the case, but it is not the purpose here to decide one way or the other. What is clear from the analysis presented earlier in this issue is that this process is not just something that has been foisted on the unsuspecting public by a self-interested faction. It is an inevitable development in a society in which there is economic freedom, increasing affluence, and the relentless accumulation of knowledge. It reflects not just the self-interest of those who promote this approach to life's difficulties (and whatever specialised knowledge and expertise they posses). It also reflects the ever-expanding range and diversity of what life has to offer, the corresponding increase in the expectations of people to gain and hold onto the benefits of these, and their belief that they are entitled to do so and that impediments to these, even those as vague as general malaise and debility, should be explained and alleviated. As was indicated in my earlier article, this is inevitably associated with the increasing complexity of the problems people face in their lives and the corresponding expansion and increasing specialisation of the range of diagnostic categories in medicine (in its broadest sense – orthodox medicine, allied professions, alternative medicine and commercial, over-the-counter medicines).

This is not just a reflection of the constant progress in understanding human physical and psychological illness and difficulty, since, for example, alternative medicine manages to flourish, expand and diversify uninformed by such progress (likewise, to some extent, commercial medicine). It is also, as I have said, associated with increasing affluence, opportunity, and so on. However, it is still inevitable that genuine advances in knowledge and its application will lead to 'medicalisation' of everyday problems. There is a scientific literature on 'stress' and scientifically evaluated ways of reducing or avoiding stress. Likewise 'post-traumatic stress disorder': the scientific study of human beings who have experienced life-threatening events such as a road traffic accident cannot help but reveal that they commonly report a constellation of very distressing symptoms and problems that other people do not, and that there are ways in which these can be eased or eliminated.

Yet we must still be aware of the principle of interdependence: this advance in human knowledge does not occur in isolation from the rest of society. I have already rehearsed the arguments for this but it is worth reminding the reader how, for example, psychiatric diagnoses have over the years rapidly

expanded and become more specialised, and that the common criteria of most of the mental and personality disorders in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV) is 'The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning'. (Diagnoses according to DSM-IV and the International Classification of Diseases of the World Health Organisation typically differ from those in general medicine (except in some instances such as, interestingly enough, irritable bowel syndrome) in that they rely, not on the identification of some underlying pathology that gives rise to the symptoms, but on a tally of the symptoms themselves. Hence a person may be suffering from psychological difficulties such as poor sleep, and nightmares and flashbacks of a traumatic event, yet not be diagnosed with a psychiatric disorder (e.g. post-traumatic stress disorder) because the threshold for the symptom tally is not reached.)

There is no stopping the medical profession, of which Dr. Fitzpatrick is a part, allied professions (conventional and unconventional) and the commercial medical sector each from laying claim to being the authentic agents whereby life's vicissitudes, annoyances disappointments and difficulties can be understood and remedied. In the case of orthodox medicine and psychiatry we can challenge the scientific legitimacy of diagnoses such as 'intermittent explosive disorder' and 'oppositional defiant disorder', but if they are, as they appear to be, based on carefully conducted surveys and analyses of human behaviour, what else can we do?

(In fairness I do not wish to exaggerate the significance of the expansion of psychiatric diagnoses which, in accordance with the principle of interdependence, is probably in important ways associated with the need to classify 'disorders' for the purposes of the funding of psychiatric treatment by American medical insurance companies and for legal and forensic purposes. In general psychiatry, the position is much simpler, as will be seen below).

A final point to make is that those who refer to the over-medicalisation of problems presumably have some criteria in mind as to what constitutes a problem for medicine and what does not. I suspect that an implicit criterion is whether there happens to be any medicine that can alleviate the problem. For example, we may complain about the medical diagnosis and treatment of daily 'stress' as being a modern and deplorable development, yet generations of patients have been diagnosed with and effectively treated for nightly stress, namely insomnia, purely because doctors have always known about the hypnotic effects of certain substances.

Consultation with Three Professionals

To further this discussion I approached three professionals for their opinions. Dr.. Trevor Jordan is an ASKE member and a retired general practitioner.

As a GP did you find that most of your patients' problems were well handled by the 'medical model' (examination of symptoms and signs, provisional diagnosis, tests, final diagnosis, prognosis and treatment)? How much did you notice the 'placebo' effect?

Dr. Jordan

As a medical student I was assigned to Dr. RH, a local GP, for experience of general practice. One day we visited a young boy who complained of a sore throat, a cough and a fever. Examination revealed very enlarged lymph glands in his neck, a heavy white coating on his tonsils and a fever. Dr. RH diagnosed 'acute tonsillitis' and issued a prescription for penicillin syrup. We left advising the boy's mother to 'call the surgery if he isn't better in two or three days.'

Outside I complained: shouldn't we take seriously the alternative diagnoses of Hodgkin's disease, tuberculosis (more prevalent then than now) and so on? At the very least shouldn't we do laboratory tests on the tonsillar exudate to determine if it really was bacterial and not the probably more common viral tonsillitis for which penicillin was useless?

Dr. RH explained: an acute infection was much the most likely diagnosis. Hospital tests, biopsies and x-rays were time-consuming and expensive. In two or three days the child would either be better, in which case further tests would be unnecessary: or he would not be better in which case the other less common diagnoses could still be considered and the tests ordered. Delaying the ordering of the tests for two or three days would make no discernible difference to the outcome. What was more, the child and his mother had not been exposed to the fears and anxieties, which would certainly arise had the more serious – but much, much less likely – diagnoses been discussed at the outset.

"But what about the antibiotic? To use your logic, the probable diagnosis is a viral infection, so your penicillin is more than likely unnecessary and will make no difference."

"Yes," replied my trainer, "but it buys us the two or three days during which any self-limiting viral illness will begin to subside. Mother will happily nurse the boy for two or three days 'while the antibiotics are getting to work' but will call us back tomorrow if we don't provide him with what she perceives as treatment…"

This scenario is repeated time after time after time in general practice. It is unscientific. It does not follow the strict 'medical model.' It depends on the experience of the physician (I was later to learn that there are other telltale signs which might lead to an immediate suspicion of the other diagnoses) and it certainly 'pleased' the patient and his mother; so to that extent it relied in part on the 'placebo' effect.

It can be argued that this has much in common with alternative medicine! There is a lack of scientific rigour; the evidence is anecdotal; it relies on 'personal experience' and there are no double-blind controlled trials; the substance used is known not to be effective in most cases; there is a conscious effort to 'please' the patient; and it 'works' because there is a strong probability that the illness will be self-limiting. But its elements are amenable to reasonable rational explanation, a characteristic lacking alternative medicine.

I then asked Dr. Jordan for his comments on the quote from the 'Sunday Times' article by Michael Fitzpatrick given earlier in this article.

Dr. Jordan

Yes, yes and yes! The situation is inevitably more complicated than this, and it touches on disciplines other than medicine, but Fitzpatrick's premises are basically sound.

Some years ago a survey suggested that we all experience an average of ten 'potentially significant symptoms' in any two-week period. Part of the enormous pressure on general practice these days is undoubtedly due to the increasing frequency with which these 'symptoms' are presented to the primary care doctor for advice. We are less and less willing to put up with our aches and pains, and the information explosion means that each is invested with unwarranted significance. Every headache becomes the warning sign of a brain tumour, every cough the early sign of lung cancer, every dyspeptic twinge is a 'peptic ulcer' and so on. (Potentially, if every symptom were to result in a surgery visit, the workload would increase from the current 7,500 consultations per GP per year to around 650,000!)

But we are taught from an early age now that we 'don't need' to suffer even the smallest discomfort and therefore 'something must be done, doctor.' But, as I said earlier, to refuse the patient medicine or a pill often provokes him or her into returning until a prescription is finally given. In self-defence the GP will therefore often comply with the assumption that there is a pill for every ill and prescribe inappropriately on the first visit. The 'illness' behaviour is now reinforced on both sides.

Additionally, the medical model specifically disapproves of the treatment of symptoms, and undoubtedly patients prefer to believe that their suffering is legitimate. So common clusters of symptoms tend to attract labels. These labels elevate the symptoms to the status of a 'known or named illness' and legitimise both the doctor's behaviour in offering treatment and the patient's behaviour in seeking it. It is socially and personally more acceptable, after all, to take time away from work because one has, say, 'Jackson's syndrome' than because one has nausea, headache and abdominal cramps which the unenlightened or unsympathetic might otherwise be tempted to call a 'hangover.'

This is true for physical symptoms, but along with our 'right' not to suffer physically we have also invented the 'right' not to be unhappy. But that isn't serious enough to warrant treatment – or a sick note – so we must suffer from 'depression' or suffer from 'an affective disorder' or 'seasonal affective disorder.' People with the first two are given pills and those with the third are prescribed sunlamps, in my view too easily and too frequently ,just as thirty years ago we too readily prescribed Librium and Valium, the panaceas of their day for all unhappiness.

Increasingly many of these 'medical treatments' are being seen for what they often are: ineffective, and sometimes even toxic – the cure is more troublesome than the disease. However there is an army of people who will promise the same reward – freedom from all discomfort and guilt – by alternative methods. Crystals, magnets, supplementary minerals, channelling of energy fields, psychic healing, homeopathy, Reiki, rebirthing: any and every theory is employed in one 'therapy' or another.

We should not be surprised that their practitioners consistently refuse to put them up for validation by independent scientists: it is their livelihood, after all. But would that more

people had the common sense of a young mother whom I met with her happy, inquisitive, energetic two-year old wriggling in her arms. “Oh, all the other kids round here are hyperactive and on pills,” she said, “but this one – he’s just a little bugger!”

There’s no pill for that complaint! Yet.

Comments by Dr. Gerry Kent and Dr. David Tombs

I also asked Dr Gerry Kent, for his opinion on Dr. Fitzpatrick’s comments. Dr. Kent is a clinical psychologist at the University of Sheffield, who specialises in health psychology and works at a pain clinic with patients diagnosed with, amongst other things, fibromyalgia and irritable bowel syndrome.

In Dr. Kent’s opinion, it is helpful sometimes for patients to have a label for their problem as it may remove the possibility of their feeling stigmatised by complaining of symptoms that are not yet given a diagnosis and makes it easier to deal with people’s reactions to their symptoms. Dr. Kent also suggested that this might be of more help in the short than in the long-term. In the case of long-term symptoms that are disabling, a label may encourage the individual to feel that he or she does not have any responsibility for what can be done for him or her – the problem is out of his or her control. However, Dr. Kent admitted that this was only his impression; he knew of no evidence to support it and, if true, he was unsure to what extent it occurs. Dr. Kent certainly felt that Dr. Fitzpatrick should back up his own assertion with some evidence.

The last view was echoed by Dr. David Tombs, consultant forensic psychiatrist, (now at Rampton Secure Hospital), but he admitted that Dr. Fitzpatrick may be right. In his opinion, what is different now from the past is the labels that are used. He does not believe that there is any tendency for people to have become more neurotic, but people seem less willing to tolerate stress or distress and more people go to their GPs on account of this. He cited the weakening of the family unit as one possible cause of this. Most people consulting their GP in this way do not need to see a psychiatrist; GPs are able to provide safe medication if necessary or refer patients for psychological therapy, such as cognitive behaviour therapy, the efficacy of which has been demonstrated.

I asked Dr. Tombs about psychiatric diagnoses and he agreed that, strictly as presented in DSM-IV and ICD-10 see earlier), these rely on the ‘totting up’ of established criteria. This method is less used in organic medicine. Dr. Tombs acknowledged the rapid expansion of psychiatric diagnoses but, consistent with my own impression, pointed out that the details of many of these are unfamiliar to most psychiatrists. He estimated that a general psychiatrist would probably consult DSM-IV or ICD-10 about 6 times a year. He made the point that, so far as diagnoses are concerned, there are probably a relatively small number of major divisions, and the same goes for medication. The most significant division for psychiatry is between psychosis and the rest – i.e. neurosis and personality difficulty or disorder, the latter being subsumed under Axis II of DSM-IV, Axis I being mental disorders.

Attitudes of the three professional to alternative medicine

I asked Dr. Jordan the following:

Have you ever as a medical doctor treated someone with what you would consider to be alternative medicine? Or have you referred or recommended your patients to practitioners of alternative medicine?

Dr. Jordan

You're right to qualify the term 'alternative medicine.' I use it to mean any method that entails 'explanations' of the causes of disease and of the curative nature of the remedy, which are no more than blunt assertions, and a refusal on the part of the practitioner to submit these assertions to any form of scientific enquiry.

That said, I have never practised alternative medicine. (I have practised hypnosis, but ethical practitioners of that discipline are not averse to scientific enquiry and so I do not subsume it under the 'alternative' label, although many of my colleagues regarded it as 'fringe medicine' at best!) And I have never referred anyone to alternative practitioners. Indeed I have had occasion actively to dissuade patients from attending one such person. Over a period of four or five years he went from the universal diagnosis of mercury poisoning (*every* patient he saw was advised to have their mercury amalgam dental fillings replaced) to the equally universal diagnosis of 'intestinal candidiasis' (*every* patient he saw in this phase suffered from an 'allergy' to the 'thrush organisms we all carry in our gut') and thence to universal mineral deficiency (*every* patient had their his or her samples 'sent to America' for analysis, which *always* showed mineral deficiencies requiring dietary supplements). On any level this is plainly nonsense and it would be unethical to recommend anyone to such a practice.

Of course there are many well-meaning and undoubtedly ethical practitioners of alternative medicine: not all are outright charlatans like the example I gave above. But until their various cures and remedies are shown to be statistically more effective that conventional medicine – which includes the time-honoured method of allowing nature to take its course as with any self-limiting disease – they cannot be a referral option for any practitioner of modern orthodox medicine.

Dr. Kent and Dr. Tombs

Dr. Kent does not have a particular view on alternative medicine and confessed not to have studied much about it. However he did draw my attention to 'regret theory'. This is the idea that an important motive for choosing an unconventional treatment is to avoid 'regret': the patient tries it 'just in case' and later does not feel any self-recrimination for not having done so.

Dr. Tombs confessed that he was not very knowledgeable about alternative medicine (he understood that acupuncture may be useful for addictions and homeopathy as a placebo) but believed this would be of benefit to people with 'fear-based symptoms'.

BOOK REVIEW

Alternative Medicine Should we Swallow it? **Tiffany Jenkins, Anthony Campbell, Sarah Cant, Brìd Hehir, Michael Fox & Michael Fitzpatrick (Institute of Ideas). London: Hodder & Stoughton, 2002, ISBN 0 34084838 3. 82 + xx pages, £5.99.**

Reviewed by Sandro G. Masoni

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Contents: Preface by Claire Fox. Notes on contributors. Introduction. Complementary and alternative medicine: Some basic assumptions. Recycling old ideas for a new age. Therapeutic touch: Nursing irrationality. The best of both worlds? The surrender of scientific medicine. Afterword.

The Institute of Ideas has organised a good number of live debates and conferences on various issues. In collaboration with Hodder & Stoughton, the Institute has more recently produced a set of books designed – like its debates and conferences – for those who have a 'thirst for intelligent debate'. This book about alternative medicines presents so controversial a matter from different points of view, involving general questions as well as sharp detail. However, the prominent tone is a rather sceptical one. In my view, given the fact that claims by alternative practitioners still remain unproven, a more credulous tone would have been in contradiction to the notion of 'intelligent debate'.

The book makes, at least, several points clear. At the beginning of Essay One, for instance, Anthony Campbell expresses his aim to make explicit some basic assumptions that distinguish alternative from mainstream medicine. Campbell brilliantly analyses concepts like 'natural', 'traditional', 'holism', 'vitalism', and 'subtle energy', which all appear to have recently become commonplace. Most people seem to have forgotten that many modern drugs are plant derived: what is synthesised in laboratories today is, in many cases, the same substance - although less affected, it is hoped, by impurities – that once used to be extracted from plants. The concept of *natural* is even more questionable when used in another sense, to indicate an uncautiously supposed 'natural state of perfect health'. According to homeopaths like G. Vithoulkas, any therapeutic system should lead a person to the objective of a 'continuous and unconditional happiness', which is, I must sadly admit, far beyond what we may be expecting to achieve through routine scientific medicine. 'Holism' has to do with the search for the fundamental cause of each disease, which is thought to be found, we are told, in lifestyle, diet, and answers to emotive questions concerning each individual 'as a whole'. The funny thing is, Campbell points out, that most orthodox doctors see alternative medicine as a sort of palliative practice which does not tackle the causes of maladies; the two groups – we are to conclude – have very different ideas about what can count as a cause.

Essay Two by Sarah Cant pays attention to the social and cultural context in which the huge

success of alternative medicines has developed. In part, it is a matter of style; it has to do with making the patients feel comfortable more than it has to do with real health improvement through one (or some) of the 160 therapies on offer. It is the patients' need to express their own feelings that mainly counts, even more than the simple clinical outcome. Today's widespread 'healthism', along with today's notion of 'feeling healthy', call for some sort of recreational and aesthetic techniques that we can hardly imagine the National Health Service (NHS) would widely supply in the near future. This rather mellow way of viewing health matters leads to the perception of orthodox medicine as 'hard medicine', a rather severe and hazardous stuff.

Thanks to Brìd Heihr's Essay Three, we are informed that one category of personnel who work in hospitals, but who are not doctors, have at last an alternative medicine all of their own. Nurses in the USA, and, more recently, in Britain and some other lucky countries – administer this thing called 'Therapeutic Touch'. By the way, in Italy we have something called 'pranotherapy', a quackery that may seem much the same, but is actually practised by healers (not nurses) in their private studios. Nurses' Therapeutic Touch features some sort of amateur mysticism along with mundane manipulations, and is hardly consistent with what other people working in hospitals, i.e. doctors, rely (or should rely) upon. This is s contradiction that makes me feel uneasy, I must confess. Brìd Heihr soundly and clearly explains the dangers of this odd discipline.

Essay Four, by Michael Fox, is about the increasing presence of alternative practices among the services supplied by the NHS. Such a state of affairs is very likely to lead to an integrated system that, according to an optimistic opinion, will give us the opportunity to pick the best of each 'world'. Were patients to choose, they would already be integrated today. It is likely that soon they will be, however, and the UK is playing a leading role; there, common law allows anyone, even totally untrained people, to practice, and there are an estimated number of 22 million visits a year to practitioners of the six main alternative medicines. I was a little more surprised to read that homeopaths, osteopaths, reflexologists, acupuncturists, tai chi instructors, art therapists, chiropractors, herbalists and aromatherapists are already at work in primary care and even in some hospitals. I hope that, should the need arise, we shall be able to find a real doctor in so picturesque a crowd.

In Essay Five, Michael Fitzpatrick points to a 'loss of nerve' on the part of orthodox medicine, one he sees as part of a more general disillusionment with scientific expertise, and this he sees as a pre-eminent cause for patients to move towards various alternative practices. High expectations, sometimes concerning problems that could, to be honest, hardly be defined 'medical', have often lead, in past decades, to deep disappointment. Hence, the quest for alternatives on the part of the patients, and the increasingly conciliatory approach that an ever-growing number of insecure doctors apparently adopt. Sadly, the sympathy towards various alternative medicines among mainstream doctors not only is a way to keep in touch with the public, so to speak, but is also a symptom of a certain unawareness of basic scientific principles which affects even doctors themselves.

'Afterward' by Tiffany Jenkins summarises the contrasting opinion concerning two crucial themes, the explanations for the popularity of alternative medicines and the consequences of integrating them into regular medical practice. About the latter theme, it is maybe worth noting that not all the advocates of alternative medicine are in favour of such integration. For instance, some of them fear that the consultation time could be cut down, or the (supposedly) equal relationship between practitioner and patient – so precious and unique – could be lost. Regulation might also mean the scientific monitoring of the effectiveness of each discipline – and more than one could fail – as well as a loss of the transcendental aura that surrounds all the 'alternative' practices today. As for the orthodox doctors who oppose such integration, they fear that it would undermine or destroy important principles - scientific principles - that they see as a great triumph. So does yours truly.

All in all, an easy-to-read, thought-provoking book. The debate concerning alternative medicines surely must go on, and we all need it to be an intelligent one. Time will tell whether it is the case that the skeptics have too little faith in alternative medicines because they know too little about them, or the credulous are too cheerfully confident because they are the ones who do not know them well enough.

THE 'COMPENSATION CULTURE' AND 'NIMBYISM'

MICHAEL HEAP

In recent years much concern has been expressed about the growing tendency for people to seek financial redress, mainly through the civil justice system, for suffering that may be caused by the negligence and incompetence (and occasionally ill-intent) of responsible others. It appears that a broad definition of 'suffering' is being employed and critics protest that this now covers everyday annoyance, disappointment, upset, and so on. Likewise, it is averred that the definition of other-responsibility has been widened at the expense of personal responsibility (e.g. when someone sues for injuries incurred while trespassing or when sufferers of lung cancer sue the manufacturers of the tobacco that they willingly smoked). For other commentators, this is a healthy sign that justice, and fairness, and the accountability of those in positions of responsibility are now the rightful expectations of all concerned.

A related trend is for people to take preventative action when a property development, highway, residential facility, or whatever is planned in their locality that they perceive will adversely affect their quality of life. The feared effects may be very serious – e.g. a health hazard such as toxic waste - or some loss of amenity, such as a walk in the fields or even obstruction of a view of the countryside. Again this trend (popularly known as NIMBYism) is welcomed by some and

deplored by others as, for example, a manifestation of greed and selfishness.

The reader who has read my contributions in previous sections of this issue will correctly anticipate that my stance on both these trends is neither favourable nor pejorative. Instead I perceive that both developments are inevitable in an affluent society in which there is political, economic and social freedom and the continuous accumulation of knowledge and its beneficial application. Of particular relevance are the ever-rising expectations of the public that they have access to the increasingly diverse offerings of modern life, and that this is an entitlement and not simply a privilege.

That the 'compensation (or blame) culture' is indeed related to affluence is evident from the fact that leading the way is the most affluent society in history, namely the USA. (I emphasise this, as I have heard it said that these trends are the fault of the welfare state or socialism.) Moreover, looking back in history we see that the wealthy minority of the population showed no restraint in seeking redress for the slightest misfortune that they ascribed to others (usually their less fortunate fellow human beings); nor were they slow in guarding their enjoyment of their estates and property. Hence the modern retired middle class couple who oppose a housing development that would spoil the panoramic view from their newly acquired conservatory are only attempting what, in a previous age, the local aristocracy would have no problem in accomplishing.

It would be tempting therefore to say that the privileges of the minority have now become the entitlements (if not then the preoccupations) of the majority (cf. adultery, divorce, heroin, and holidays in Spain). However, the minority were always more inclined to perceive their opportunities as entitlements.

A more comprehensive analysis of these phenomena requires us to acknowledge the principle of interdependence previously expostulated: along with the above trends come the legal services with their own demands, their agenda of expansion and diversification, and their need to promote their own perceived authenticity. But more of that at another time.

I am very grateful to Arthur Kaufman for the following book review on the subject of 'The Compensation Culture'.

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BOOK REVIEW

Compensation Crazy: Do we Blame and Claim too Much? **Ellie Lee, John Peysner, Tracey Brown, Ian Walker & Daniel Lloyd (Institute of Ideas). London: Hodder & Stoughton, 2002, ISBN 0 340 84839 1, 74 + xx pages, £5.99**

Reviewed by Arthur Kaufman

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Contents: Preface by Claire Fox. Notes on contributors. Introduction. Compensation crazy: Do we blame and claim too much? The social costs of a compensation culture. The case for compensation. The compensation culture: A new legal perspective. Afterword.

The title *Compensation Crazy*, implying that some or too many of us have gone sue-happy, is immediately tempered by its sub-title, *Do We Blame and Claim Too Much?* thereby leaving prospective readers (a) wondering if they are on the slippery slope of suing one and all for all they can get or (b) thinking they are being deprived of what they are entitled to when things go wrong through no fault of their own.

The debate is both introduced and 'afterworded' by Ellie Fox, sociologist and editor of 'Debating Matters' *(a series of publications by the Institute of Ideas)*, although prefaced by the Institute's director, Claire Fox, who cautions against finding all our questions answered within the 74 pages of lively and informative text. This is somewhat of an understatement given the nature of the arguments, ranging from the morality of compensation itself to the legal technicalities involved. In her Introduction, Ellie Lees gives a helpful overview of the issues, summarising same areas of agreement and disagreement between the contributors. She also discusses what lies behind terms such as 'torts' or 'duty of care' and the needs of society in relation to those of individuals who are demanding compensation for injuries sustained at work or, when simply going about their business, they are, say, mowed down by a drunken driver.

Lees helpfully explains legalistic thinking behind the concept of 'fault', which is often not as clear-cut as laypersons might assume. For example, 'For a claim to succeed it must be proved that the defendant was in a sufficiently proximate relationship to the plaintiff so that the defendant could reasonably foresee the consequences of his actions to the plaintiff…..Fellow road users are considered to be in a proximate relationship with one another, as are doctors and their patients.' However, it also seems that 'Exactly what constitutes a proximate relationship is decided on a case-by-case basis' and has been 'redefined by successive generations of lawyers', something that most readers will not find surprising.

In the opening essay, which bears the title of the book, John Peyser, a solicitor and Professor of Civil Litigation at Nottingham Law School, first looks at the question 'Are claims increasing?' Surprisingly, he starts by saying there is no easy answer.

One example of this 'surprise' is that, while claims for personal injury may be increasing, the actual number of cases ending up in Court 'has rapidly fallen.' Fortunately, Professor Peyser reminds us of the recent reduction of available legal aid which, together with the settlements reached behind the cloak of 'commercial confidentiality', helps in explaining the apparent anomaly in the rise in litigation while as much as possible is kept well away from HM judges.

He also reminds us, 'lawyers have always been as expensive as emergency plumbers' but that the former's repairs take longer, to which he might have added that in the case of the plumbers there is a reasonable prospect of being left high and dry whereas with lawyers there is the risk of ending up 'dry' albeit not particularly 'high'.

Professor Peyser also focuses on the phenomenon of the Claims Management Companies and the worries over being overwhelmed by an American style culture of compensation, although he emphasises that the jury version of deciding damages in the USA is distinctly different from that in the UK where judges and not juries deal with civil matters, including personal injury.

Other aspects of compensation, such as claims that are brought against various government agencies, the National Health Service (NHS), the 'no fault' model and claims arising from disasters, are discussed in some detail. Peyser ends by saying that our system of compensation, with all its drawbacks, constitutes a reasonable compromise, albeit one which needs a 'constant and informed' critique and 'not a knee-jerk cry that we blame and claim too much'.

The second essay is by Tracy Brown, a risk analyst who has worked with companies and institutions faced with problems of litigation and who has been an outspoken critic of the increasing trend of 'litigation avoidances' and legal-defensive practices within organisations. She takes the view that Britain is 'in the throes of a compensation culture' with posters and business cards of personal injury lawyers being displayed even in Accident and Emergency Departments, not to mention claims brokers who remind us that 'where there's blame, there's a claim'.

The result is that many British organisations, including large companies and local authorities have set up still growing legal departments to handle claims and complaints that could result in claims. Another result is that many organisations are limiting the range of activities offered while introducing litigation avoidance services, even counselling for trauma experienced at work.

Ms. Brown reminds us that most large organisations prefer to settle cases that they would otherwise have a reasonable chance of winning. In such instances the cost of success can far exceed that of early settlement. Besides, disposing of troublesome, albeit weak, claims may avoid potentially unfavourable publicity. Moreover, many claims are now settled by what she describes as 'quasi-legal' services, such as mediation or

'brokering' through trade unions, with the number of such services rising exponentially. Not only does this increase claims while steering clear of the courts (as well as gaining greater flexibility where legal principles are concerned); it also results in an 'erosion of informality' whereby conflicts and problems once dealt with in the normal course of human relationships have now become a matter of professional intervention, with all that this implies.

Her concluding sections, 'The effects of the compensation culture' and 'Why compensation claiming is not social justice', -are concerned with how litigation is altering the ways people organise and behave in terms of their relationships with others and within their social networks and, in effect, how they interact with one another, bearing in mind how claims for compensation are evolving. She argues that the compensation culture can be an impediment to 'social justice' since claims are undertaken for the benefit of individuals without having to bother about the 'bigger picture.' Is it right, for example, to withdraw a play service for children because of an unexpected and chance accident to one child? For Ms. Brown, the so-called 'social justice' aspect of compensation has failed in that it is neither a means of improving justice nor even an effective way of redistributing wealth.

For his part, Ian Walker, a Senior Partner in a law firm's personal injury department, makes no bones about all the good he and his legal colleagues do in pressing for compensation for clients injured through no fault of their own. He opens his case by asking the reader to imagine that he or she is suddenly struck down from behind by a car and sent flying into a lamppost, and is not only left badly injured with two fractured legs plus an 'unimaginable amount of pain' but after several months convalescence is still in pain, with a limp and problems of employment, all because of a driver who was speeding while under the influence of alcohol.

Mr. Walker also provides other examples that on the face of it seem to justify the assertion that seeking proper compensation for injuries incurred -including psychological injuries arising from stress at work -is a wholly right and reasonable way of seeking redress.

He goes on to claim that the debate over the compensation culture 'has become distorted by what are seen as "fringe actions" for damages' and he ventures to suggest that 'those people who are in the forefront of the clamour against a "blame culture" and a "compensation-driven society" would not hesitate to bring a claim' if they felt justified in doing so. He also pulls no punches in saying, 'The level of hypocrisy in this debate has now got really got out of all proportion'. This seems to suggest that those with opposing arguments have got it all wrong or are entirely to blame for all the fuss over blaming and claiming too much.

He further argues that claims for compensation will fail unless negligence can be established. This is true for claims of clinical negligence, which can be very difficult to prove. He also joins the social side of the debate by asking why innocent victims of a doctor's negligence should be in a different position from that of the road accident victim as already described. In both instances the person harmed is entitled to be compensated and to argue otherwise is 'frankly, ludicrous'. He thereby seemingly reinforces his position on the 'level of

hypocrisy' of those who would take issue with his views.

In discussing these and other issues relating to common law (which 'exists to ensure that we are all held accountable for our actions'), Mr. Walker wonders, 'Why, therefore, is there any debate at all?' when it comes to compensating victims for injuries where somebody or some organisation is at fault. He goes on to cite some examples, such as what would happen if we drove our cars as though it did not matter if we negligently hit pedestrians or other vehicles.

Despite his apparent dismissiveness of opposing views, Mr. Walker reminds us that in many serious cases of personal injury the damages for the actual trauma may be only a small percentage of the overall award and he describes several cases where 'no one would believe 'that the money received in compensation was worth the suffering involved. He also indicates that more claims are now being brought at a higher level than 20 years ago, not because people are financially motivated (does this apply in all cases?) but for many other reasons. Amongst his concluding remarks are 'People do not rush off to lawyers every time misfortune befalls them. They rush off to lawyers every time their rights are infringed.'

In the fourth and final essay, Daniel Lloyd, a barrister currently involved in organising a conference on the Human Rights Act, examines what he calls the' types of new claims ' being made for compensation, namely claims that could not have succeeded in the not-so-distant past. He also examines what legal issues have arisen as a result of such claims and how the law has attempted to address them. He follows this by offering his own views on how problems of the compensation culture might be resolved.

Mr. Lloyd starts off with a lively comment on the opportunities that the 'new' sorts of claims have opened up for some of his legal colleagues: 'Today, for plaintiff lawyers, the law of tort is a wonderful place of fantasy and adventure where the law is a laboratory for experimentation with new kinds of claims.

For example, the Ministry of Defence is being sued by soldiers who have served in various theatres of war, because they were not properly prepared for the horrors of war, one case even having been brought for damaged hearing due to artillery. Another example given is that of a woman who sued Durex because she became pregnant when her partner's condom broke!

There is also the problem that unelected judges are being put in the' paternal' position of deciding if and how much public money {from taxpayers) is to be allocated for claims of medical negligence where the NHS is concerned, not to mention the increasing trend for doctors to practise defensive medicine because of the greater likelihood of being sued compared with years gone by. This raises the question 'Are doctors more negligent than they have been in the past?' Added to this is the matter of money in that - 'Lawyers would appear to be taking their pound *{should this be pounds x lots?)* of flesh. In two-thirds of claims for less than £50,000, the amount claimed by lawyers in legal costs exceeded the amount of compensation awarded.'

Mr Lloyd also points out how the law has been 'stretched' in that 'liability has expanded' in

terms of what can be regarded as ‘reasonably foreseeable’. In other words, matters have now reached the point where in some instances individuals should not have to accept the consequences of their own actions even though they would have been aware of the risks beforehand. In other cases, group actions have been brought against holiday operators for wrongs over which the operators could not have any conceivable control.

On top of all this are the increasing amounts of damages awarded and changes in the law that make it easier to bring claims for compensation and therefore more likely that these will continue to rise. Nevertheless, Mr. Lloyd cautions against blaming parts of the judiciary for the present situation, as he considers they should be viewed as ‘reeds breaking in the wind’ and, in relying mainly on judges to hold back the tide, ‘the law will continue its path towards creating an indeterminate liability to an indeterminate number of people’.

Mr. Lloyd ends his essay by proposing, ‘Parliament should address the question of what kind of harm should be compensated for. ‘After all, it is not fair to expect judges to resolve this matter on their own, as they are there to interpret laws and not make them. They are also in the position of having to assess expert opinion on a 'case-by-case' basis without any ‘clear guidance from statute.’

He also recommends that Parliament should deal with the question of damages along with ‘reasonable foreseeability and proximity, the concepts that lie at the heart of the law of negligence.’ Although he feels that ‘Parliament is much better placed to give guidance on these questions than a lone judge sitting in court’ the sceptical reader might feel just a little uneasy over there being so many MPs in the House of Commons {as well as in the ‘other place’) who just happen to be lawyers. Or does it all came down to being a matter of the 'devil you know' where compensation and costs are concerned?

Ms. Lee's 'Afterword' emphasises that the contributors to the book have had to deal with the problem that discussions about compensation by solicitors, academics, professional bodies, insurers, and health care workers are often disconnected from one another, which may help to explain, for example, why there are complaints about how legal practice is conducted. She rounds off the book by summarising the opinions of the contributors and acknowledging that the issues raised present difficult questions for future policymakers in understanding the implications of compensation and its impact on society.

Perhaps part of the problem, at least where medical negligence claims are concerned, -is that lawyers are the instrument by which the doctors are sued, sometimes for decisions that have to be made quickly in difficult circumstances. It also seems more likely than not that there are now many more specialist lawyers to bring actions against doctors than there are lawyers specialising in bringing claims against other lawyers for damages arising from litigation-induced stress if nothing else.

The volume itself is very readable with good explanations of legal concepts and technical points. It should interest all those with a 'bee in their bonnet' about how well or how badly the law and the 'quasi-legal' systems of compensation perform and whether or not they

are evolving for better or for worse. While it is not likely to convert those whose opinions are more or less fixed, it may give them just a modicum of food for thought, which is perhaps all one can hope for in the present climate.

SPECIAL FEATURES by 'Skepticus'

THE WESTERN WAY OF ILLNESS

I have gradually succumbed to what people earnestly tell me is a very serious malaise. Colleagues and friends inform me that I and others so afflicted should seek medical help immediately. However, we all appear to be 'in denial' or at least to be affecting a complete indifference to our plight.

I shall **not** be consulting a doctor about it; neither will any of my fellow sufferers.

No X-ray photographs nor any scans will be taken of my head or body; no pathologist will be called upon to examine my blood, sputum, vomit, urine or stool.

Not a single orifice of my body will be required to grant admittance to any liquid, tablet, capsule, powder or length of tubing. The keenest of surgeons will be denied access even to the innermost of my organs. Consequently, I shall not have to wait interminably for the privilege of their attention, neither shall I be wracked by the dilemma of whether to 'go private'.

By the time the Diagnostic and Statistical Manual of the American Psychiatric Association has reached its tenth version, and every human difficulty and eccentricity has been classified, labelled, codified, and deemed to be the sole property and responsibility of the psychiatric profession, my own affliction will remain overlooked.

No academic journals devoted to the study of this disorder will be gathering dust on the shelves of our medical libraries. No equivalent learned societies will be founded. Researchers will not be boarding aeroplanes destined for exotic places to attend conferences on 'the latest findings' on this problem.

No-one will be jolted out of his or her bed by an announcement on Radio 4's 'Today' programme of 'a major breakthrough' by scientists in the treatment of this problem (coincident upon their applying for a renewal of their research grant). Nor will it be announced that they have now 'discovered a gene for it'.

No national organisation of sufferers of my condition will be founded; hence no member of the Royal Family who has yet to fall into disrepute will be invited to be Patron of such.

Lawyers need not excite themselves. Neither I nor my fellow sufferers have any intention of suing a single doctor or health trust for negligence; neither shall we be claiming compensation from the electricity board, the water companies, the nuclear power industry, the Ministry of Agriculture or the local gas

works. We shall **not** be demanding 'A Public Inquiry'.

No healing hands will be waved around us or laid upon us, nor will they massage our bodies, stroke our heads, pummel our feet, manipulate our spines, swing pendulums above us, pass crystals over us, stick needles into us or douse us with fragrant oils.

We shall not be regressed to our childhood, nor to our previous lives, nor progressed to our future lives.

'Experts' will not be called upon to remedy our condition by instructing us on how to stand, sit, lie down, breathe, or have sex, nor where, when and how to perform any of our bodily functions, nor in what ways we should and should not enjoy ourselves.

The local Lions club will **not** be holding a head-banging marathon to raise funds to send any of us up the Zambesi River for snake venom treatment.

I, for one, have experienced little difficulty in resisting any temptation to travel to Lourdes.

No celebrity will be persuaded to come on breakfast television to give us a moving account of his or her battle to overcome this disorder; no equivalent best selling book will appear, nor any serialisation in the Sunday Times colour supplement, nor any film of the same name.

Needless to say, there is no risk of any epidemic of this affliction. Indeed, a remarkably immunity to this malaise is shown by all those who work in the health and the social services and by politicians, trade unionists, journalists, sports people, religious leaders and anybody who has anything to do with the legal profession.

The illness from which I am suffering is characterised by a complete inability to take anything seriously any more. Any suggestions as to how my fellow sufferers and I may overcome this affliction will be treated with overwhelming indifference.

PICKING THE TEAM
A One Act Play

Dramatis personae: Mr. Roger Flannel and Ms. Maggie Skirt, Health Service Administrators
Mr. Sid Groper, Health Service Storekeeper

Scene: The storeroom of Mr. Groper. Mr. Groper is at his counter. Enter Mr. Flannel and Ms. Skirt

Mr. Flannel *(to Mr. Groper)* Are you Mr. Sid Groper?

Mr. Groper Yes squire. What can I do you for?

Mr. Flannel I am Roger Flannel, acting co-chairperson of the District Mental Health Executive Committee's *ad hoc* Steering Group on Financial Planning Implications of Staff Developments.

Ms. Skirt And I am Maggie Skirt, assistant secretary to the Unit Managerial Committee's Executive Working Party's Task Force Study Group on Multidisciplinary Teamwork.

Mr. Flannel We've decided to set up a Multidisciplinary Mental Health Team. Can we order one from you?

Mr. Groper Certainly Sir. Do you have anything particular in mind?

Ms. Skirt Yes, we-----

Mr. Flannel -----We've had a number of meetings over the last three years and we have formulated a viable strategic framework for implementation *(hands Mr. Groper a scrap of paper).*

Mr. Groper Now then, what have we got here? One gentleman in a suit, one fat lady, a young man with a beard, and a girl with a ring through her nose.

Ms. Skirt *(glaring at Mr. Flannel)* I should explain that our budget has been cut five times since we started the project.

Mr. Groper *(scratching his head)* Well, I suppose you have the basic essentials But we're looking at a rather outmoded model here. I'm afraid I don't touch this kind of thing anymore *(hands paper back).*

Mr. Flannel Sorry to trouble you. Good-bye!

Ms. Skirt No, wait! Have you any suggestions?

Mr. Groper Well let's see. You'll want a psychiatrist of course.

Ms. Skirt Yes. Have you got any in stock?

Mr. Groper We've just got one in at the moment.

Mr. Flannel Where is he?

Mr. Groper *(looking at his watch, and in a solemn and apologetic manner)* I'm sorry, sir, he's been delayed, but we are expecting him any minute.

Ms. Skirt Oh good! Now have you any psychiatric nurses?

Mr. Groper We always have plenty of those in stock.

Mr. Flannel One psychiatric nurse then.

Ms. Skirt Make that two. Now, what about a social worker?

Mr. Groper We've just got a special one in today. She's a *community* social worker.

Mr. Flannel What's a *community* social worker?

Mr. Groper It's a social worker with an attitude.

Mr. Flannel *(strikes forehead)* Just what we need!

Ms. Skirt Have you any occupational therapists?

Mr. Groper We've only one in stock.

Mr. Flannel What's she called?

Mr. Groper *(looking at catalogue)* Let me see. Doris.

Ms. Skirt Haven't you got one called Fran or Liz?

Mr. Groper *(studying catalogue again)* I tell you what. We've got one called Wanda

Mr. Flannel
} Wonderful!
Ms. Skirt

Mr. Groper The only trouble is, she's not an occupational therapist.

Ms. Skirt What is she then?

Mr. Groper She's an art therapist.

Mr. Flannel What's the difference between an occupational therapist and an art therapist?

Mr. Groper Nothing that's going to be of the slightest consequence, sir.

Ms. Skirt Good! We'll have Wanda the art therapist then. *(Mr. Flannel starts showing signs of agitation.)*

Mr. Groper No problem. And I'll throw in Doris for you every other Tuesday.

Ms. Skirt Have you got a psychologist as well?

Mr. Groper *(looks puzzled)* I beg your pardon?

Ms. Skirt A psychologist.

Mr. Groper *(still puzzled)* What do you want him to do?

Mr. Flannel We want him to turn up.

Mr. Groper *(shakes head)* Oh dear! I haven't had one of those in for a long time. *(Checks catalogue)* I'll tell you what. I can go one better for you.

Ms. Skirt
} Yes?
Mr. Flannel

Mr. Groper We've got a special one in. He *never* turns up.

Ms. Skirt Really?

Mr. Groper Mind you - he'll cost you more.

Mr. Flannel *(strikes forehead)* Oh dear!

Ms. Skirt OK. One psychologist who never turns up.

Mr. Groper *(to Mr. Flannel)* Well, it's better than not having one at all, isn't it sir?

Mr. Flannel *(with a sigh)* I'd never have thought of it like that. I suppose that will be all we need now.

Mr. Groper Well, you'll want a chiropodist, of course.

Mr. Flannel A chiropodist? Why would we want one of those?

Mr. Groper Sir, you'd be amazed how much mental illness is caused by bad feet.

Ms. Skirt *(getting more excited)* One chiropodist!

Mr. Groper That should please your dance therapist.

Mr. Flannel *(with alarm) Dance* therapist?

Mr. Groper *(jotting it down)* One dance therapist. And of course a music therapist.

Mr. Flannel *(with more alarm)* A *music* therapist?

Mr. Groper Well, if you're having a dance therapist you're obviously going to need a music therapist aren't you?

Ms. Skirt *(with great enthusiasm)* Naturally. One music therapist please.

Mr. Groper And a drama therapist?

Ms. Skirt Indeed!

Mr. Groper So obviously you'll need a speech therapist

Ms. Skirt *(triumphantly)* One speech therapist.

Mr. Flannel *(with great agitation)* But....but....but....

Mr. Groper Now, can I introduce you to our completely new range of therapists? No multidisciplinary team these days should be seen to be without them *(studies catalogue).* We've got a herbalist, a homeopath, an osteopath, an acupuncturist, a healer, a reflexologist, a hypnotherapist, an aromatherapist, a crystal therapist, a colour therapist, a massage therapist, a beauty therapist.....

Mr. Flannel *(mopping brow)* But wait! Aren't all these people...um....er....well.....quacks?

Mr. Groper Sir. All therapists are quacks, but some quack louder than others.

Mr. Flannel That's it. No more! *(To Ms. Skirt)* Let's cut our losses and run!

Mr. Groper If you insist. Let's see what we've got. One psychiatrist as soon as he comes, one psychologist who never turns up, two psychiatric nurses, one community social worker, Wanda the art therapist, Doris the occupational therapist (every other Tuesday), one chiropodist, one dance therapist, one music therapist, one speech therapist and one drama therapist. Ah! We seem to have left out the most important person.

Mr. Flannel Who's that?

Mr. Groper A business manager!

Mr. Flannel utters a shriek and collapses into Ms. Skirt's arms

CURTAIN

VISIONS OF THE YEAR 2003

By

The Grand Oracle of the Pentacles

Following the stunning success of her predictions for 2002 (see last year's *Skeptical Intelligencer* the Grand Oracle of the Pentacles has once again presented the Editor with her predictions for the New Year, that have come to her as visions during the last seconds of the old year. As usual, the Oracle wishes readers to bear in mind that her predictive powers do not operate strictly in accordance with the solar year and some of her visions may extend into 2004……

PROLOGUE

Family, friends and strangers draw together
To make once more a gladsome noise, and greet
The New Year's coming. Yet my soul must steal
Away and rise above this joyful scene
Into the cold clear night, to soar above
The fields and shining roofs, onward and up
To seek the awful silence of the void
And there await the visions of the dawning year.

THE VISIONS

At the junction of two great waters.
The earth trembles. A bridge is destroyed.
Those who heeded not the warnings
The deadly fire consumes

The lands where the old kings once ruled
Now rue their common enterprise.
Disappointment and recrimination! Across the water
The old lady smiles and keeps her distance.

Where the mighty eagle once was held aloft
With haughty pride, great fear now looms.
The bearded one earns some gratitude,
While the hairless leader fades.

In a great city (the letter B)
Hope returns. Great joy for those numbered 11.
Elsewhere, shots ring out in a crowded scene,
The one who wears the hat is spared.

In summer comes great hope for those in pain.
Lo! A grieving widow and a rescued child.
As the year grows old, the noise of guns subsides
Relief for the two who gambled.

Now fade the visions, as distant song and laughter
Steal once more upon my senses. In the gathering mists,
The man in white bids his last farewell,
As, ever louder, chimes the dawning New Year's bell.

EPILOGUE

Let those who, by these prophecies, great riches seek
By chancing on the fate of man and beast
On three renowned pastures, now take heed.
What sounds like fire, silver and gold may be.
A river so described, in a garden do we see.
And that which can be worldly wise, so do the bird and bee.

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ASKE is an association of people who support the following aims and principles:

- ASKE is committed to the application of rational, objective and scientific methods to the investigation and understanding of ideas, claims, and practices, especially those of an extraordinary and paranormal nature.

- ASKE is committed to challenging the uncritical promotion of beliefs and claims which are unsupported or contradicted by existing objective and scientific knowledge.

- ASKE opposes the misinterpretation and misrepresentation of science for purposes which deceive the public.

- ASKE supports the objective evaluation of all medical or psychological techniques offered to the public and opposes the uncritical promotion of techniques which are unsupported or contradicted by existing scientific knowledge.

- ASKE supports all efforts to promote the public awareness of the rational and scientific understanding of extraordinary and paranormal claims.

- ASKE is committed to a rational understanding of the reasons and motives which underlie the promotion and acceptance of irrational and paranormal claims and beliefs.

- ASKE accepts the rights of individuals to choose for themselves their beliefs about the world.

Membership of ASKE costs £10 a year, which includes a subscription to the *Skeptical Intelligencer*. For an application form, or further information, contact The Secretary, ASKE, P.O. Box 5994 Ripley DE5 3XL. See also the ASKE website at: <http://www.aske.org.uk>, which also includes details of the ASKE Challenge.

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