Integrating homeopathy and biomedicine: medical practice and knowledge production among German homeopathic physicians

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Abstract

The purpose of this study is to assess the ways in which homeopathic physicians deal with the conceptual tensions between homeopathy and biomedicine. The data-collection included twenty semi-structured interviews which were conducted with homeopathic physicians in Berlin. Three distinct patterns of homeopathic practice emerged from the data: a) segregating the patients into categories of homeopathic and biomedical patients; b) complementing a predominantly homeopathic practice with a few biomedical strategies for diagnostics; c) focusing on homeopathy and condemning biomedicine with the exception of emergency medicine and surgery.

On the level of medical knowledge the physicians’ perspectives on the efficacy of homeopathy and some of its controversial concepts (opposition to vaccinations, miasm, vital force) are examined. It also becomes evident that German homeopathic physicians do not sacrifice central aspects of homeopathic concepts in order to gain legitimacy.

Finally, it is argued that complementary medicine and alternative medicine are both rather unfortunate terms for studying homeopathy in micro-sociological settings. Heterodox medicine is favoured.

Keywords: homeopathy, alternative medicine, heterodox medicine, medical knowledge

Introduction

There is increasing evidence for a change in the medical scenery in the last 20 years. Non-biomedical practice has become more significant and more accepted among the public (Fisher and Ward 1994, Eisenberg et al. 1993, MacLennan et al. 1996, Matthissen et al. 1992) and within the medical profession (Haltenhof et al. 1995, Tovey 1997, Knipschild et al. 1990, Verhoef et al. 1995).
Physicians combining biomedical and non-biomedical modes of treatment have not thus far stimulated extensive social scientific research. This is surprising since it is particularly physicians practising non-biomedical modes of treatment who can benefit greatly from the increasing popularity of heterodox medicine (Schepers and Hermans 1999). It seems as if there is more concern with the separation of medical areas than with their overlaps within the sociology of health and illness. May and Sirur (1998) studied physicians practising both homeopathy and biomedicine within the NHS. These physicians noted an improved relationship with their patients and the availability of remedies without side-effects as positive aspects of homeopathy. For them, however, biomedical theory and practice remain unchallenged, and they hardly mention homeopathic concepts in their study.

Another line of research analyses developments in the theoretical framework of professionalisation. Professional groups aspire to construct a monopoly in their domain, which is established on the basis of specific expertise, state recognition and market position. Strategies of social closure serve to maintain this monopoly, which is also realised in the self-regulation of all professional matters by professional organisations and the standardised teaching of monopolised knowledge. The development of the medical profession often serves as a paradigm of successful professionalisation (Freidson 1970). Saks (1992, 1995) applies this perspective for studying the relationship between biomedicine and heterodox medicine in Britain. He shows how acupuncture was completely rejected at first, but has gradually gained legitimacy within biomedicine since the late 1970s. Acupuncture was adapted to biomedicine by separating it from its theoretical framework within Chinese medicine and allocating it to the narrow area of pain therapy. Acupuncture’s effectiveness was explained scientifically: inserting needles releases endorphins and alleviates pain in this way. In parallel to this growing acceptance, non-medical acupuncturists continued to be attacked for their lack of biomedical training (Saks 1994). This is interpreted as an attempt by physicians to preserve their dominance in health care by incorporating acupuncture in a modified form and subordinating it to their authority (Saks 1994). Cant and Sharma (1996) focus on the consequences of professional strategies in relation to homeopathic knowledge and training. They observe increasing standardisation and formalisation in education which had previously been rejected in homeopathy. Medical and non-medical homeopaths isolate controversial aspects from their homeopathic concepts. The premise of the individuality of each single case, the extensive taking of case histories and the concept of the vital force are losing significance. The publication of an anti-vaccination booklet has been stopped, in order not to threaten public acceptance of homeopathy. Homeopathic organisations no longer present homeopathy as an alternative to biomedicine, but rather as a means of complementing biomedical treatment. They aspire to scientific evaluations of efficacy and precise mechanism of homeopathic remedies. Cant and Sharma offer a rich study of changes in homeopathic knowledge in Britain. The
results, however, cannot be easily transferred to medical practice. It is possible that public representation and medical reality diverge.

These studies from Britain show a certain relationship between biomedicine and heterodox medicine. Isolated heterodox techniques (homeopathic remedies, acupuncture) are incorporated into the therapeutic arsenal, while the dominance of biomedical concepts remains unchallenged. The lesson from Britain seems to be a biomedicalised, fragmented version of heterodox medicine which is absorbed and whose potential challenge to biomedicine is thus tamed. Physicians’ reactions to heterodox medicine may take other forms. Their gravitational centre might be on the biomedical or the heterodox side of the equation. The first such form is outright rejection, this being the dominant form until the late 1980s, as clearly reflected in the BMA report from 1986 (BMA 1986). A less hostile approach would be to keep practising biomedicine, while referring patients to heterodox practitioners. This is illegal in most European countries and medical doctors risk severe sanctions from their professional organisations for co-operating with non-medical practitioners. A third possible approach is a rather hybrid medical practice in which biomedicine is practised alongside heterodox medicine. There might be overarching meta-theories of biomedical or heterodox provenance determining which medical system to use in which case. A rather consumerist approach, with the patients deciding how they want to be treated, is equally possible. Finally, it is also likely that some physicians ‘convert’ more or less completely to heterodox medicine and only use few – if any – biomedical strategies. This study attempts to show which of these forms are the most prevalent among German homeopathic physicians.

Little research has been conducted on German physicians practising heterodox medicine, even though Germany is said to be more open to it than other European countries (Cant and Sharma 1999: 174). Degele (1998) analyses the pressure on medical homeopaths in the German health care system. For economic reasons, classical homeopathic strategies are hard to uphold within the system of German public health insurance, especially the taking of time-consuming case histories and the subsequent therapeutic decisions. Degele predicts that homeopathic physicians will be compelled to choose between modifying homeopathic concepts in order to alleviate this pressure (shortened case histories, prescription of drug-combinations) and leaving the public insurance system to open up a privately run practice.

Homeopathy is widely used in Germany. There are a large number of Heilpraktiker\(^1\) practising homeopathy. In addition, it is estimated that some 16,000 physicians are using homeopathy, 3,000 of whom hold the occupational name ‘homeopathic physician’. The three-year-course for this title is organised by the organisation of homeopathic physicians (Degele 2000). Homeopathic physicians’ practice appears to be particularly well suited for studying integrational patterns of heterodox and orthodox medicine, since the conceptual differences between homeopathy and biomedicine are exceptionally sharp, and produce a significant challenge to physicians’ efforts to
integrate them into one system of medical practice. There is hardly any common ground shared by homeopathy and biomedicine. Every single aspect of medical knowledge and practice is conceptualised in an entirely different way. Theoretically, homeopathic remedies should produce the very symptoms in a healthy human being which they eliminate when applied to a person with a particular disease. Remedies are described in terms of symptoms, which should resemble the patient’s symptoms as much as possible. This principle of *similia similibus curentur* (like cured by like) is the central strategy in homeopathic healing. A regulating, health-preserving and immaterial entity – the vital force – is the most important point of reference in this process. Its weakening causes illness. Pharmacology can be said to be the most controversial area of homeopathy. Homeopathic agents are diluted until there is not a single molecule left in the final product. This is done gradually through vigorous shaking, so that the ‘spirit’ of the remedy is preserved and becomes therapeutically useful. This process is called ‘potentising’ and ‘dynamising’. Higher potencies (i.e. more diluted remedies) are thought to be more effective than lower potencies. All these strategies are foreign to biomedicine and there seems to be no area of convergence between the two medical systems.

This study is not primarily concerned with the issue of whether an integration of non-biomedical modes of treatment in the health care system is taking place, but of how it unfolds on the micro-level of medical practice. How do the conceptual tensions between homeopathy and biomedicine influence homeopathic physicians, and how do they attempt to resolve them in their day-to-day practice? The analysis of medical practice will focus on the use of several elements of biomedicine and homeopathy and on criteria for these medical decisions. Medical knowledge will be examined similarly. What are the ways in which medical legitimacy is established and what are physicians’ attitudes towards particularly controversial aspects of homeopathic knowledge? Finally, the findings will be used to disentangle terminological debate and to discuss previous suggestions in this field of sociology.

**Methods**

The application of semi-structured interviews – including a flexible handling of open-ended questions – seemed most promising for the purpose of this study. The interviews were conducted between July and September 1999 in Berlin. In 1999, 105 physicians holding the occupational title ‘homeopathic physician’ were listed in the Yellow Pages. Forty-two of them were randomly selected, mailed once and asked to participate in this study. This led to 20 interviews, which lasted between 30 and 75 minutes.

Half of all participating homeopathic physicians worked within the public health insurance system, while the other half ran privately organised practices. The distribution of homeopathic physicians within Berlin was uneven
as the majority of clinics were set in wealthy suburbs. This is representative of the situation in Germany and hardly surprising, since patients from poorer areas can be expected to be less willing and/or able to pay for their medical services out of their own pockets. Homeopathic clinics in Berlin were even more unequally distributed between former East- and West-Berlin. Only one participating physician ran a practice in former East-Berlin. This too is representative and can be explained by the socio-economic conditions of the patients and the low prestige of heterodox medicine in the health care system of the German Democratic Republic.

In addition to all these geographical and socio-economic features, there was a strong gender effect in the practice of homeopathy. Seventy per cent of the participants were female, while the proportion of women in the total of the homeopathic medical profession in Berlin was 73 per cent. Whether this indicates, that homeopathy is a ‘feminist form of medicine’ (Scott 1998: 191) cannot be answered here.

The interviews were audio-tape-recorded and transcribed. A system of codes and categories was developed for the material in accordance with Mayring’s (1988) method of qualitative content analysis. Further interpretative tools included cross-case analysis as well as individual analysis. Afterwards, this text was written up and sent to the participants in order to find out whether they agreed with the interpretation and their categorisation under the typology given below.

Medical practice – integrating biomedicine and homeopathy

At a conceptual level, homeopathic and biomedical strategies appear to be mutually exclusive. This paper will show how homeopathic physicians deal with the resultant conceptual tension, and how they navigate this medical pluralism within their own clinics. Several patterns of integrating homeopathy and biomedicine emerged and these have been developed into a typology of the ways in which physicians combine the two systems.

Type I – Segregating patients
Both homeopathy and biomedicine play important roles in this first type of clinic. The physicians adopting this position categorise their patients as either ‘homeopathic’ or ‘biomedical’ patients. A certain number – usually the majority – are treated exclusively with biomedical means, while 20 to 30 per cent will receive homeopathic treatment. The respondents related this strategy to the history of their clinic. Just a few years ago, they took it over from physicians who practised biomedicine exclusively. The patients remained the same and were familiar only with biomedical treatment. As newly-introduced physicians they had to be prepared for a majority of patients who were at best indifferent to, at worst disapproving of, homeopathy. Since then, the proportion of homeopathic patients has been growing, and a gradual
further increase of this kind of patient is anticipated by physicians. They advise biomedical patients for whom they deem homeopathy would be especially beneficial to give it a try:

My predecessor was not in favour of natural medicine at all. So the patients’ attitudes are the same. You cannot suddenly sell them homeopathy, when the predecessor told them, that it is all humbug. So you have to proceed with some diplomacy and cleverness. You propose it to some people: ‘Do you want to try something different?’ They have already realised they are not getting better with biomedicine and then they are ready to pursue a different path (physician 2).

Newly-acquired patients are more likely to be interested in homeopathy than those who have already been treated by the predecessor:

P§: In the long run, it [the proportions of the patient-categories] will change automatically, to more homeopathy. It all depends on how good you are and how much success you have.

R: So new patients are more likely to be homeopathic patients?

P: Yes. Some of them read ‘homeopathy’ on the sign outside and want it for themselves (physician 2).

The patients’ request is the most important criterion for allocation to orthodox or homeopathic treatment. Some come with an explicit preference for homeopathy, others will be attracted during the treatment. Another group of patients demands biomedical treatment and will be assigned to this category.

Apart from this emphasis on patients’ wants, diagnosis is an important criterion for categorising. It marks the beginning of treatment and determines further procedure. The biomedical strategy of diagnosis is framing the treatment and can possibly lead to homeopathic therapy.

I start by diagnosing and then I decide the mode of therapy. So I only decide then, after taking a good look, which type of therapy I choose (physician 1).

Diagnostic procedures are applied to clarify the patient’s disease – the central entity in biomedical concepts. Once it is known, it leads to certain therapeutic choices according to the patient’s categorisation, as long as he/she has not expressed a preference for some particular mode of healing. Physicians of this type advise homeopathic treatment when they decide that homeopathy is more effective for certain complaints, including increased susceptibility to infections, chronic, non-life-threatening diseases like eczema, allergies, asthma and psychosomatic conditions. Biomedicine is preferred for high blood pressure, heart-attacks or tumours.
In the course of the treatment, the therapeutic success of the respective medical system becomes an important criterion for further treatment.

[If the homeopathic] case is not going well, I need something that helps the patients. I have to resort to the time-tested biomedicine. It is clear, as I don’t want to risk a) the patient becoming dissatisfied and b) the life of the patient (physician 1).

Lack of biomedical success is dealt with similarly: after a while it is suggested to the patient that he/she might want to change the therapeutic approach. Biomedical and homeopathic strategies serve each other as residual options of treatment which will be used in case of failure. Even though these physicians assign their style of practice to external factors, they appraise their approach quite positively. The parallel use of different therapeutic methods has its merits because homeopathy is perceived to be emotionally intense and exhausting:

I take one new homeopathic case every one or two weeks. And I couldn’t do much more than that. It is very intense. You enter this person’s life and keep ruminating at home, what kind of fate this person had and which remedy he might need. You can’t do too much of that. So that’s why I don’t dislike it, when people turn up just wanting shallow treatment, just receiving their antibiotics and their medical certificate and leave. I don’t take them home (physician 2).

Well, it is not as if I don’t enjoy biomedicine. I like biomedicine, I have studied medicine and I don’t know whether I would like doing homeopathy on a daily basis, doing one case history each day. It is really draining and sometimes I also like doing a bit of biomedicine. That it goes quickly at times, that some acute cases come, which don’t need that amount of time and emotional care. It is very exhausting (physician 11).

This pragmatic mixture of homeopathy and biomedicine is not that simple for all respondents. For three of them, the difficulties in reconciling the two medical systems lead to conflicts which shape their professional identity:

R: Do you sometimes feel as if you’re falling between two stools?

P: Yes, sometimes. It happens. But then I try to set up rules for myself, who to treat homeopathically and who not. And I also used to stand in for a purely homeopathic physician and people there are just not as sick, as the ones we have. That’s why I sometimes get the feeling, that homeopathy is an illusion as well. It doesn’t work for everyone. We need biomedicine. So now I try to muddle through all that somehow (physician 2).
Physicians of this type use biomedicine and homeopathy in a parallel way. Neither of the two medical systems dominates their practice, but they are used pragmatically according to the patients’ preferences and the diagnostic results. This type of physician can only be found in clinics which are part of the system of public health insurance. This is not surprising as the take-over of an existing clinic was the very reason for the emergence of this configuration. Five of the 20 respondents corresponded to this type.

**Type II – Biomedicine as complementary medicine**

Homeopathy is the main source of medical action and knowledge for this type of physician. Patients who predominantly want to be treated biomedically are not admitted and 85–95 per cent of the remedies are homeopathic. The treatment starts with the taking of homeopathic case histories instead of diagnostic procedures, even though these might follow in order to complement the information collected. This homeopathic hegemony, however, is not associated with an antagonistic relationship with biomedicine. Rather, these physicians value biomedicine, even though they complain about its limitations on a therapeutic level. They attack biomedicine for its inability to effect permanent cure and criticise the side-effects of its therapeutic devices. Nevertheless, biomedicine has its place in homeopathic practice. Physicians of this type appreciate its diagnostic technology which enables them to recognise or rule out dangerous conditions:

I do want to clarify diagnostics so that I can be sure that I don’t miss anything, even though our homeopathic thinking is different. Maybe I have been a biomedical physician for too long and I have seen a lot (physician 5).

If the patient says: ‘There is something over here’, I will sound them, I will touch their belly, I will check their reflexes. I have recognised things in the past which would have gone terribly wrong without my examination (physician 15).

Patients are also referred to biomedical consultants for diagnostic examinations. This may be at the patient’s request or in order to rule out dangerous conditions. Co-operation with consultants is sought only for diagnostic purposes, while therapy continues to be homeopathic. The respondents stressed having a broad network of consultants who knew and accepted the respondents’ therapeutic work:

By now, I have at least one trustworthy colleague of any speciality who I can refer to, who provides me with high-quality diagnoses and who accepts my mode of treating the patients (physician 8).

Biomedical diagnostic procedures are not only used for ruling out dangers but for the prognosis of homeopathic therapy as well:
Then I am able to recognise and know: ‘I can only achieve such and such and probably not much more’. For myself as well, like when I know there is a terrible tumour, then I know that I might not be able to cure him, but might do something good on another therapeutic level (physician 5).

The remedial spectrum is dominated by homeopathy, despite this high regard for biomedicine. Biomedical drugs are limited to the continuation of medication for chronic disease. The goal is always to reduce the use of biomedical drugs as much as possible in the long run:

A lot of my patients are pretty sick and are – for example an asthmatic or an epileptic patient – already on long-term medication when they arrive here. You cannot just remove the drugs all of a sudden and say: ‘Here! Take a homeopathic drug!’ It is a little bit more tricky than that and you have to reduce the drugs slowly and apply homeopathic remedies in between (physician 12).

Biomedical drugs are also an option in dangerous acute cases. Antibiotics may be used in such circumstances. The tensions between biomedicine and homeopathy have to be resolved anew in dangerous situations. Physician 8 describes a typical way of dealing with this problem:

I am unwilling to risk the health of my patients, but if it is an intelligent patient, you can often agree on a concept, say: ‘All right, it is a serious disease right now, maybe even pneumonia, I’ll administer the homeopathic remedy immediately, but I’ll also give you the prescription for the antibiotic. Let’s wait for a couple of hours and then you call me in the evening. Then we take a look: How is the child now?’ And if it has not improved or even become worse, we will use the antibiotic, but you don’t need it very often.

This strategy to reduce medical risks is used by many physicians of this type. They always stress how rarely the biomedical emergency drug is needed after all. They are only used a couple of times a year, while in all the other cases the homeopathic drug cures the patient. Risk becomes an important criterion for medical action. While any physician will contemplate the potential dangers of a disease, this is even more pronounced in homeopathic physicians. The limited social acceptance of homeopathy produces a feeling of increased vulnerability to attacks of all kinds. The medical threat is also a legal one:

If I miss something it has a completely different status from when something occurs to some cardiologist – who is riding on cloud nine in his ratings. I have to protect myself in a completely different manner (physician 8).
Everything which is required will be done to the same degree as before my homeopathic practice. Even a bit more as I have to protect myself absolutely (physician 15).

The homeopathic concept of the vital force is very significant for the medical practice of these physicians. Its appraisal is crucial for all following therapeutic decisions and influences the choice between homeopathic and biomedical drugs as well as the potency of homeopathic remedies. If the vital force is perceived to be low, type II physicians tend to prescribe homeopathic remedies, as biomedicine is seen to be too weakening for the already assaulted body. A rather low potency is chosen as well – for similar reasons: Higher potencies are – according to homeopathic teaching – more effective and provide a stronger impulse for the patient. A patient with an already weakened vital force might even be endangered by a remedy with too high a potency, so physicians shy away from it.

It differs. First of all, it depends on the vital force of the patient, how much I can demand from it, in terms of potency. I cannot treat seriously sick patients, very old patients for example, with high potencies. That is even dangerous. You have to be more cautious, but if the vital force is strong and the acute disease very vehement, you can give really high potencies (physician 12).

Well, if the vital force is weakened, I would tend to give homeopathy even more, because any biomedical method would usually weaken the patient (physician 20).

To be ‘non-dogmatic’ is at the core of these physicians’ professional identity. They do not reject either of the two medical modalities, but describe homeopathy – particularly in respect of therapeutics – as far superior. Yet physicians of this type have not completely turned their back on biomedicine, but continue to use its potential. Benefits and limitations of both systems are stressed:

Of the medical tools I think that – among the remedies – homeopathy is so superior, that I never want to go back – never – into purely biomedical practice for therapeutics. We need surgeons. We need internal medicine, urgently. If I didn’t have physicians of internal medicine, if we didn’t have cortisone and antibiotics in case of doubt, we would be in trouble (physician 15).

Some physicians describe their homeopathic career as a process of maturing. After a euphoric early phase of homeopathic practice they have become more modest in appraising homeopathy’s healing potential:

I mean, it is quite normal. When I learned about homeopathy, I also thought: ‘Jesus, you only have to find the correct remedy and everything
falls into place’ and that is bullshit. It doesn’t work like that (physician 12).

Well, I have to say, that I am not dogmatic. I have a solid biomedical education and I want to know what I am treating. I know the limitations of homeopathy. I think my patients value that. Apart from that, I am a Family Physician with additional qualifications, so that I can support patients in difficult periods of their lives more effectively. So I am a GP focusing on homeopathy and psychosomatic medicine (physician 17).

The majority of the respondents follow an explicitly complementary model of this kind. Eleven physicians correspond to this ideal type. Five of them practise within the system of public health insurance, six in privately run clinics.

Type III – Homeopathy as alternative medicine

The third type of physician emerging from the data distance themselves most markedly from generally accepted modes of treatment. Here, there is little attempt to complement or integrate and the relationship between homeopathy and biomedicine is rather antagonistic. Type III physicians rely almost exclusively on homeopathy and reject biomedical strategies. An exception to this rule is to be found in a few diagnostic techniques which serve to recognise dangerous conditions. ‘Therapeutic diagnosis’ (physician 19) can be another reason for using diagnostic procedures. They are applied to calm particularly frightened patients. Sometimes the twin aims of legal protection and the satisfaction of (perceived) patients’ demands are combined:

Well, to rule out dangers. That is the first thing. To calm myself and the patient down. For forensic protection as well, so that I don’t get into trouble. Sometimes I am – because of my biomedical experience – so sure that I don’t have to check the leukocytes. Then I will do it for patients even though I am sure that the homeopathic remedy will act (physician 10).

These physicians value biomedical diagnostics much less than types I and II. At times consultants’ advice might be sought, but this co-operation is limited to few diagnostic techniques. There is no attempt to join hands therapeutically.

While biomedical diagnostics enjoy little prestige for physicians of this type, biomedical drugs receive no regard at all. Such drugs are criticised for a multitude of reasons. Apart from the claim that biomedical therapy is weakening and full of side-effects, new arguments are mentioned:

I have a strictly scientific family background. And I always knew that medicine is not a science. It can be a damned crude thing to do. It is so vague, so unscientific, and so ruthless at times (physician 10).
Biomedical treatment is considered inappropriate in most areas of medical practice. Its drugs are only used when an immediate removal of long-term medication is impossible. Surgery and emergency medicine are also exempted from this fundamental attack:

Of course you have to, when there are fractures, when you can do something physically, you have to do that. Hahnemann said that 200 years ago. You won’t leave broken bits of glass in there and give a homeopathic remedy. You won’t leave an arm dislocated. That’s clear (physician 10).

Apart from these narrowly-defined medical areas, biomedicine is generally rejected. Physicians of this type ascribe a far-reaching curative potential to homeopathy and even use it in cases of multiple sclerosis and cancer:

Well, not in every single case, of course, but when it is not a rapidly expanding cancer – I get good results, even in cancer-treatment, with high homeopathic potencies.

( . . . ) The prognosis is not that bad with homeopathy, as long as the patients are not too old and not too weakened by drugs which they have been receiving earlier on. I don’t dislike treating cancer. Of course, I don’t promise: ‘You are going to be healed!’ (physician 4).

Only a few physicians of type I and II would agree with this. For them, tumours belong to the realm of biomedically-treated conditions. They only apply homeopathy for reducing the side-effects of irradiation and chemotherapy. Complementary concepts of this kind are hard to find in type III physicians, because they regard homeopathy as an alternative model to biomedicine.

On a theoretical level, there are spiritual interpretations of homeopathic concepts among these physicians. These can include ideas of the New Age-movement or Christian semantics:

It is also a certain path along which one is led. I keep saying: My guardian angel takes me by the hand and tells me: ‘Right. That’s what you are doing and it’ll be fine’ (physician 10).

The idea of miasm sits perfectly well with my spiritual world view, just the idea that previous lives produce certain predispositions in this life (physician 3).

This pattern of use was discovered in four of the 20 clinics. Not surprisingly, it was only found in privately-run practices: among all the respondents, these physicians distance themselves most severely from established medical practices. Biomedical diagnosis receives little recognition, its therapeutic devices even less. Homeopathy is applied to all patients. It is seen to be a potential
solution for all kinds of medical conditions and its concepts can be interpreted in a spiritual manner. How wide the gap between them and biomedical techniques can be is illustrated by the following example:

P: I am not only examining and treating patients, who are right here, by the way. You can also do it by pulse with an assistant, who has to be

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Table 1  *Patterns of integrating biomedicine and homeopathy*

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<th>Type I</th>
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<th>Type III</th>
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<td><strong>general characteristic</strong></td>
<td>parallel use of biomedicine and homeopathy</td>
<td>homeopathic dominance complementary orientation</td>
<td>alternative orientation</td>
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<td>segregation of biomedical and homeopathic patients</td>
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<td>crucial</td>
<td>ruling out dangerous conditions prognosis</td>
<td>ruling out dangers calming the patients (‘therapeutic diagnostics’)</td>
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<td>85–95%</td>
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<td><strong>criteria for medical decision-making</strong></td>
<td>patients’ requests diagnosis therapeutic success</td>
<td>risk vital force</td>
<td>risk</td>
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<td>diagnostic technologies positive therapeutic devices negative</td>
<td>negative, except emergency medicine and surgery</td>
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<td><strong>importance of biomedical drugs</strong></td>
<td>valued therapeutic option</td>
<td>long-term medication emergency</td>
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<td><strong>proportion of respondents</strong></td>
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<td>4 physicians in private practice</td>
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<td><strong>professional identity</strong></td>
<td>‘falling between the stools’</td>
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quite balanced, with the help of a drop of blood. That’s why I have quite a few patients, who had been in Berlin before or who are on holiday or working in Istanbul. They call me when they are having an acute problem and tell me: ‘I have got this and that.’ I have a drop of their blood and I can detect immediately: ‘Ah! He has twisted his ankle or has a viral infection.’ No problem! This is established within just a couple of minutes. And then I can prescribe a homeopathic remedy. So, I have got quite a few patients who do not live in Berlin. Who come to Berlin every six months or so, and I treat them like that. By a drop of their blood!

R: Which they had left with you?

P: Yes! They had left it when they were in Berlin or they send a relative, who gives it to me. But it doesn’t have to be, I mean, if they have the flu and the blood is four weeks old, that’s no problem. I’ve got a radionic machine – there are more methods, but that’s not that interesting – so when I put the blood on the machine and my assistant lies down in front of me, picking up the electrode, then I am only measuring the symptoms of the patient, who gave me his blood, right at this point in time (physician 4).

This is not a typical type III physician. Most homeopaths would find these strategies rather obscure. What type III physicians do have in common, however, is that they don’t have any complementary concept of medicine in mind, but regard homeopathy as an alternative to biomedicine. There are no ambiguities in their professional identities. They see themselves as classical homeopaths, distancing themselves strictly from biomedicine.

Medical knowledge

Perspectives on establishing homeopathic knowledge claims
When the value of medical modalities is examined, the issues of therapeutic efficacy and its precise therapeutic mechanism are regularly conflated. The legitimacy of a medical system can come under challenge if the latter is unknown. In this paper, the physicians’ attitudes to both issues are addressed.

There is a widely-accepted path for evaluating therapeutic devices in biomedicine: randomised controlled trials (RCT) promise to establish the efficacy of a therapeutic device, and also to control for the placebo-effect which might emerge in the participants. So why not apply this method to the controversial remedies of homeopathy as well? All the physicians interviewed rejected this notion because of the specific ideas behind homeopathic treatment. In homeopathic treatment it is rather the entirety of a patient’s symptoms that is crucial and not the diagnostic entity. A hundred patients of a certain biomedical diagnostic category might receive a hundred
different homeopathic remedies. The most important sampling criterion in RCTs – the common diagnostic category of all participants – is irrelevant for homeopathic prescriptions, and thus makes the application of this method for evaluation quite problematic:

You cannot really compare a placebo-patient with one who took the actual remedy because homeopathy is so individualized. And I think that the diagnosis is not the vital point in homoeopathy. You wouldn’t really test migraine patients but rather their present health status, because someone may be a completely healthy person and still suffer from migraine. He will be cured in a very different manner from someone who is very sick and has a low vital force (physician 20).

I don’t care for that at all! I see how it works. Sometimes it doesn’t – like any other treatment. I really don’t care! I think it is bullshit! And all those discussions, like one-drop-in-ahuge-lake, I rather withdraw from that, as I don’t give a damn. He who heals is right (physician 7).

Although homeopathic physicians reject RCTs as a method of evaluation they are interested in proving the efficacy of homeopathy scientifically, as long as the methods are adapted to homeopathic concepts. The value of these trials for their own medical practice, however, is low. There is no need for scientific evidence after homeopathic education and years of experience because doubts have already been dispelled. The desire for successful evaluations is rather politically motivated: scientific evidence might be helpful in achieving increased societal acceptance, including effects on policy-makers and the public. For their own sake they do not matter too much, as knowledge derived from clinical experience dominates over scientific knowledge.

So scientific paradigms for clarifying the issue of whether a therapeutic device is effective or not are not significant for homeopathic physicians. But what about its mechanism? What is the referential framework for homeopathic physicians in this most controversial issue in homoeopathy? High potencies of homeopathic drugs do not contain any remedial substance any more, and consist purely of solvent. To claim this remedy as medically helpful challenges common sense as well as scientific thought. This contradiction is homeopathy’s unguarded flank which has been attacked by its critics since its foundation. It is also an obstacle to homeopathy’s social acceptance. To counter this criticism homeopathic physicians refer to modern physics. In the manufacturing process homeopathic agents leave an ‘informational imprint’ on the solvent. Several respondents called it ‘the memory of water’ which is still effective after the last molecule of the agent has vanished. The stored information reaches the patient via subatomic processes and supports him/her in being cured because the ‘vibration’, the ‘energetic impulse’ is strengthening the vital force. That is why homeopaths focus on shaking the remedies in the manufacturing procedure. Otherwise, the imprint on the solvent would not be achieved:
You have to take modern physics as a premise. Just a tiny bit of energy is created by manufacturing the remedies. If you imagine what Einstein and Heisenberg have taught: ‘this table (physician knocks on the table) is just a bunch of vibrating molecules’. Like our body. When we are sick, Hahnemann would say, ‘It is out of tune’, and a physical scientist would say, ‘the wave length is not correct any more’. And this untuned organism can be retuned by a tiny bit of energy as you can observe in all of modern physics (physician 10).

Well, it is widely known that there is no substance left in the remedy. I explain it by the memory of water. Well, every substance has as electromagnetic field, right? And when I dilute this with water and shake it, then I think some energetic process unfolds, in which the water receives this energy somehow (physician 2).

Homeopathic physicians are not physical scientists and therefore their interpretations of the mechanism of homeopathic remedies remain simple. This is not surprising as a theoretical foundation framed by (medical) metatheories is insignificant to them. Practice counts. The efficacy of homeopathic remedies has been experienced numerous times in clinical practice, so that it does not have to be supported by compatible scientific models:

For myself, I am way beyond the point of needing evidence for myself. At the beginning – yes, when you have been receiving a scientific education, you keep wondering: ‘How on earth can this work? And is this a placebo-effect?’ and all that. But I always find the attempt of turning it into something scientific quite problematic. ( . . . ) I wouldn’t mind if you could never ever prove it, as long as it still works (physician 20).

The typical response to the question of their own explanation for the efficacy of homeopathic remedies was two-fold: First, the reference to modern physics and the expectation that it will provide theoretical models for homeopathic healing, and – in the second part of the answer – the notion that theoretical foundation does not matter that much after all, since it works in practice.

Two of the 20 physicians explained homeopathic healing spiritually. Again, this could be embedded in New Age thought and Christian semantics:

The efficacy of homeopathic remedies? That is a fairly tricky question. Well, I have been pursuing a spiritual path for quite some years. I would say it like that. So everything which is part of the earth’s polarity is of a spiritual nature (physician 6).

If I hadn’t believed in the goodness of God, I would have had to start believing in it (physician 10).
Controversial areas of homeopathic knowledge

Homeopathic theory is not easily integrated into accepted scientific theories. This is not, however, the only area in which homeopathy diverges from established concepts. The idea of an invisible force, keeping human beings alive, is no longer widespread. Still, it plays an important part in the respondents’ medical theories. Homeopathic physicians believe that homeopathic theory would collapse without the concept of the vital force. Its condition is also crucial to the choice of remedy and therapeutic prognosis. Strengthening the vital force is homeopathy’s most important goal for all respondents. Their answers were quite homogenous in this respect:

A very important role. I can forget about homeopathy without the vital force. I really depend on the patient developing strength, so that I can heal him homoeopathically (physician 8).

Of central significance! No-one can get well without the vital force and I think that’s what we are doing. Trying to strengthen the vital force, reaching and touching it. And when it is not there any more or vanishing, you can do whatever you like with whichever remedy (physician 18).

At first sight, vaccinations resemble homeopathic healing as they are close to the principle of similarity. Small amounts of (pathogenic) substances are administered to promote health. In homeopathy the purpose is therapeutic, in vaccinations preventative. While tailoring these substances in as individual a manner as possible is vital to homeopathy, all vaccinated persons receive the same agent. Therefore, it is not surprising to find that a lot of homeopaths are opposed to vaccinations – a view which is hardly convenient. What is the view of physicians with both homeopathic and biomedical socialisation on this issue? There was a large degree of ambiguity in their answers. Physicians reflected on both the medical benefit of vaccinations and the risk of malpractice suits in the event that non-vaccinated patients contracted serious diseases, potentially as well as on the harmful consequences of vaccinations, which could appear as physical or mental disorders in children.

The highest priority is: if I have no cure in case of disease, I always favour vaccination. However, I am opposed to vaccinating eight-fold, because I think it prevents the immune system from developing. If I think of the immune system battling eight types of viruses at a time and producing immune bodies – I cannot see that working well for a long time. And you can observe it not working well (physician 14).

Well, I am in two minds about that. I am not saying it loudly – that I don’t recommend vaccinations that much – because I am a bit scared if the child actually gets the measles and develops complications. Then I am in a
vulnerable position having recommended not to do it. I mean, it is a legal problem as well (physician 1).

The decision on vaccination is usually transferred to the children’s parents through a counselling process. Most of the respondents recommend vaccination for tetanus, polio and diphtheria and advise against the vaccination of children's diseases. Sometimes they leave it completely to the parents.

Tetanus, polio and diphtheria. On a legal basis as well, so that no-one can point his finger at me afterwards and say: ‘he has advised me against vaccination’. With all the other vaccinations I advise the patients and leave the decision to them (physician 8).

It has to be dealt with very individually. There are very dogmatic homeops and very dogmatic paediatricians around. The former strongly opposed, the others strongly in favour. I discuss it individually with the parents. I always tell them that there is no final answer to it and that the risk of vaccinations is surely higher than commonly thought. ( . . . ) Some parents don’t want any vaccinations. Then I advise in favour of tetanus and polio. Whooping cough and diphtheria is not that necessary. The parents may decide that (physician 15).

A controversial topic within homeopathy is the application of combined remedies – drugs in which several substances are mixed together and prescribed in particular cases, such as flu. In this way, the prescription breaches two principles of Hahnemannian homeopathy: the application of one single remedy at a time and – even worse – the therapeutic decision relating to the entirety of a patient's symptoms. This modification of homeopathic strategies moves homeopathy into closer proximity to biomedicine. The data paint a rather uniform picture about the application of combined remedies. Homeopathic physicians are not enthusiastic about them. Nine of the 20 respondents reported using them every now and then. The most common reason was the request of patients who had been given a particular combined remedy in the past and wished to take it once more:

Combined drugs is easy to answer: very rarely! Sometimes at patients’ request, who love it. Retired people love their Ratikohel. If it helps them, I don’t mind. Hahnemann says: ‘he who heals is right’ (laughing) (physician 8).

On top of that, physicians utilise combined remedies in case of minor diseases when the entirety of symptoms is rather vague:

Combined remedies are a small part of my practice, because I am – as a classical homeopath – not that familiar with the concept, but sometimes
I give them every now and then. For some young patients with a sore throat and not an angina, just sore throat, and who cannot tell me: ‘I have this and this symptom.’, but can only describe fuzzy symptoms; I give combined remedies to them at times (physician 2).

Even physicians using combined remedies are not happy about using them, and limit their application to non-threatening diseases and the explicit request of a patient. The proportion of combined remedies rarely exceeds one to five per cent. All the other respondents rejected combined remedies. A particularly vivid example is physician 12:

Never! Combined remedies is only for pseudo-homeopaths. Homeopathy is one remedy, one remedy only and if you can’t find it, because you are incompetent or want to work too quickly, then you choose combined remedies. But that is not homeopathy! That is biomedical thinking applied to homeopathy!

Discussion

One important purpose of this study was to assess patterns of medical practice of homeopathic physicians in Germany. It does not seem to be as predictable in terms of the institutional framework – private versus a public insurance setting – as Degele (1998) suggested. Yet, of type I physicians who categorise their patients as biomedical or homeopathic, all practise within the system of public health insurance in which the rejection of biomedicine, characteristic of type III physicians, would hardly be possible. Within the group of type II physicians, the same proportion work in private as in public institutional settings. In terms of practice styles, it is a rather homogeneous group. The source of a practice’s funding, therefore, cannot be the only decisive factor leading to a combination of homeopathy and biomedicine. Even though the economic framework remains an influential factor, medical reality seems to be less clear-cut than Degele’s (1998: 189) alternatives of ‘adapting to or leaving’ the system of public health insurance. Homeopathic physicians still have various strategic options which are not completely determined by the clinic’s institutional structure. There seem to be more factors at work. One of them is the conditions under which the respondents have set up their homeopathic practice. Taking over from a purely biomedical physician forces them into a more consumerist approach, in order not to alienate patients by heterodox medicine. Opening up an entirely new clinic enables homeopathic physicians to pursue a more purist approach, but might lead to economic difficulties, at least in the early phase of homeopathic practice, as new patients have to be attracted. The reasons for adopting types
II or III styles are less obvious. The majority of type II physicians, however, had started practising homeopathy during the 1990s, when acceptance of heterodox medicine had grown already and ideas of complementary medical practice had become more widespread. Three of the four type III physicians had set up their homeopathic clinics before that – one of them as early as 1960. They had begun practising homeopathy in a very different social context from that of most of type II physicians, as popularity among patients was increasing during the late 1980s and early 1990s. Views held by type III physicians, therefore, have been shaped in an environment that was more hostile towards homeopathy than today’s, possibly leading to a rather antagonistic relationship and fierce opposition to biomedicine. It is certainly premature to make a prediction on the basis of just 20 participants, but if this speculation is correct, it can be expected that type III physicians become increasingly rare as long as the health care system continues to open up for a (partial) integration of heterodox medicine.

Homeopathy has always been under attack for the fact that neither the efficacy of homeopathic remedies nor the validity of homeopathic theories could be proven in a scientific fashion. However, since there are increasing calls for an ‘evidence-based medicine’ (EBM), the question of what actually constitutes ‘evidence’ becomes even more pressing. In biomedicine, randomised controlled trials (RCT) are the dominant way of establishing knowledge claims, even though a large number of widely-used therapeutic options in biomedicine has not been tested in that way. Cant and Sharma argue that the influence of EBM might lead to a ‘backlash’ against alternative medicine (1999: 105). Homeopaths experience this pressure and try to conform to demands of scientific evaluation. However, as the method of RCTs is hardly applicable to homeopathy’s concepts, they call for better adapted, yet still scientific, methods. The respondents clearly distinguish between their professional project of increasing public acceptance and their own individual practice where scientific studies are insignificant, as they have long been convinced about the efficacy of homeopathy and there is no need for further evidence. Similar issues are at work with the construction of the homeopathic knowledge base. Even though homeopaths draw connections with modern physics, their passion for scientific reasoning is limited. Clinical experience remains as the most powerful point of reference, while creating a shared theoretical basis of biomedicine and homeopathy is not important for homeopathic physicians. Interestingly enough, the only area of medical knowledge in which the typologies under discussion differed was that only type III physicians mentioned religious and spiritual interpretations of homeopathy. In all other areas of defining ‘good homeopathic practice’, respondents adhere to ideas of classical homeopathy, prescribing single, highly-potentised remedies according to the entirety of the patients’ symptoms. They only deviate from classical homeopathy by withdrawing from the previously tough line against vaccination, and by delegating responsibility to the children’s parents. Again, there is a broad consensus of what homeopathy
should be, while the degree of biomedicine’s inclusion differs among homeopathic physicians.

Diverse efforts to achieve credibility of homeopathic concepts in different contexts can be identified. In order to increase societal and political acceptance, homeopathic physicians favour scientific testing in the hope of strengthening their knowledge claims through scientific legitimacy. Consequently, they do not actively challenge the role of science in determining the distribution of resources in health care, but criticise its dominant methodological tool, the RCT. On a very different front – within the community of homeopathic physicians – ideas of classical homeopathy are vital for the respondents. Within their own practice, however, the experience of treating patients successfully is the most important source of faith in homeopathy for all participants.

So how helpful are these results for the terminological dilemma in this area of research? Numerous terms are used to describe non-biomedical systems. Alternative medicine is probably the term most widely used in scientific and public discourse. Apart from linking these medical systems to ‘alternative’ lifestyles, counter-culture and political exclusion, this terminological choice also implies an antagonistic relationship with biomedicine. Whether this is true for their day-to-day medical reality is usually not discussed. A similar problem occurs for the – increasingly applied – term complementary medicine: It implies a certain division of labour in health care. The ‘other’ medicines are supposed to complement biomedicine, without questioning its hegemonic position. The term complementary medicine indicates an integration of diverse strategies of healing in a pluralistic system of health care rather than a sharp demarcation between orthodox and heterodox medicine. The pivotal criteria in these attempts to define non-biomedical practice are the patterns of their use. They can be an alternative to biomedicine which aims to replace or complement biomedical practice. Both terms mark terminologically a medical reality which should evolve from the empirical study of patients. Proposals like holistic medicine or natural medicine also suffer from limitations. The degree of holism varies and also depends on the actual patterns of use. Herbal remedies, for example, can be prescribed in a rather reductionist, symptom-oriented fashion. The insertion of needles into the body practised in acupuncture, on the other hand, does not appear more natural than biomedical treatment. The term unconventional medicine focuses on the conceptual tension between biomedical and other systems of medicine. It is however misleading, as it suggests that these systems do not follow any internal conventions, and also that they tend to be rare. Yet, some of them have now become so popular that they are no longer unconventional in that respect.

In light of the presented data, the term complementary medicine appears to be a macro-sociological one. From this perspective, the term seems to be adequate for describing homeopathy which assumes tasks, such as chronic diseases and psychosomatic disorders, which have been neglected by
biomedicine. Biomedicine is said to have little to offer and homeopathy has its strengths in those areas. On the macro-level of the health care system, homeopathy complements biomedicine. It can be assumed that this is applicable for various other modes of treatment. Complementary medicine is a precise and useful terminological solution for macro-sociological research. However, it is not quite the same for micro-sociological settings. Even in this rather modest sample of 20 physicians it becomes evident how flexible the use of homeopathy can be. It appears as a medical chameleon. It can complement biomedicine, thereby satisfying patients’ wants, and it can cure diseases which do not respond so readily to biomedicine. It can become the dominant medical approach, while only a narrow area is allocated for biomedical competence. In addition, type III physicians – in their outright rejection of biomedicine – could hardly be called ‘complementary’. Here, alternative medicine appears to be the most appropriate terminological choice. Sixteen of the 20 physicians, however, pursue complementary strategies. We can observe a parallel residual use, in which both strategies complement each other, by categorising patients according to their demands and diagnosis (type I). Type II physicians prefer homeopathy and only complement it by diagnostic procedures and in emergency cases. Consequently, biomedicine complements homeopathy and would have to be labelled ‘complementary medicine’. This of course would render it all but useless as an umbrella term for all non-biomedical systems of medicine. Suddenly, complementary medicine appears to be a rather vague term. It includes micro-social and macro-social facets of medical practice which have little in common.

It is conceivable that even more patterns of homeopathic practice might emerge by examining more institutional frameworks like Heilpraktiker or homeopathically untrained GPs. But even the analysis of this particular area shows that the patterns of use cannot serve as a helpful criterion for defining all non-biomedical modes of treatment. Heterodox medicine – a term proposed by Stollberg (2001) – might well be a more appropriate descriptive tool. It appears as a useful umbrella term for all medical strategies outside the biomedical realm while still leaving room for the multitude of ideas, techniques, institutions, as well as different forms of utilisation by patients and practitioners – an invaluable aspect in such a heterogeneous field of sociological study.

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Notes

1 While this institutional category is specific to the German health care system, it is comparable to that of ‘lay practitioners’ elsewhere. The practice of *Heilpraktiker* is based on legislation passed by the Nazi regime in 1935, trying to regulate the practice of ‘lay practitioners’. Applicants have to pass an exam in subjects like anatomy, physiology and pathology. Once they pass this test, they are allowed to practice whatever medical tradition pleases them. Without it, professional practice of treating patients is illegal in Germany.

2 While most of the respondents felt comfortable with the interpretations, one physician deeply regretted her answers in the interview, saying that her comments would come across as ignorant and stupid.

3 In the following, ‘P’ will be the abbreviation for ‘physician’ and ‘R’ the abbreviation for ‘researcher’.

References


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