

Medical Acupuncture in Germany – Patterns of consumerism among physicians and patients

Abstract

Since the (re-) emergence of heterodox medicine across the ‘Western’ world, there have been numerous interpretations of this phenomenon by the social sciences. Heterodox patients were said to be *active consumers* holding post-modern values, while heterodox physicians were described as heretics. Medical doctors taking up heterodox medicine were criticised for acting in their own financial interests. To examine these notions, we selected the most prominent heterodox mode of treatment in the German healthcare system: acupuncture. 26 semi-structured interviews with medical acupuncturists and their patients were conducted. On the physicians’ side, we analyse their styles of practice. To what extent is acupuncture incorporated into biomedical models? Are there any doctors who completely convert to Chinese ideas about health and illness? The patients’ activities before and during treatment are addressed. What made them choose acupuncture? How strongly did and do they collect information on heterodox treatment? The patients’ perception of their relationship with their physicians and the decision-making processes during the consultations are also examined. Finally, we argue that while some modes of heterodox medicine resemble parallel forms of general practice, acupuncture tends to become a medical speciality in which physicians tailor their practice to the individual patient's (perceived) demands. From the patients’ perspectives, a more *passive* than *active* form of consumerism emerges, involving ideas on medical services that closely correspond with classical modernity.

keywords: heterodox medicine, complementary medicine, acupuncture, active consumerism, doctor-patients-relationship, hybridisation

Introduction

The (re-) emergence of heterodox modes of medicine over the last twenty years (Eisenberg et al., 1993, Fisher & Ward, 1994) was not anticipated by the social sciences. It was a surprising development, particularly for scholars working from the perspective of modernisation theory, as there used to be no doubt that scientific medicine (i.e. biomedicine) would consolidate its hegemonial position in the healthcare systems of modern society, which is increasingly governed by scientific expert knowledge and professional authority (Parsons, 1951). Accordingly, 'irrational' strategies of healing or 'folk medicine' (i.e. heterodox medicine) were expected to gradually disappear. Since these assumptions proved wrong, there were various attempts to explain the growing popularity of heterodox medicine. Their attractiveness has been interpreted as a move towards a post-modern organisation of healthcare, involving a stronger focus on 'products' that are individually tailored to consumer demands, while modernism - including biomedicine - had disappointed and alienated patients (Bakx, 1991). Giddens (1994) argues that patients' interest in heterodox medicine corresponds with the concept of *reflexive modernity*, as the knowledge of (medical) experts has become increasingly provisional and fragile. At the same time, it is easier for patients to become experts themselves, as information about their disease and treatment options is readily available. Therefore, patients tend to become experts on their own health and decide about their treatment on the basis of *active trust* (Giddens, 1994: 132). For Kelner & Wellman (1997), heterodox patients represent a newly emerging phenomenon of 'smart consumerism' in healthcare. Patients gather knowledge on the whole spectrum of therapeutic options, and then decide in favour of one medical device of their choice. They appear to be more akin to customers than to patients. The popularity of heterodox medicine has also been attributed to 'post-modern values', such as technophobia, holism (Siapush, 1998, Astin, 1998) as well as gentleness (Douglas, 1996).

Sharma (1992) identified three types of heterodox patients: 'Earnest seekers' try to find a therapeutic solution for one particular, usually chronic disease. Although initial contacts with heterodox medicine may not have led to a complete cure, they prompted the patient to consult more practitioners. 'Eclectic users' also seek help from various heterodox medical systems. However, they do not consult

practitioners for just one single condition, but for health problems of all kinds. 'Stable users' do not roam in this way, but remain faithful to one heterodox medical system. Very few heterodox patients completely turn their back on biomedicine, but most use it in a complementary way (Sharma, 1992).

In another typological construction, Schulz (2001) categorises four possible patient approaches to heterodox medicine: ecological, psychotherapeutic, utilitarian-pragmatic and spiritual-religious. The latter is said to correspond with East Asian philosophies of health. Despite the heterogeneity in this field of sociological research, neither Sharma nor Schulz make a distinction between patients who seek different modes of heterodox treatment.

Social scientists paid less attention to *physicians* practising heterodox medicine. Goldstein (1985) suggested that spirituality is a major reason why medical doctors turn to heterodox medicine. They dedicate more time to their patients and earn significantly less than their biomedical colleagues (Goldstein et al., 1988). Wolpe (1990) described heterodox medical doctors as *heretics* challenging the dominant discourse of medical orthodoxy. Dew's (1997) portrait of the New Zealand physician Tizard gives a similar impression: Tizard, who practised electro-acupuncture, was severely disciplined and punished by biomedical organisations. He was fined and stripped of his license to practise medicine. From these studies, a heroic picture of physicians fighting against the malevolence of the biomedical world emerges.

Heterodox medical doctors have also been examined within the theoretical framework of professionalisation (Saks, 1992, 1995). After a period of outright rejection by British biomedical organisations, acupuncture gradually gained acceptance within the medical profession from the late 1970s. Acupuncture was adapted to biomedicine by separating it from its theoretical framework within Chinese Medicine¹ and restricting it to the narrow area of pain therapy. Acupuncture's effectiveness was explained scientifically: Inserting needles releases endorphins and thus alleviates pain. At the same time as acceptance of acupuncture grew, non-medical acupuncturists were continuously attacked for their lack of biomedical training (Saks, 1994). Saks interprets the growing interest of medical doctors in heterodox medicine as an attempt to preserve their dominance in healthcare by incorporating acupuncture in their practice in a modified form and subordinating it to their authority

(Saks, 1995). They thereby fend off the ‘alternative challenge’ (Saks, 1992). As this analysis is based on the strategies of the respective organisational bodies, we hesitate to transfer these results directly to the level of practising physicians where the use of numerous forms of heterodox and biomedicine is conceivable. Physicians might opt for a biomedicalised, fragmented version of heterodox medicine, in which isolated heterodox techniques are integrated into the therapeutic arsenal, while the dominance of biomedical concepts remains unchallenged. It is also possible that some physicians convert completely to heterodox medicine and only use few - if any - biomedical strategies. A third possibility is a rather hybrid medical practice where 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 is equally likely, with patients deciding how they want to be treated. Therefore, we are able to analyse heterodox medical doctors’ practice by two criteria: by their focus being on the biomedical or the heterodox side and by the intensity with which biomedical and heterodox ideas are melted into each other. This study attempts to show which forms are most prevalent among German heterodox physicians.

table 1: types of medical acupuncture

focus degree of hybridisation	biomedicine	heterodox medicine
weak	<ul style="list-style-type: none"> - complementing biomedical practice with acupuncture - no further meta-theory - loose combination 	<ul style="list-style-type: none"> - complementing heterodox practice with biomedical procedures - no further meta-theory - loose combination
strong	<ul style="list-style-type: none"> - inclusion of acupuncture in biomedical paradigms - predominantly biomedical practice 	<ul style="list-style-type: none"> - fusion of diverse conceptual ingredients into one unified model

As heterodox medicine is a broad field that includes a wide range of medical ontologies, treatment options, and institutional settings, it is preferable to examine each mode of heterodox medicine in its own right. In the following, we will focus on a mode of treatment that has become particularly popular among patients and physicians in ‘Western’ societies: acupuncture (Norheim & Fønnebø, 1994). In the case of the United States, it has been argued that patients use acupuncture for “healing the fragmentation of both human bodies and human experience accentuated by technological intervention and the biomedical model.” (Hare, 1993: 43). In this process, the physician’s empathy for the patient’s daily life plays an important role (Hare, 1993). This implies a clear-cut dichotomy between Asian and biomedicine, while Barnes (1998) sees a specifically US-American version of Chinese medicine emerging: Chinese concepts of treatment are blended with psychotherapy and thus reflect the values of the ‘baby-boomer’ generation, such as the importance of verbalising emotions and blending psychological and spiritual aspects of life.

In this study, we explore the perspectives of German medical doctors and patients using acupuncture. Acupuncture is the most prominent heterodox mode of treatment in the German healthcare system. While it is hard to estimate the number of patients resorting to acupuncture, around a third of all German medical doctors use it in their own practice (Stollberg, 2001, Marstedt & Moebus, 2002). The situation differs from the US-American case, as there are only a few acupuncturists of Asian descent in Germany. It appears challenging for medical doctors to reconcile the diverging Chinese and biomedical ideas on health, illness and therapy: In Chinese medicine, the flow of *qi* through the body is central to people’s health. If *qi* can flow undisturbed, the complementary principles of *yin* and *yang* are balanced, resulting in good health. While it is impossible to translate the term *qi*, it can be described as similar to an immaterial force/energy. Its paths through the human body can be localised on twelve routes, called meridians, each of them connected to an organ, even though these organs differ strongly from their biomedical equivalents. Along the meridians, there are hundreds of spots in which needles can be inserted in order to enable *qi* to flow smoothly again. Apart from body acupuncture, which originated in China, skull-acupuncture was developed in Japan, and ear-acupuncture was a European innovation. All these forms soon diffused to China and became popular (Hsu, 1996). Drugs and dietary regulations, which are prescribed according to a complex system of

correspondence, are equally important in Chinese medicine. Chinese medical practitioners examine the patient's tongue, the pulse and inquire about the medical history to find out the reasons behind any disruptions that cause illness. Central to our study will be whether German medical acupuncturists tend to embrace these ideas, hybridise them with 'Western' medical thought, or resort to a merely technical adoption of acupuncture.

On the patients' side, we will look at their activities before and during treatment in order to test the hypothesis on active consumerism (Kelner & Wellman, 1997). What made them choose acupuncture and how strongly did and do they collect information on heterodox treatment? We will also examine the patients' perceptions of their relationships with their physicians, since opponents as well as proponents often trace the success of heterodox medicine to a particularly satisfying, personal physician-patient relationship (Oepen, 1995, Fairclough, 1992). However, heterodox consultations are not always harmonious and often involve complex processes of negotiation (Frank, 2002a). In order to analyse decision-making processes, we refer to theoretical models that were developed in medical sociology. In applying his structural-functionalist theory to medicine, Parsons (1951) described the clinical encounter as a paternalistic event. It includes a decisive physician and a passive, compliant patient. The concept of the *informed decision* involves a more egalitarian relationship between physician and patient. The physician elaborates on the potential risks and benefits of therapeutic choices. The patient then decides autonomously on the basis of this information (Gwyn & Elwyn, 1999). The model of *shared decision-making* is similar. Physician and patient co-operate to find a consensus on therapeutic strategies. Information, however, flows in both directions. (Charles et al., 1999, Stevenson et al., 2000). Both the latter models are closely linked to the concept of *patient-centred medicine* (Mead & Bower, 2000).

Methods

Between April 2001 and January 2002, we conducted semi-structured interviews with medical doctors who practise and patients who use acupuncture. Fourteen physicians were selected randomly from two different lists (The Yellow Pages Berlin and the register kept by the largest professional organisation

(DÄGfA)), and were contacted by telephone. The participation rate was 100%. Some physicians explained their readiness to be interviewed by saying they were ‘doing it for acupuncture’, while others expressed curiosity about the results of the study. Because of these motives, it was – even more than in other empirical studies - important to pay attention to processes of social desirability and self-presentation during the designing, data collection and analysis phases. The interviews were conducted in the physicians’ practices and lasted between 35 and 85 minutes. Half of the interviewed acupuncturists worked within the German system of public health insurance companies, while the other half practised privately.

Patients were selected with the help of the physicians. The physicians asked one or two of their patients if they would be willing to participate in our study. This resulted in twelve interviews with acupuncture patients. One of the reasons for this procedure was the relatively strict privacy law in Germany, which prevented a more randomised selection. Therefore, we must assume that dissatisfied patients are under-represented in this study, and that the responses from patients about the perceived efficacy of acupuncture and any disagreements during the clinical encounter are not representative of all patients. We also expected that *stable users* would be over-represented and *eclectic users* under-represented in our sample (Sharma, 1992). However, our central research questions remain untouched by the limitations of our sampling procedure. Patients were between 30 and 75 years old, with half of them being under 40. As in previous studies (Kelner & Wellman, 1997), there was a significant gender imbalance, with two thirds of the patients being female. Six patients were members of private health insurance companies, while the other six were covered by the public health insurance system. None of the patients had to pay for the treatment out of his/her own pocket. Private health insurance companies always provide reimbursement for medical acupuncture. Public health insurance companies, which cover 90% of the German population, restrict their financial assistance to treatment for particular ailments: chronic pain and migraine. While patients’ self-payment is common in acupuncture practised by German *Heilpraktiker*², it is rare in medical acupuncture.

The periods of time during which patients lived with an illness before seeking heterodox care varied. Some of the patients went to see an acupuncturist within three months after their complaint started, while others had suffered for decades before they sought help from heterodox medicine. While our

sample represents a wide range of professions, all of the patients participating in our study were working in service industries of various kinds.

All interviews were audio-tape recorded and transcribed. Assisted by software for qualitative data analysis, both authors independently identified key concepts emerging from the data. Each sequence of the interviews was coded and a system of categories was developed for the whole material along the lines of qualitative content analysis according to Mayring (1988). Further interpretation included cross-case analysis as well as individual analysis.

Practising acupuncture – physicians’ perspectives

Type I – Biomedically dominated coexistence

In this first type of medical practice, the degree of hybridisation is weak, and biomedicine represents the focus, i.e. most patients are treated by biomedical means. Acupuncture is merely extending the therapeutic arsenal, while biomedical practice remains the dominant mode of medicine. Physicians do not reconcile the conceptual tensions of their various treatment options, but let them coexist alongside each other. Choices between these modes of treatment are based on biomedical disease categories. While physicians of this type will resort to biomedicine in most cases, they apply acupuncture in well-defined areas:

I believe that Western and Eastern medicine should complement each other. Both have their areas of application. (A³³)

Acupuncture is the treatment of choice in cases of chronic pain, migraine and back pain. Type I physicians combine biomedical disease categories with Asian therapeutics. German health insurance companies implicitly promote this procedure, as they only reimburse patients suffering from chronic pain. Thus, it is not surprising that nearly half of our respondents follow this type of practice. The proportion of the entire practice represented by acupuncture patients rarely exceeds 10-15% among

The demands of the patient constitute another important criterion in choosing the appropriate treatment option:

Ideally, the respective medical traditions would complement each other beautifully, but on the other hand, you have to realise that some patients want this, and others want that. Many of them prefer to swallow some pills, keep drinking their beer and having their sausages without changing their lives in any respect. (A5)

Hybridisation in the practice of type I physicians is minimal: Biomedicine dominates their practice, and it is complemented by the occasional insertion of needles. Whether it is valid to label this mere coexistence as a form of 'hybridisation' is open to discussion. We decided to do so, because physicians introduce criteria by which they orientate their practices: biomedical models (i.e. disease categories), and/or consumerist ideas by tailoring therapeutics to their patients' demands.

Type II - Coexistence with heterodox dominance

Similar thoughts guide physicians of this second type. However, biomedicine is only of minor significance to them. Most of these physicians practise more than two heterodox modes of treatment. Acupuncture is often combined with neural therapy, chiropractic therapy, herbalism or homeopathy. However, acupuncture remains their most frequently used heterodox mode. In specific situations of severe, acute diseases, all of these physicians resort to antibiotic drugs:

Biomedicine matters, at least when I need a strong and quick solution. I still prefer biomedicine in cardiovascular conditions. Hypertension, for example, is a condition where I don't mess around needling or cupping for too long, but where good old beta-blockers do the trick. And - if it is really necessary - antibiotics in cases of hefty inflammations, acute stuff. In those cases I use it, but as a therapy on its own biomedicine does not exceed 5% of my practice. (A13)

Acupuncturists of this type appreciate biomedical diagnostic methods. Even though it doesn't provide any information for Asian therapeutics (e.g. *qi*-flow), it is highly esteemed as an informational source for the decision between orthodox and heterodox medicine. It also helps to rule out dangerous diseases, which might not be discovered by Chinese diagnostics:

For me, decent diagnostics have to precede acupuncture. I never insert needles in anyone who comes in here saying, 'I've got this and that – what are you waiting for?' (A12)

It appears to be difficult to reconcile this type of medical hybridisation with the framework of public health insurance as all four medical acupuncturists of this type work in private practice.

Type III – Biomedical incorporation of acupuncture

While type I and type II physicians practise rather loose combinations of heterodox and orthodox medicine, we now turn to forms in which the various concepts are blended together. According to our logical framework, the first alternative is the inclusion of acupuncture in biomedical paradigms. Its efficacy is not explained by Chinese, but by biomedical concepts:

There is feedback in the brain, which triggers the selective distribution of opiates. Reflexes are triggered and a selective relaxation takes place – particularly in muscular and orthopaedic conditions. I don't think it would be too difficult to prove that scientifically. (A2)

Only one of our interviewees is integrating acupuncture in this way. This is surprising given the prominence of this line of argument within the sociology of heterodox medicine (Saks, 1992, 1994). Most of our interviewees showed little interest in scientific explanations of acupuncture. For them, clinical legitimacy exceeds scientific legitimacy: 'He who heals is right.' (A8)

Type IV – The great medical melting pot

Intense hybridisation of acupuncture happens more often in practices with a focus on heterodox medicine. Conceptual tensions between Chinese medicine and biomedicine are resolved by heterodox means:

I can also explain the efficacy of homeopathic remedies from a Chinese perspective. And

Chinese drugs as well. Over here, they are broken down into categories of effective agents. Therefore, it is easy to forget that the actual antibiotic *effect* was already known in China – not by chemical definitions, but with this whole complex range of other components, which might even reduce the side effects of the drug. (A1)

It even happens with biomedically treated patients that I find myself typing: ‚A typical heat-syndrome.‘ My receptionists know that by now. At first, they were a little horrified when they read: ‚Tongue‘ – ‚Tongue?! In orthopaedics?! And pain along the so-and-so meridian?!‘ I don’t keep that separate. Why should I? (A4)

These physicians do not only have to integrate acupuncture and biomedicine into one model of treatment, but they deal with up to ten different traditions of healing. The heterodox ingredients used are similar to those of type II physicians, but there are new principles structuring their medical practice:

I combine acupuncture with other modes of treatment – homeopathy or bio resonance – in 80% of my cases. I use Chinese concepts – like the five elements or touching the meridians – for everyone. I decide later whether to insert needles or proceed differently. Right now, I avoid it whenever possible. There will always be thorough case taking and examination, where I look at the energetic status of the patient. This is always first. And you can also discover disturbances by bio resonance, and treat by magnetic field therapy right away. Let’s assume a patient comes along with lumbago. If it is very bad, I will reduce pain by biomedical means. As soon as he is better, I will try to stabilise him with ear- and body-acupuncture and go for homeopathic case taking to find a good remedy. This is all done more sequentially than simultaneously. I switch systems when I realise: ‚All right, it can be more gentle now.‘ And there you can say: Biomedicine has strong, but short-term effects. Acupuncture’s effect is moderate and medium-term. Homeopathy is gentle and long-term. And whenever possible, I will prescribe homeopathic remedies. If it becomes more acute, I will insert needles, and if it becomes really hefty, biomedicine comes into play. I always say: ‚Acupuncture is the most surgical natural medicine.‘ You are entering the organism with a needle - that hurts - and you are pushing it around. You are in the closest contact with the patients’ qi and I don’t like it that much. (A9)

There is a hierarchy of gentleness, combined with the speed of therapeutic results. These two factors appear to be mutually exclusive: Gentle healing cannot unfold quickly, and speedy recovery requires drastic intervention. These criteria form a meta-theory guiding the hybridisation of several medical systems. It is remarkable that these methods of treatment are applied in sequence, not at the same time. Three of the fourteen acupuncturists, who - unsurprisingly - work in private practice, practise this intensely hybridised form of medicine.

The relevance of Chinese medicine

In our typology, an important component of incorporation-theory was neglected: It is argued that acupuncture is isolated from the context of Chinese medicine. Therefore, it is worth looking at the further elements of Chinese medicine that are relevant in medical acupuncturists' practice. Many of them include Chinese concepts in their practice - in varying degrees. Those with a generally more heterodox style (type II and IV) are more open to Chinese remedies or moxa therapies⁴. However, these modes of treatment are always of minor significance in their overall practice. The acupuncturists mention practical reasons for only rarely applying these treatments. In moxa therapy, it is usually the smell that prevents them from using it more frequently:

It is so smelly and people might think that I am smoking marijuana. But I use it in selected cases, preferably in summer. If the patient suffers from tennis elbow, he has to put his arm out of the window, because otherwise... But it is great. (A9)

Do you really want your practice to smell like hell? We don't do it very often and prefer to do it at the end of consultation hours. I used to do it a lot when I was working in hospital, but now in my own practice, I sometimes find myself thinking: 'Do we *have* to do it today?' Stupid reasons, but that's how it is. (A4)

It is also a time issue. You have to remain there as otherwise the patient might get burned. That's why I only use it when it is really important. (A13)

Only two of the fourteen respondents use Chinese remedies on a regular basis. For the other twelve, the complexity of Chinese pharmacology and high costs prevent them from using Chinese remedies:

It's not that I don't believe in it, but it is such an extensive study. Chinese pharmacology is always mixed, made up of several herbs that have to complement each other. And there are few pharmacies willing to store so many herbs. It would be good, but it's just too much. (A9)

I mix Chinese and European herbs. Well, 80% of the herbs are actually European as they are cheaper and much more readily available. (A14)

The majority of our participants use ear acupuncture as well as Chinese (tongue and pulse) diagnostics. The relevance of Chinese theoretical models depends on the degree of the physician's

heterodox orientation. Type II and IV physicians tended to include ideas about *qi*, *yin/yang* and the five elements more extensively than their biomedically-oriented colleagues (type I and III).

Receiving acupuncture – patients’ perspectives

The (perceived) demands of patients are an influential factor in acupuncturists’ considerations, particularly for the majority of physicians, whose treatment can be categorised under type I or II. Therefore, it is even more important to analyse the perspectives of patients who are using acupuncture. To what extent do they engage in *active consumerism* (Kelner & Wellman, 1997)?

The introduction to acupuncture

Eleven of the twelve patients who participated in our study were suffering from conditions of chronic pain, while one patient wanted to reduce his susceptibility to allergies. In the course of treatment, some of them also resorted to acupuncture for treating other more general ailments, such as sleeplessness or ‘stress’. In four cases, the acupuncturist was also their GP. After attempts with biomedical treatment, the physician offered the patient the option of “trying something else”. The other eight patients sought acupuncture for one specific disease.

The most common reason for patients choosing a particular physician was related to convenient access. For seven patients, the proximity of the acupuncturist’s practice to their homes was the decisive factor in their choice. Some of them consulted the Yellow Pages, while others followed the advice of members of their personal network. Consideration of the financial issues completed this pragmatic attitude:

It was on my mind for some years, but it was too expensive when I was a student. But when health insurance started covering the fees, I told myself: ‘I’ll give it a go!’ because even if it doesn’t help, I don’t lose that much money. Then I grabbed the Yellow Pages and he [this patient’s acupuncturist] was the closest to where I live. (P⁵⁵)

We expected the patients to criticise biomedicine to a certain extent. This expectation was not met, and there was no ideological background to the patients' preferences. All of them had tried – unsuccessfully - to confront their diseases by biomedical means. Therefore, the only charges levelled against biomedicine were the limited efficacy and side-effects of biomedical drugs:

I stopped the biomedical stuff, because it didn't help, even though the drugs were strong enough to produce severe side-effects. They even gave me this beta-blocker for my migraine which caused me to hallucinate as the dosage was that high. (P5)

I tried all kinds of conventional painkillers, but nothing helped. Then I received these particular migraine-drugs, but I got this terrible kidney pain from them. Then I took strong headache medication which sent me into a state of semi-consciousness, but I didn't care anymore. I just wanted the pain to ease. (P4)

Despite these negative experiences with biomedical treatment, patients of acupuncture do not turn their back on biomedicine. It is more common to choose acupuncturists as consultants for conditions involving chronic pain. While most of the younger patients said that they do not consult many physicians, as they are – apart from their chronic complaint – healthy, the older patients in our sample reported that some of their chronic conditions are still being treated by other medical doctors.

For my heart problems, I swallow this beta-blocker and that's it. (P4)

Biomedicine is necessary. Without it, you can't fight severe diseases. But it doesn't always *have* to be biomedicine. If you know what you have and it is not life-threatening, you can always go for gentler methods. (P3)

If there was someone with pneumonia or appendicitis, I wouldn't tell him to go to an acupuncturist, I would send him to a biomedical physician. But for trivial conditions or someone like me, who has tried everything for certain chronic complaints, I would say, 'Try it out.' I didn't experience any side-effects. (P5)

Of course I still go to a biomedical physician. I had lumbago the other day, received an injection and it was fine. And I also have diabetes for which I need my pills. (P10)

This hierarchy of disease severity is a common way for patients to structure their healthcare choices. Most patients in our study assessed the efficacy of biomedical treatment and that of heterodox treatment on the basis of disease categories. It is a clearly pragmatic and complementary approach to medical pluralism in Germany. This pattern is further enhanced by the limits set by insurance

companies. Patients have to make an application for reimbursement for their acupuncture treatment, and it is always a series of ten consultations that are granted. For further treatment, patients have to apply again.

While all patients reported extensive experience with biomedicine, just four of them had used heterodox modes of treatment before trying out acupuncture. Some of the eight other patients even gave decidedly sceptical accounts of heterodox medicine:

I never went for alternative medicine before. Back in Frankfurt, my wife had this GP with – how should I call it – homeopathic leanings. Minor flus were treated with these little pills, these placebos. [patient laughs] (P2)

This patient appears to make an exception for acupuncture. Five of the twelve patients had used acupuncture in the past at a practitioner other than their current one. While one of these patients changed his acupuncturist because he moved to another part of the city and preferred a physician closer to his home, the other four patients' previous attempts with acupuncture had been unsuccessful. This is remarkable in that it shows that patients did not attribute failed attempts to cure a condition to the particular method of treatment applied, but rather to the physician who applied it. Patients appear to distinguish between the healing potential of acupuncture as a mode of treatment and the individual practitioner administering the needles. The fact that patients give acupuncture a second chance is another sign that acupuncture has already gained legitimacy within the German healthcare system.

Consumerism in (heterodox) healthcare

The popularity of heterodox medicine among patients has often been explained by increasing consumerism in healthcare. Our data confirms the notion of consumerism to an extent. Patients are very conscious of the quality of the medical services they receive. Our questionnaire included an open question on what patients appreciate most about their acupuncturist. We had expected the patients to value extended consultations involving patient-centred communication. However, most of our respondents mentioned rather pragmatic and mundane aspects they appreciated most in their

I was referred to this urologist for some diagnostics. And it was great as far as the technology goes. But apart from that, it was ridiculous. The receptionist was yelling my name across the waiting room, then shouting: 'Is your bladder ready now?!' Afterwards, she was yelling: 'Next time you come, make sure you show up with a full bladder!' All these other patients around – it was unbelievable. It didn't only happen to me, but to the other patients as well. (...) And there is such a long time between the appointments: 'Alright. Please come back in two weeks.' All that hassle – it was cancer diagnostics that didn't produce any results – took six weeks. You're always left hanging and nobody tells you what you have. They examine and say: 'Ok. Please get another appointment at the desk.' And that's it. The next time I went there and asked about the previous diagnostics, they said: 'The boss will tell you.' Well, he did - six weeks later. And that's why I love going to her [the acupuncturist], because whenever she checks something, the results are back within two or three days, while it takes ages at other physicians. I mean, the insurance is a bit more expensive, but it is worth it. (P7)

What I thought was very positive was that appointments were kept. You don't turn up on time and wait for another hour. I hated that about other physicians. (P5)

I chose her because she also visits her patients at home. Who does that nowadays? (P1)

Quick diagnostic results, reliable appointments, home visits – it is no surprise that patients approve of these aspects. However, these reasons are not quite the ones we expected *heterodox* patients to mention as the most important. They appear typical of patients' assessment of private medical care in general. While these notions of good medical service represent a rather passive form of consumerism in healthcare, we will now turn to patients' *activities*. Far from becoming experts in their own health, patients did not generally collect a significant amount of information on different methods of treatment. Most patients were also highly indifferent to Chinese medical knowledge, and this did not change during the course of treatment.

Read books about it? No. I mean, I go to a physician because I tell myself: 'This is an expert. In the medical field, he can help me.' Just like parents come to me, saying: 'Teach my child how to play the guitar. You know how to do it.' You have experts for all parts of life and I am not forced to study everything. I don't think I would comprehend it anyway. He once tried to explain it to me, but I didn't understand a thing. That's what I consult an expert for. (P12)

Only some patients theorise about why acupuncture is effective. However, not even these patients are interested in Chinese medical thinking. Rather than conceptualising Chinese medicine as a holistic or spiritual mode of medicine, they incorporate acupuncture in readily available mechanistic models. To

circulation' (P3), and works along 'nerve fibres' (P2). They were quick to add that they do not really care 'as long as it helps' (P7). Focusing on efficacy, the patients participating in our study revealed strongly pragmatic ways of dealing with the foreign body of Chinese knowledge. Only one out of the twelve participants deviated from this typical behavioural pattern, as he had gathered a large amount of information about all kinds of treatment options. By using the Internet extensively and consulting the information centre at a university hospital, he collected wide knowledge about potential biomedical or heterodox modes of treating his migraine. Still, he was far more knowledgeable about his condition than about available treatment options, and he showed no interest in studying the underlying theories of the therapies he contemplated trying out.

Physician-patient interaction in medical acupuncture

Among the patients that participated in our study, there is little curiosity about any details of acupuncture or Chinese medicine. It is surprising that this pattern can be found in all our patients. Their limited knowledge about acupuncture is not without consequences for the decision-making process in the consultation. *Shared* or *informed* decisions would imply that patients and physicians had discussed the appropriate points at which needles should be inserted. However, if the patients had no knowledge about acupuncture, these discussions would be useless. The only decisions to be made are between various (biomedical or heterodox) modes of treatment. Patients are usually strongly involved in these choices. However, even in these decisions we can find strongly paternalistic patterns:

I only knew that he was a pain therapist⁶. But then he said that he also does acupuncture and that we should try it again. I didn't really want that, as it hadn't helped when I did it the first time. But he simply said: 'Lie down. We'll start right away.' I was taken by surprise. While we were talking, he was listening and nodding and then - well. Luckily! Maybe I would have said no, but I wasn't asked - lying down, needling. Now, I am happy, because it worked so well, but... (P11)

The relationship between heterodox physicians and their patients is an important element in the debate about the popularity of heterodox medicine. Opponents seize upon the patient-physician relationship in heterodox medicine, claiming that its perceived benefits are nothing more than placebo effects

Supporters argue that biomedical interactions alienate patients, while heterodox medicine allows a more human and holistic approach. Extensive consultations matter strongly in some heterodox modes of treatment, such as homeopathy (Frank, 2002b). They appear to be less important in acupuncture. Apart from a lengthy first consultation, our interviewees' accounts of the interactions with their acupuncturists are homogenous: Some five to ten minutes of conversation⁷ (which include pulse and/or tongue diagnostics) are followed by the insertion of needles. In these twenty to thirty minutes, while the patients are lying in a separate room, the receptionist occasionally looks in on them⁸. Afterwards the receptionist removes the needles and the patient leaves. None of our respondents appeared to be dissatisfied with this procedure as they had the impression that there would be the option of a longer conversation with the physician if needed:

At other GPs, the waiting rooms are packed. That's normal and you start to have a bad conscience as soon as you require two additional minutes. For those doctors I tend to rehearse my symptoms beforehand so that it takes as little time as possible. But with him [acupuncturist] – I don't know whether he is so well organised or whether he doesn't have that many patients – it is not that full. I always have the feeling that I could talk longer if necessary. (P10)

None of the patients reported ever having used this 'extra time'. Rather than complaining about the relatively brief conversations (compared to other heterodox methods), nearly all of the patients praised the relaxing effect of the period when they are lying down with needles inserted in their bodies. They described the consultations with their physicians as pleasant events, but there are some exceptions to this rule:

At the beginning she talked a lot. I found it a bit redundant and arbitrary at times. But it got less and less, because I think she realised that I wasn't that keen on it and that I didn't respond terribly much. Then she started telling me things about her private life, what she did the night before, whether she went to the movies, asking me what I did in the evenings or where I would go to. Things you talk about with your girlfriends. Quite bizarre. I think she's great at feeling the pulse and with the needles, but as regards the conversation, I never had the feeling of benefiting from it or being in good hands. (P6)

This patient, who strictly restricts the acupuncture treatment to pulse diagnostics and needling, is an extreme example. However, verbal communication was not a crucial aspect of any of the patients'

for analysing the patterns of interaction between medical acupuncturists and their patients. For an in-depth analysis, quantitative surveys and/or observational data (e.g. video-taped consultations) would be required.

Discussion

There has been widespread enthusiasm about patient-centred medicine and egalitarian concepts in the medical encounter. However, there have also been words of caution, as not all patients are keen to participate in medical decision-making (Arora & McHorney, 2000). According to our data, acupuncture patients neither aspire to gain deep insights into the rationale of Chinese medicine, nor do they seem to be particularly interested in getting involved in medical decision-making. The most suitable concept to describe clinical encounters in acupuncture seems to be the paternalistic model inspired by Parsons (1951), because all decision-making control is centred on the physician. We hesitate to generalise these results, as there is no such thing as *the* quintessential heterodox medical interaction. Homeopathic patients appear to be much more interested in being involved in therapeutic decisions (Frank, 2002a). It is also conceivable that we might find different patterns in other institutional settings, such as the practices of non-medical acupuncturists.

Patients of acupuncture do not readily fit the mould of ‘active consumers’. They certainly show aspects of consumerism by assessing the quality of the medical services they receive. However, there is little evidence that they try to become experts on their own health by seeking information and comparing various treatment options. Instead, they appear to be *passive* consumers who are conscious about good service, but who also leave it up to their physician to deliver a high quality of service. Our patient sample is certainly limited – not only in its size, but also because we allowed the physicians to choose the patients. Therefore, satisfied patients are almost certainly over-represented in our study. It is unclear to what extent this bias also influences other aspects. Quantitative surveys would be helpful in assessing how important patients regard factors such as convenience (proximity to their homes) and

assessing the quality of their acupuncturist's service. Does our data demonstrate patients' perspectives and behaviours specific to acupuncture or – equally possible – to the particular diseases for which patients consult acupuncturists? Can we find more active patients among heterodox forms of treatment, for which the patients have to pay for themselves? Patients using Ayurveda in Germany, who do not receive any reimbursement by health insurance, are similar to patients of acupuncture in terms of their indifference towards Asian medical knowledge. However, Ayurvedic patients show a higher level of activity in implementing the nutritional advice given by their physicians - they even regard the opportunity to become actively involved in coping with their disease as an important asset of Ayurveda (Frank & Stollberg, 2002). It would be premature to attribute these behavioural differences to the varying economic contexts as they might as well be caused by the specifics of the respective medical concepts, by difference in the patients' sample or the physicians' practice styles.

While there is little evidence of the patients engaging in active consumerism, it is up to the physicians to *actively* engage in consumerism. All of the medical acupuncturists in our study practise at least biomedicine and acupuncture, and the majority of them also uses further heterodox modes of treatment. With this wide arsenal of healing methods, they are able to tailor their therapies to patients' specific demands or what they regard as their patients' needs. This consumerist model corresponds with accounts of heterodox medicine being part of increasingly flexible delivery of healthcare (Bakx, 1991). Again, it is not possible to generally apply this adaptive model to all forms of heterodox medicine. In Germany, only a minority of medical homeopaths practises in such a flexible and occasionally hybrid fashion. While some of them segregate their patients into categories of homeopathic and biomedical patients in a consumer-oriented way, the majority complements homeopathic remedies with a few biomedical strategies for diagnostics. Most German homeopaths do not adapt their ideas of homeopathic practice to individual patients, but reject patients who disagree with their practice styles. Therefore, they show few signs of flexible consumerism (Frank, 2002c).

The medical profession has been criticised for countering the 'heterodox challenge' by incorporating acupuncture in biomedical models (Saks, 1992, 1994). As these studies are based on an analysis of the strategies of the professional bodies, their results tell us little about day-to-day medical practice. In our study, half of the medical acupuncturists isolate acupuncture from the context of Chinese medical

theory. However, there is little evidence that they make acupuncture subordinate to biomedical hegemony. While scientific explanations of acupuncture (e.g. efficacy via endorphins) are used for teaching⁹ and for increasing societal acceptance of Asian medicine, they remain almost irrelevant for practising physicians. Similarly, biomedicine does not always dominate the physicians' overall treatment. At times, it is biomedicine that is made subordinate to heterodox medicine and used in a complementary manner.

While our data only confirms notions of incorporation to a limited extent, we can find even less evidence that medical acupuncturists regard themselves as heretics. This might have historical reasons. Studies by Goldstein (1985) or Wolpe (1990) are based on data collected in the early 1980s. By then, heterodox medicine was much less accepted than at the beginning of the 21st century. It is possible, that heretics and mavericks played a more significant role at this stage of the diffusion of acupuncture to the 'Western' world (Cant & Sharma, 1999). None of the fourteen medical acupuncturists in our study practised in a purist fashion or had converted completely to Chinese medicine.

Our findings on patients of acupuncture diverge from previous studies. While we can identify one *eclectic user*, Sharma's (1992) typology does not appear to be applicable to our data, as the patients combine elements of *stable users* and *earnest seekers*. Out of Schulz's (2001) four approaches to heterodox medicine, the utilitarian/pragmatic orientation clearly prevails among the patients in our study, as none of them consulted their acupuncturist for psychological problems or came from an ecological or spiritual/religious social environment. As both of these studies are based on a wide range of treatment options, it is appropriate to ask how much medical acupuncture still has in common with other heterodox modes of healing. Should acupuncture be labelled *heterodox*, *complementary* or *alternative* medicine? While acupuncture is still heterodox in the sense that it is grounded in a foreign body of knowledge, the prominence of acupuncture in the German healthcare system implies that the standing of acupuncture within society might be somewhere between biomedicine and less legitimate heterodox modes of treatment. It might also be suitable to analyse acupuncture as being on the way to becoming a medical speciality that can be used to treat specific conditions, mostly involving chronic pain. We can observe similar processes for chiropractors who tend to become consultants for spinal

complaints (Coulter et al., 2002). The reimbursement policies of German health insurance companies, who only cover acupuncture fees for migraine and lower back pain, accelerate this process. By contrast, physicians practising other heterodox modes of medicine, such as homeopathy or Ayurveda, are consulted like general practitioners, as patients seek help for a broader spectrum of complaints (Frank, 2002b). Instead of antagonistic dualism between heterodox and biomedicine, a process of social differentiation appears to unfold. Given the surprising results on patients' expectations in acupuncture, further studies could compare whether these resemble the expectations of consultants or rather those of other heterodox patients.

It has been argued that patients using heterodox medicine hold post-modern values (Siapush, 1998, Astin, 1998). Our data material on patients of medical acupuncture does not confirm this interpretation. The patients' approaches correspond with classical modernity, including strong trust in medical experts and little patients' involvement in decision-making. However, while we did not observe post-modern patients, the increasing popularity of heterodox medicine represents a move towards post-modernisation of health care on a more structural level of (medical) pluralism. Not only does the number of available treatment modalities rise, but the various forms of hybridising heterodox medicine and biomedicine serve to even further multiply heterogeneity. At first sight, the options for combinations appear unlimited. However, not all possible permutations of the ingredients are actually realised. There is, for instance, no model in which Chinese diagnostics lead to a biomedical therapy, and acupuncture is praised in particular for its *therapeutic* value. Therefore, hybridisation is not a random process, and the limits of hybridisation would be an interesting area of future research. Additionally, hybridisation of medical concepts also implies the dissolution of fixed boundaries between the respective modes of treatment. But there are more distinctions that are challenged by the developments in the last two decades. The integration of heterodox forms of medicine into formal sectors of health care delivery and the physicians' increasing openness to practising heterodox medicine and to referring patients to the respective practitioners appear to show a sweeping success of heterodox medicine. However, this is only the case for certain treatment modalities, such as acupuncture, homeopathy, naturopathy or chiropractic, while others remain marginal. Instead of a

clear-cut dualism between biomedicine and heterodox medicine, a new continuum - with medical concepts commanding varying degrees of social acceptance and state support - emerges in the medical pluralism of 'Western' countries. With fragmentation and hybridisation of medical concepts, patients choosing as – in this case passive - consumers from these options, with the dissolution of binary oppositions (orthodox/heterodox, established/marginal, scientific/non-scientific health care), the (re-) emergence of heterodox medicine seems to have contributed to a more post-modern health care system. However, there are counter-currents as well: Highly relevant dualistic distinctions remain firmly in place: Whether heterodox medicine is practised by a medical doctor or by a 'lay practitioner' determines their legal status as well as reimbursement policies by health insurance companies all across Europe. Furthermore, biomedicine remains dominant in 'Western' countries and concepts of evidence-based medicine (EBM) become increasingly influential. Within a modernity/post-modernity distinction, EBM surely represents a modernist approach as it rests on the meta-narrative of scientific progress. This already affects heterodox medicine as professional bodies of certain modes of healing (Cant & Sharma, 1996) as well as practising heterodox physicians (Frank, 2002c) claim the label 'scientific' for their approach and thereby alter their knowledge base in a modernist fashion. An increasing number of randomised-controlled trials that are supposed to test the effects of heterodox medicine are the result (Ernst et al., 2001, Marstedt & Moebus, 2002). Therefore, we can speculate that developments in health care – such as EBM – tend to modernise heterodox medicine, while the increasingly strong presence of heterodox medicine contributes to a post-modernisation of health care delivery in 'Western' countries.

¹ Acupuncture is often described as part of *TCM (Traditional Chinese Medicine)*. This term appears to be misleading as there is no equivalent to it in Chinese and – more importantly – this *traditional* form of medicine is a rather recent development dating from the late Qing dynasty (19th century) when a wide range of divergent practices was labelled *Chinese medicine* in order to juxtapose them against *Western medicine* (Croizier, 1976, Unschuld, 1992). It was not until Maoist healthcare politics that the idea of *Traditional Chinese Medicine* became influential (Hsu, 1995, Farquhar, 1994).

² 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 practise whatever medical tradition pleases them. Without it, professional practice of treating patients is illegal in Germany.

³ "A" stands for acupuncturist.

⁴ pastilles which are burned on acupuncture-points.

⁵ "P" stands for patient

⁷ We have to be careful not to overestimate the accuracy of the patients' estimates. Their accounts are, however, consistent with the physicians' reports.

⁸ While it is believed that acupuncture has no side-effects, there is a small chance of the patient collapsing during acupuncture.

⁹ participant observation by Frank & Stollberg of acupuncture courses offered by the largest German organisation of medical acupuncturists (DÄGfA) in 2001.