

Complementary and alternative medicine: the next generation of health promotion?

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SUMMARY

This paper reports on a research study into the professional interface between health promotion and complementary and alternative medicine. The study was conducted in the UK, the USA and, to a lesser extent, Eastern Europe. Professionals from both sides of the interface were interviewed. The findings suggest that health promoters committed to individual empowerment and community

action are the most likely to support some form of involvement with complementary and alternative medicine, while the least likely are those committed to structural changes through a public health agenda. The paper identifies the potential for closer integration but also reports on substantial barriers to collaboration between these two professional groups.

Key words: alliances; complementary and alternative medicine; health promotion; professional interface

INTRODUCTION

At the dawn of the 21st Century, health promotion and complementary and alternative medicine (CAM) are on the threshold of exciting new developments in health and health care. Health promotion is at a pivotal point in its history and must redefine and reposition itself in the light of an expanding public health movement. CAM appears to be increasingly popular with the public and to be gaining credibility within biomedical health care. As with health promotion, CAM must redefine its boundaries and establish its place within a changing and expanding health movement.

During the last 20 years, conventional views on health and health care have been subject to increasing criticism and there has been a growing interest in CAM. Surveys show that approximately one third of the population in the UK (Ernst, 1996) and slightly more in the USA (Kuhn, 1999; Wootton and Sparber, 2001) have used CAM. There is evidence that mainstream

health care professionals, while still calling for more research, are increasingly interested in integrating some forms of CAM (Coulson, 1995; Hoffman, 2001). A recent House of Lords Select Committee Report in the UK concluded that for some CAM therapies there was sufficient evidence to recommend their use within mainstream health care (House of Lords, 2000).

An important feature of the new health developments is an emphasis on working in collaborative partnerships (DOH, 1999) and there is growing recognition of the need for health promotion to work in partnership with other professions (Scriven, 1998). This paper reports the findings of research into one possible such partnership—the interface between health promotion and CAM. It also identifies the potential for closer integration and reports on the substantial barriers to collaboration between the two professional groups.

Terms used in this paper

Concepts such as health, health promotion and complementary medicine are used in many different ways across, and on either side of, the HP–CAM interface. Within this paper the following meanings apply:

The term *health promotion* (HP) covers the promotion of positive health and the prevention of illness, through health education and public policy initiatives. The term *health promoter* (Hp) is used to refer to individuals whose primary professional role involves health promotion as defined here. The term *complementary and alternative medicine* is used here to describe a wide range of medical systems, diverse therapeutic practices and alternative health care systems that fall outside the boundaries of conventional biomedicine. The term *complementary therapy* is used to refer to specific therapies that fall under the umbrella of CAM. Both terms are used here in reference to CAM as it is practised in developed countries, particularly in the UK. *Complementary therapist* (Ct) refers to any individual whose primary professional role involves one or more complementary or alternative therapy.

The literature

There is a fairly wide range of literature relating to the relationship between mainstream biomedical healthcare and CAM [e.g. (Coward, 1989; Ernst, 1996; Micozzi, 1996; Ranjan, 1998; House of Lords, 2000; Hoffman, 2001)], but very little that specifically examines the relationship between CAM and health promotion.

The main academic health promotion texts commonly used in the UK rarely include complementary medicine [e.g. (Naidoo and Wills, 1994; Tones and Tilford, 1994; Katz and Peberdy, 1997)]. One exception is to be found in *Health and Wellbeing: A Reader*, produced for a second level Open University course (Beattie, 1993). This text includes three relevant chapters: one on Afro-Caribbean remedies; one on concepts in alternative medicine; and one on natural medicine. However, even these chapters do not directly address the interface with health promotion.

Lupton (Lupton, 1994; Lupton, 1995) offers an interesting sociological critique of public health, including health promotion, which includes a brief consideration of CAM. She is initially quite positive about CAM, arguing that it provides sensitive care for individuals and plays a useful

role in challenging the scientific basis of medical orthodoxy. However, she expresses concern that CAM, like health promotion in her view, places undue responsibility on the individual.

Given the popularity of CAM and health promotion's growing awareness of the importance of partnership, one might expect to find reference to the HP–CAM interface in texts on inter-professional work. It is therefore particularly significant that CAM is not even mentioned in a health promotion text devoted to collaboration with other professional groups (Scriven, 1998). It should also be noted that a report on a systematic search of the literature on effectiveness of alliances for health promotion did not identify any examples involving CAM (Roe *et al.*, 1999).

Academic and professional journals in health promotion rarely include articles on CAM. Where articles are included, they mostly consist of relatively non-problematic accounts of the practical application of one or more particular therapy. A typical example of this type of article is to be found in the then Health Education Authority (HEA) journal *Healthlines* (Millar, 1995). The article describes how elderly residents appear to have gained from the introduction of complementary therapies into the routine of residential homes. Other types of article tend to focus on either the introduction and/or funding of complementary medicine in the National Health Service (NHS) [e.g. (Nelson, 1995)], or the effectiveness and/or safety of particular therapies [e.g. (Samarel, 1997)].

One brief example that directly addresses the HP–CAM interface can be found in an early edition of the *Journal of Contemporary Health*, which reports on an interview with Donald Nutbeam (then Professor of Public Health at the University of Sydney). Nutbeam was asked about the interface and is reported as saying:

... there are a number of approaches to alternative medicine which seem to me to be entirely in tune with the underlying concepts and principles of health promotion ... I think the relationship could probably be symbiotic, rather than one harnessing the other ... (Gibson *et al.*, 1995).

The UK health promotion publication that is most frequently mentioned in relation to CAM is the *HEA Guide to Complementary Medicine and Therapies* (Woodham, 1994). It gives a brief introduction to the relationship between CAM and biomedicine and then offers an A-to-Z guide to the most popular forms of CAM available in

the UK, but it does not attempt to explore issues concerning the HP–CAM interface.

There has been some discussion in the CAM literature concerning the World Health Organization's (WHO) approach to health promotion. For example, an article in the *International Journal of Alternative and Complementary Medicine* discussed the relationship between primary health care (as recommended by WHO charters and declarations), complementary medicine and health promotion (Correa, 1999). Such articles usually endorse closer collaboration, but rarely debate the issues that might be involved in any depth.

One of the most detailed discussions to date is that of Whitehead (Whitehead, 1999). Whitehead argues that health promotion and CAM are closely related and draws attention to similarities in philosophy between health promotion and CAM, concluding that constructive dialogue between CAM and health promotion could lead to a positive paradigm shift in contemporary health care. However, Whitehead is more persuasive than analytical and does not address, for example, the different models of health promotion commonly found in the literature or the diversity of forms of CAM available to the public.

Theoretical models of health promotion do not appear to any extent in the literature on CAM. Most often CAM texts make assumptions about health promotion that may offer little resemblance to the term as it is used by health promoters. For example, in the text entitled *Holistic Health Promotion: A Guide for Practice* (Dossey *et al.*, 1989), the authors are interested in a highly individualistic, transpersonal view of health that goes beyond, or even against, much contemporary health promotion.

Although the literature offers little discussion of theory relating to the interface, there are many examples of CAM texts that include aspects of health promotion that would be acceptable to many professional health promoters [e.g. (Woodham and Peters, 1997)]. However, as with the example by Dossey discussed above and the *HEA Guide*, these present the interface in action but do not offer any discussion of the HP–CAM interface in itself.

THE RESEARCH

The research addressed issues relevant to the professional interface between health promotion and CAM in developed countries, particularly

within the UK. It examined a wide range of health promotion models and different types of CAM. It explored the perceptions of both health promoters and complementary therapists in relation to the interface.

The research employed methods designed to bring together theoretical and empirical data (Lader, 1998). The theoretical data were drawn from an extensive literature review, encompassing health promotion, CAM and biomedical texts. The empirical work was exploratory, and used qualitative fieldwork methods. The empirical data were primarily collected through interviews with 52 key informants from a range of relevant settings, primarily in the UK but also in the USA and Eastern Europe. The interviews were conducted between 1995 and 1998.

The fieldwork methodology borrowed extensively from many of the principles and practices of contemporary ethnography [e.g. (Hammersley, 1990; McKenzie *et al.*, 1997; Miller and Dingwall, 1997)]. The research therefore adopted an in-depth approach to interviewing whereby the researcher could explore the meanings and interpretations of participants in relation to the HP–CAM interface. The interviews were conducted in such a way as to enable meanings to emerge through discussion and were not designed to collect pre-determined, fixed perceptions.

The key informants were chosen because their position and/or publications indicated that they might have useful insights into the research issues. They were selected on the basis of theoretical sampling, using both deductive and inductive methods. That is, some participants were selected on the basis of prior theory and insights from previous data, and some were chosen as a result of emerging data (Layder, 1998).

Interviews were carried out with health promoters from education, the health services and the voluntary sector, and complementary therapists working in different settings and from a range of therapies. Professionals using complementary therapies that were more or less acceptable to the world of mainstream biomedicine were interviewed, including those who were not medically trained.

Although the research was UK focussed, it examined the professional interface between health promotion and CAM as it is practised in developed nations. The USA appeared from the literature to be at the forefront of many initiatives in the use of CAM and had recently set up an Office of Alternative Medicine as part of the

American National Institutes of Health (now the National Centre for Complementary and Alternative Medicine). Twelve key informants were therefore interviewed in the USA.

A focus group interview was also conducted in Budapest. This focus group was composed of national co-ordinators of the East European Network of Health Promoting Schools. Key professionals in the development of health promotion within their own countries, mostly working at a national level and responsible for health promotion in many contexts including schools, brought a range of perspectives to the research.

The interview data were analysed following the principles of grounded analysis (Bartlett and Payne, 1977; Ball, 1990; Boulton and Hammersley, 1996; Anzul *et al.*, 1997; and Layder, 1998). The analysis identified a number of significant issues, which are reported in the following section.

FINDINGS FROM THE RESEARCH

The study found that the two sides of the interface function largely as separate entities without shared activities. The study also found considerable, albeit minority, evidence of innovative, collaborative work, including interesting examples of joint HP–CAM projects in the UK, the USA and Eastern Europe. These examples included individual and community-based health promotion, involving a wide range of different complementary therapies. They appear mostly to have been initiated by keen individuals, acting as innovators and/or change agents.

The findings indicate that health promoters and complementary therapists hold a wide range of views relevant to the HP–CAM interface. There is uncertainty about the definition and boundaries of CAM, and which therapies should be considered complementary to biomedicine and which considered alternative, or even ‘fringe’. However, participants generally agreed that CAM is increasingly popular with the public and has growing acceptance within biomedicine. Most health promoters believe that CAM can be effective and typically argued that there are some randomized control trials that support this view. However, they also call for more research into both efficacy and safety.

Many participants were anxious that, in addition to randomized control trials, appropriate forms of research should be developed to test the claims of CAM. Some were interested in the very

nature of knowledge and discussed issues relating to meaning and metaphor in postmodern terms. For example, it was suggested that the great systems of complementary medicine offered *rich narratives* from which people could make sense of the changing medical world and negotiate the rocky waters between different knowledge systems—different ‘knowledges’ (Hp 13).

Most participants called for more training and registration of complementary therapists:

One of the difficulties is ... the issue of quality control. There are some very good people around—there are also some rip-off artists. (Hp 21)

In particular, health promoters argued that complementary therapists need more and better training in the theory and practice of health promotion. Several voiced concerns that complementary therapists appeared to them to be working with individualistic, victim-blaming models, which most health promoters now consider counter-productive.

Participants claimed that their personal experience of CAM influenced their professional judgement:

You promote your own particular view of the world. And you promote your own particular view of complementary therapies. (Hp 36)

In this study, 23 participants recounted personal experience of CAM that was perceived as having a positive impact. Only three participants reported negative experiences. Reported experiences covered 24 different therapies, with the following therapies receiving most attention: acupuncture; crystals; energy healing/therapeutic touch; homoeopathy; massage and aromatherapy; meditation and visualization; personal development and counselling; and yoga and Tai Chi.

Participants also discussed the nature of health, and in particular the importance of positive health to both health promotion and CAM. Most supported the concept of holism, but many health promoters admitted to limited opportunities for holistic work in practice. CAM was seen to be more holistic than biomedicine, which was accused of reductionism. CAM was also associated with the concept of spiritual health. Spirituality was seen as an essential component of health by most complementary therapists:

We have got to go beyond the scientific realm in terms of how we treat people. We have to take into account

the spiritual. If you don't deal with the spirit ... then you are still missing the boat. (Ct 2)

Spirituality was a more controversial area for health promoters. Few claimed to include spirituality in their work and some felt that it could be problematic, particularly if you 'put a dogma and a theology on it' (Hp 32). However, a minority welcomed the possibilities that CAM offered in the area of spiritual health.

Attention was given to the social and environmental context of health. Health promoters keen to incorporate aspects of complementary medicine into their work often complained at the limitations imposed by government control and management priorities. The costs of complementary medicine concerned some participants in the UK who were worried about equal access to health resources. American participants were keen to stress the low cost of complementary therapies in comparison with biomedicine. Most health promoters argued that poverty was the main cause of ill health. However, they were divided concerning the appropriateness of health promotion pursuing structural changes. The research identified some interesting examples of CAM incorporated into community action initiatives, but it was quite clear that those health promoters most committed to a social model of health promotion were least likely to argue in favour of greater collaboration with CAM.

Participants rarely discussed issues related to gender, race or sexuality in this study. However, issues of culture were discussed at length and, while some cultures were seen as particularly sympathetic to CAM, it was recognized that other groups object to CAM on religious grounds. Although there was recognition of the importance of the physical environment to health, there was only marginal reference to either the local environment or global concerns in this study.

Participants discussed the nature of health promotion and debated whether promoting health was the same as health promotion. There was considerable confusion regarding the meaning(s) of health promotion. Many complementary therapists appeared to use the term health promotion when talking of health education. Health promoters discussed the different models used in health promotion and many of them were interested in developing new approaches. Particular attention was given to the empowerment model and participants debated issues of choice and responsibility.

We need to find things that can help empower people ... complementary medicine gives people a bigger smorgasbord to choose from. (Hp 32)

Complementary therapists were mostly committed to increasing personal responsibility for health, but many health promoters saw this as a form of victim blaming. There was also disagreement as to whether complementary therapies offer an empowering approach to health.

Training for health promoters in and about CAM was discussed in detail and most health promoters called for more training in this area. There was also a call for more and better health promotion publications on CAM. There was some criticism of materials produced to date and a lack of training materials was noted.

The interviews included discussion of future developments at the HP-CAM interface. Complementary therapists were clearly in favour of greater collaboration and were more likely than health promoters to see this as an inevitable development. Health promoters were more divided. Most considered that closer links would be desirable:

... sooner or later somebody's going to get the idea that holistic medicine and health promotion need to converge ... (Hp 2)

I just think that the increase in complementary therapies will provoke health promotion to do something about it. (Hp 19)

However, only half considered that positive developments were likely in the foreseeable future. Many difficulties were identified, such as: the wide range of complementary therapies involved; concerns about efficacy and safety; lack of training and registration for some complementary therapists; and other pressures on health promotion. However, a small minority of health promoters took the view that health promotion wouldn't survive if it ignored new developments, and it was suggested that CAM should be seen as 'the next generation of health promotion' (Hp 32).

DISCUSSION AND RECOMMENDATIONS

To be effective in the 21st Century, health promotion must work in partnership with other professions. At the structural level, health promotion should continue working closely with

public health. At the individual and community levels, the study indicates that health promotion could benefit from closer collaboration with at least some forms of CAM. A list of potential benefits, based on the research findings, is presented in Table 1. In the author's view, this list of benefits outweighs the potential disadvantages that are shown in Table 2. This is not to deny that there are significant difficulties involved in collaborative work in this area, and specific suggestions designed to help overcome these difficulties and suggestions for further research are included in this section.

The first recommendation is that the issue of collaboration with CAM merits consideration by national health promotion agencies. These organizations should review their positions and clarify their roles in relation to CAM. Each national health promotion organization should have a position statement on CAM and a named person to respond to enquiries on the HP-CAM interface. National organizations with responsibility for health promotion should also fund research projects designed to identify and evaluate health promotion activities at the interface. Where possible, national organizations for CAM should

play a similar role to health promotion organizations in relation to leadership at the HP-CAM interface.

Health promoters, biomedicine and the public demand more evidence concerning the safety and efficacy of complementary medicine and more research clearly needs to be carried out. However, health promoters also recognize that CAM does not entirely lend itself to traditional research techniques. Further recommendations are, therefore, that new styles of research should be explored and that more appropriate research tools be devised to complement traditional research methods.

Many participants in this study were unsure as to what counted as CAM and there was no overall agreement on which therapies should be included in any integration with health promotion. Some health promoters seek guidance concerning the merits of different therapies and research is needed to determine whether health promoters interested in CAM should limit their involvement to particular therapies.

Further research is needed into the extent to which CAM is compatible with different models of health promotion. For example, this study found

Table 1: Perceived benefits of closer HP-CAM integration

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- Opportunities to respond to the needs and interests identified by clients in relation to HP-CAM
 - Health gains for health promotion clients
 - Health promotion gains for CAM clients
 - Opportunity to correct misinformation and counter myths about CAM and biomedicine
 - Opportunities for culturally sensitive practices and the celebration of diversity
 - Providing health promoters with alternatives to biomedical views on health and health care
 - A shared focus on positive health and holistic well-being, including the spiritual dimension of health
 - Opportunity to share commitment to personal growth and (in some cases) empowerment and/or community action
 - Opportunities for developing new models of practice and identifying a new direction for health promotion/CAM
 - Improved health promotion training for complementary therapists
 - Improved training in CAM for health promoters
 - An opportunity for health promotion to work in partnership with a developing area of health care
 - An opportunity for CAM to work in partnership with an established area of health care
 - Opportunities for joint research and dissemination
 - Opportunity to clarify terms and reduce misunderstandings across the interface
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Table 2: Perceived disadvantages of closer HP-CAM integration

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- Reduced health promotion attention to structural issues/public health
 - Time, energy and expense necessary to overcome a variety of difficulties
 - Undermining of health promotion credibility if associated with unproven therapies/fringe activities
 - Risk that health promotion will give credibility to unproven and/or unsafe practices
 - Objections from some religious groups
 - Risk of health promotion adopting a new form of victim blaming
 - Reduced autonomy for two currently independent areas
 - Undermining the alternative/non-conformist role of CAM
 - Expansionism and social control on the part of HP-CAM
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little compatibility between CAM and the social change model of health promotion, but this needs further investigation. Similarly, some participants questioned whether CAM is empowering and some voiced concerns about the potential victim blaming involved in CAM. Further work is needed to address these concerns and, in particular, to explore the concept of responsibility for health as it is understood on either side of the interface.

It is also important for health promoters to examine the spiritual dimension of health in relation to the interface. Inclusion of a spiritual dimension to health appeared to be a defining characteristic of CAM for many complementary therapists and yet it is an area that most health promoters avoid, at least in practice (Hill, 1995; Hill and Stears, 1995). This area will need considerable attention if there is to be greater HP-CAM collaboration.

Another area relevant to this study concerns the training of complementary therapists in the theory and practice of health promotion, and vice versa. The study found that many health promoters were concerned about the health promotion offered by complementary therapists. The study also found that most complementary therapists had little understanding of the key issues in professional health promotion. The health promotion content of all CAM courses should be reviewed to ensure appropriate coverage of relevant health promotion issues. Similarly, suitable training in and about CAM is requested by and needed for health promoters if they are to work in this area.

CONCLUSION

The research reported in this paper explored the professional interface between health promotion and CAM, identifying the potential for greater collaboration and closer integration between the two. It is hoped that this paper will help engender and contribute to a debate concerning the future direction and focus of the interface, and that the recommendations will encourage further research and help overcome the many obstacles that stand in the way of future partnership. Although it seems unlikely that CAM will become the next generation of health promotion, the future of the interface is difficult to predict. However, one thing appears certain—health promotion in the 21st century cannot afford to ignore developments in CAM.

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