

Towards Quality in Complementary Health Care: is the German “Heilpraktiker” a Model for Complementary Practitioners?

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Complementary medicine is increasing in popularity. In most countries its practice is in the hands of non-medically trained practitioners, professions which are often not properly regulated. When discussing solutions to this problem the German “Heilpraktiker” is often mentioned. The history and present situation of this profession are briefly outlined. The reasons why the “Heilpraktiker concept” is not an optimal solution are discussed. It is concluded that the best way forward consists of regulation and filling the considerable gaps in knowledge relating to complementary medicine. Copyright © 1996 Elsevier Science Ltd.

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INTRODUCTION

Complementary (or “alternative” as it is still sometimes termed) medicine is becoming increasingly popular. This raises a number of complex issues. When regulatory problems in this area are discussed, the German “Heilpraktiker” is often cited as a viable model. This article details the German example with the aim of identifying a way of increasing quality of service in complementary health care.

DEFINITION

Most experts define complementary medicine (CM) by what it is not rather than by what it is, e.g. it is not “a system of health care which lies for the most part in the mainstream of conventional medicine” [1]. A positive definition is difficult because of the heterogeneity of the field; it encompasses techniques that have little in common and often even contradict each other. Our group has recently defined CM as “diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole, by satisfying a demand not met by orthodoxy or by diversifying the conceptual framework of medicine” [2].

PREVALENCE

In the US, about one-third of the population has used some form of CM [3], and in Europe this figure varies between 24% in Denmark and 49% in France [4]. Two different reports [4,5] suggest that, in the UK, one in every four individuals has used CM within the last year.

The motivation for turning towards CM is complex and may differ from population to population [6]. Reasons that rank prominently are the need to use all options of health care—in most cases CM is employed in addition to conventional care [3], with the hope of being cured without side-effects, and as a result of disenchantment with mainstream medicine.

On the basis of the increasing popularity of CM, mainstream medicine is changing dramatically. Recent surveys indicate that 65% of general medical practitioners believe that comp-

plementary therapies have a place in mainstream medicine [7] and that 67% of all health authorities are purchasing one or more such treatment options [8].

PRACTITIONERS

Non-medically trained practitioners (NMTPs) are the main providers of complementary health care in Britain [4]. This situation is similar in other (but not all) European countries, and in the US, it varies according to state legislation. Today NMTPs practice largely without compulsory regulation or control. In many countries, there are no formal licensing procedures and no formal continuous education programmes. It is therefore often impossible to judge the medical competence of NMTPs. In Britain only about half of them have been subjected to formal training [9]. Many doctors therefore fear that the safety of their patients may be jeopardized [10]. The BMA's call for registration, control and good clinical practice is thus understandable and timely [11]. In the UK, some complementary disciplines have made decisive steps in this direction [12], and others are likely to follow.

In the discussions surrounding these complex issues, comparisons are often made with the situation in Germany which, for many years, has had a system allowing the practice of officially registered, non-medically trained "Heilpraktiker" (literally translated meaning "health practitioner") alongside medical doctors. In a climate of change within CM [13], and the prospect of harmonization within Europe, a closer look at the German "Heilpraktiker" might provide valuable insights to guide our way to quality in complementary health care.

THE HISTORY OF THE "HEILPRAKTIKER"

Influenced by the Romantic philosophy of the 19th century, a division within medicine occurred around the turn of this century. On the one hand, the achievements of science set the stage for modern medicine. On the other hand, all-encompassing, naturopathic or holistic ideas experienced a revival, most extensively in lay circles. The German "Volksheilbewegung" (movement for health in the population) in-

cluded millions of people and resulted in thousands taking up the practice of hydrotherapy, naturopathy, homeopathy and other popular remedies postulated to be true "alternatives" to orthodoxy [14]. No law prevented NMTPs from treating patients in this way, and in the 1930s, the number of "Heilpraktiker" was equal to that of medical doctors [15]. This historical situation therefore bears similarities to that of Britain and other European countries as well as to the US today.

The Nazi government "unified" all lay organizations under their leadership in order to generate the "Neue Deutsche Heilkunde"—the "New German Medicine" [14,15]. After long disagreements, the "Heilpraktikergesetz" (the law regulating health practitioners) brought official recognition of this profession in 1935 [14]. This law was a most unusual compromise offering recognition to the existing "Heilpraktiker" while at the same time forbidding their *de novo* generation. It was therefore programmed to render the "Heilpraktiker" profession extinct. Goebbels himself called it the "cradle and the tomb of a profession" [15]. After the war, a ruling of the German High Court effectively legalized the training of the "Heilpraktiker". Since then this profession has practised medicine in West Germany, and since unification in the entire country.

THE GERMAN SITUATION TODAY

At present, the ratio of practising "Heilpraktiker" to physicians is thought to be 1:4 [16]. "Heilpraktiker" are *not* obliged to undertake medical teaching or training. A "test" is conducted by the local health authorities to "exclude danger to the health of the nation" [17]. If someone fails, (s)he can repeat the examination *ad libitum*. The failure rates at different locations vary from 0 to 100% with an average around 60% [18]. Thus, a thriving "examination tourism" has developed to those authorities with high average pass rates [18]. The "test", mainly covers legal issues. Medical knowledge is rarely included; when tested it was judged to be "acceptable" in the areas of anatomy and physiology, but "almost non-existent" in pathology, pathophysiology, differential diagnosis and general sciences [17].

The *therapeutic* repertoire of "Heilpraktiker"

is similar to that of British NMTPs, yet it puts more emphasis on "alternative" (non-validated) *diagnostic* procedures. While NMTPs of other countries usually specialize in one or two therapies, the German "Heilpraktiker" would employ many at the same time. Since the "Heilpraktiker" may also perform injections, for instance of homoeopathic remedies and other invasive procedures, complications are predictable, and fatalities are reported with depressing regularity [19–21].

In addition to these characteristics, the German health care system is hallmarked by other important peculiarities. Ninety-five per cent of German physicians practise some form of CM, and many of these have acquired an "MD for naturopathy" through courses approved by the state medical associations [22]. In Britain, by contrast, this figure is merely 20% [23]. The German health care system offers patients the choice of whom they want to consult. Many insurance schemes reimburse for consultations and treatments by Heilpraktiker. The country also has a long history of spa-medicine which was traditionally heavily based on naturopathy.

THE WAY FORWARD

The German example shows, amongst others, that registration without proper training and back-up through scientific rigour will not necessarily lead to acceptable results. Even an intrinsically "safe" remedy will inevitably become hazardous if it is administered inappropriately [24]. The long-term solution is therefore to scrutinize scientifically all therapeutic and diagnostic approaches used in complementary (*and* mainstream) medicine [25,26]. Subsequently, consumer demand may direct the choice between *validated* options of health care.

At the same time, one needs to question the competence of some NMTPs. If a therapist (mainstream or complementary) takes over full responsibility for patients (s)he should be demonstrably competent. If this pre-condition is not fulfilled, a professional who (through proper training and experience) can be seen to be competent must assume the ultimate responsibility [27]. Not surprisingly therefore, British medical students feel strongly that practitioners

of CM should, in fact, be medically qualified [28]. An initiative to harmonize the nationally different situations on an EU level proposes that all practitioners of CM receive formal training which, in length and thoroughness, is similar to that of medical schools; such practitioners would subsequently be of equal legal standing as doctors [29].

How can one choose a NMTP while the present, unregulated situation persists? The British National Association of Health Authorities and Trusts (NAHAT) has recently published guidelines on this matter [30] stating that one should select NMTPs who hold membership of professional bodies with codes of conduct, ethics and discipline, and who have indemnity cover, adequate qualifications and experience. Again this seems to be a step in the right direction, yet critics will stress that proper training and a qualification in nonsense must still amount to (at the very best, harmless) nonsense. Thus, regulatory mechanisms will be virtually meaningless without rigorous research of the effectiveness and safety of the therapy in question [25, 31].

CONCLUSION

The German "Heilpraktiker" is a concept specific to Germany, where the profession is embedded in history and has a defined legal status. In this respect, it differs from NMTPs of other countries. In other respects, the two are similar. Neither "Heilpraktiker" nor NMTPs need be medically qualified, both are essentially unregulated and have a range of training and competence which must, to some extent, make the buyer beware.

One of the most pressing issues is the regulation and control of competence of NMTPs. Going too far in one direction might put patients at risk, while going too far in the other direction would threaten a sector of health care that has become of considerable socio-economic importance [3,4], that attracts an increasing number of individuals, that is perceived as moderately effective, even by critical GPs [32], and has (for what it is worth) "stood the test of time". The best way forward, it seems, is to keep an open, yet critical, mind and to research the area systematically.

REFERENCES

1. Downer S M, Cody M M, McCluskey P, Wilson P D, Arnott S J, Lister T A and Levin M L, Pursuit and practice of complementary therapies by cancer patients receiving conventional treatment. *Br Med J* 309: 86–89, 1994.
2. Ernst E, Resch K L, Mills S, Hill R, Mitchell A, Willoughby M and White A, Complementary medicine—a definition. *Br J Gen Pract* 45: 506, 1995.
3. Eisenberg D M, Kessler R C, Foster C, Norlock F E, Calkins D R and Delbanco T L, Unconventional medicine in the United States. *N Engl J Med* 328: 246–252, 1993.
4. Fisher P and Ward A, Complementary medicine in Europe. *Br Med J* 309: 107–111, 1994.
5. NN. Healthy choice. *Which Magazine*, November 1995: 8–13.
6. Ernst E, Willoughby M and Weihmayr T H, Nine possible reasons for choosing complementary medicine. *Perfusion* 8: 356–358, 1995.
7. Adams J, With complements. *Health Service J* June 23, 1995.
8. Coulson J. *BMA News Rev* July 16, 1995.
9. Fulder S J and Munro R E, Complementary medicine in the United Kingdom: patients, practitioners, and consultations. *Lancet* ii: Sept 7; 542–545, 1985.
10. Gill G V, Redmond S, Garratt F and Paisey R, Diabetes and alternative medicine, cause for concern. *Diab Med* 11: 210–213, 1994.
11. BMA, *Complementary medicine, new approaches to good practice*. Oxford University Press, Oxford, 1993.
12. Maxwell R J, The osteopath's bill, *Br Med J* 306: 1556–1557, 1993.
13. Ernst E, Complementary medicine—changing attitudes on the fringe. *J Br Hosp Med* 50: 299–300, 1993.
14. Haug A, Die neue deutsche Heilkunde. In: *Medizin im Dritten Reich*, Bleker J and Jackertz N (Eds). Deutscher Ärzteverlag, Cologne, 1989.
15. Ernst E, Außenseiter, Schubmedizin und nationalsozialistische Machtpolitik. *Dtsch Ärztebl* 92: 104–107, 1995.
16. Kuni H, Oepen J and Becker P, Der staatliche Qualifikationsauspruch an die Ausübung der Heilkunde. *Arzt Krankenh* 35: 286–289, 1982.
17. Eberhart J and Püschel K, Sachkunde und Überprüfungspraxis bei Heilpraktikern. *Off Gesundh Wez* 50: 579–583, 1988.
18. Lubbe R, Die Heilpraktikerüberprüfung 1980–1991 im Bereich des Regierungspräsidenten Detmold—Bestandsaufnahme und Analyse, *Gesundheitsw* 55: 253–258, 1993.
19. Brettel H I, Akupunktur als l'odesursache. *Münch Med Wschr* 123: 97–98, 1983.
20. Hildebrand E. Lehren an einem Oxontherapie-Todesfall. *Med Welt* 38: 1228–1231, 1987.
21. Zimmer G, Miltner E and Maltern R, Lebensgefährliche Komplikationen unter Heilpraktikerbehandlung. *Versicherungsmed* 46: 171–174, 1994.
22. Himmel W, Schulte M and Kochen M M, Complementary medicine: are patient's expectations being met by their general practitioners? *Br J Gen Pract* 43: 282–285, 1993.
23. Perkin M R, Percy R M and Fraser J S, A comparison of the attitudes shown by general practitioners, hospital doctors and medical students towards alternative medicine. *Roy Soc Med* 87: 523–525, 1994.
24. Ernst E, The safety of homoeopathy. *Br J Homoeop* 84: 193–194, 1995.
25. Ernst E, Complementary medicine—scrutinizing the alternatives. *Lancet* 341: 1626, 1993.
26. Smith I, Commissioning complementary medicine. *Br Med J* 310: 1151–1152, 1995.
27. Ernst R, Competence in complementary medicine. *Compl Ther Med* 3: 6–8, 1994.
28. Furnham A, Hanna D and Vincent C A, Medical attitudes to complementary medical therapies. *Compl Ther Med* 3: 212–219, 1995.
29. Lanoye Report (personal communication)
30. Worth Ch, *Guidelines to employment of complementary therapists in the NHS*, 1995.
31. Ernst E, Science and anti-science in complementary medicine. *Br J Hosp Med* 54: 304–305, 1995.
32. Ernst E, Resch K L and White A R, Complementary medicine. What doctors think of it. *Arch Intern Med* 155: 2405–2408.