Bioethical Analysis Of an Integrated Medicine Clinic

Robert Lyman Potter and Jennifer Schneider

This paper considers the bioethical analysis of an alternative medicine project: first, it proposes a "bioethics analysis grid" constructed from the principles, virtues, and goals established by the discipline of bioethics; second, it describes the development of a public clinic that integrates conventional and natural medicine, and third, it supports the conclusion that this unique project has a core set of values that generally comply with the standards of bioethics.

The significant role of alternative or complementary treatment modalities both in history and in today's health care environment has been established in other papers in this issue of *Bioethics Forum*. In this paper we propose a method of evaluating the ethical issues that arise in the integration of conventional and alternative treatment modalities.

Ethical Analysis

An ethical analysis of the integration of natural and conventional medicine poses the following question: Of all the questions that arise in regard to health care, which of them qualify as bioethical issues?

One can intepret the discipline of bioethics either narrowly or broadly. When interpreted narrowly, only certain philosophical issues qualify as appropriate issues. When interpreted broadly, all human values, motivation, reasoning, and action may qualify under a general definition of ethics and be applied specifically to bioethics. In this paper we accept the interpretation of bioethics as applying to the broad spectrum of human behavior.

Bioethics as a Subset of the Philosophy of Medicine

Established views of the philosophy of medicine have placed bioethics under its umbrella (Pellegrino and Thomasma 1981 and Wulff 1986). Five clusters of issues organize a practical analysis of the major parts of the philosophy of medicine and identify the issues that are relevant to bioethics (Potter 1991):

1. philosophical anthropology, which develops a model of the human being as the proper subject of medicine;
2. causation factors for health and disease that creates a broad definition of pathological influences and therapeutic interventions;
3. clinical encounter of patient-provider as the focal point of medicine's power to influence health and disease;
4. bioethics as the discipline that provides a framework for critique of the multiple value issues involved in the entire spectrum of medical decision making from public health policy to clinical interventions;
5. cultural dialogue between medicine as a subculture and the larger society of which it is an institution.

Robert Lyman Potter, PhD, MD, is clinical ethics scholar at Midwest Bioethics Center, Kansas City, Missouri. Jennifer Schneider is a graduate student in public health at Portland State University.

This larger screen can be used to further evaluate any health care delivery system. Each of the five clusters are concerned with areas relevant to the comparison of differing philosophies of medicine. This paper will concentrate on the constellation of bioethics issues.

Bioethics Analysis Grid

The ethical grid or framework by which one analyzes any health care issue or project can be constructed from a combination of three sets of materials: bioethical principles, virtues of providers, and the goals of medicine. These elements correspond to formal ethical theories of deontology, virtue ethics, and teleology that are commonly included in the composition of broad ethical models (Becker 1973). Through a matrix of rules, virtues, and goals, a comprehensive analysis grid can be constructed.

For nearly a generation, the dominant principles in use among bioethicists have been autonomy, nonmaleficence, beneficience, and justice (Beauchamp and Childress 1994). This is a proven method of approaching the mass of bioethical issues. A recent initiative attempts to balance these principles with a practical form of virtue ethics (DuBose 1994). The virtues of integrity, respect, and compassion have been selected by the American Board of Internal Medicine as the desirable characteristics of an humanistic physician (American Board 1984). Other thinkers have suggested a more elaborate virtue schema, which will be kept as background material but not thematized here (Pellegrino and Thomasma 1993).

As an organizing metaphor for bioethics, the goals of medicine have been less well defined (Cassel 1991; Nordenfelt 1987). While there are more expansive definitions of medicine's objectives, for this analysis the diffuse goals will be compressed into dipolar aspects: maximizing human flourishing and minimizing human suffering. As an approximation, maximizing human flourishing corresponds to the promotion of health, and minimizing human suffering corresponds to the treatment of disease and providing comfort care to the incurable.

The particular idea that holds all these bioethics elements together is to place the patient at the center of concern. Although other moral agents participate in the total health care encounter, it is the patient's perspective that the principles, virtues, and goals ought to reveal and support (Gerteis 1993).

Principles

Autonomy

Autonomy is the bioethics principle that recognizes self-determination as central to human dignity. Each person is to respect the other person's values and freedom of choice in such a profound way that any personal encounter is characterized by truth telling, promise keeping, confidentiality, privacy, informed consent, and open dialogical decision making. In order to fulfill this principle all agents must have an understanding of their personal identity and the cultural competence to understand and accept the belief systems of other persons. Personal and cultural sensitivity are required by the principle of autonomy.

Questions that providers might ask to test their personal and cultural sensitivity toward patient autonomy include

1. Is the voice of the patient being heard?
2. Are the patient's values being honored?
3. Is there a careful guarding of information about the patient?
4. Is there an honest involvement of the patient in the decision-making process?
5. Is the patient's cultural context being given its full importance?
6. Are the patient's beliefs being fully respected?

Nonmaleficence

Nonmaleficence as a bioethics principle is usually expressed as a caution to avoid doing harm. Because there are multiple interventions that a provider might use in any clinical situation, it is necessary to make a judgment as to which interventions actually can reliably bring about a good

result and which ones are more likely to cause more harm than good. Without a strong empirical foundation in clinical outcomes such a judgment can be distorted by individual provider bias.

The critical questions which providers would ask to test this ethical principle are:

1. Has this intervention been accepted by a substantial portion of the medical scientific community as being the most likely to avoid harm and provide a good outcome?
2. Is this intervention creating a risk to the patient without expectation of providing benefit?
3. Is the justification for this intervention based on inadequately tested "clinical experience"?
4. Is the justification for this intervention based on inadequately tested "folk knowledge"?

Beneficence

The bioethical principle of beneficence, or doing good for the patient, has been analyzed extensively (Pellegrino and Thomasma 1988). Pellegrino and Thomasma have sorted out four aspects of defining the good: medical good, the patient's sense of the good, societal good, and a theological interpretation of the good.

Questions that providers must always ask themselves are:

1. Is this intervention as good as it is claimed to be?
2. Is this intervention more of a societal convention than a demonstrated good?
3. Is this intervention violating the patient's sense of what is good for him or her?
4. Is this particular good the most good possible?

Decisions about what is beneficial to the patient are very complex. What may appear to be a professional, clinical judgment based on science and experience may, from another persepective, lack attention to a personal belief system and to the larger cultural context.

Justice

The bioethical principle of justice tends to focus on distributive justice, although there are reasons to include broader forms of justice such as as respect for diversity. Norman Daniels has made the difficult subject of justice more practical by asking these questions (Daniels 1985):

1. What kinds of health care services will exist in a society?
2. Who will receive them and on what basis?
3. Who will deliver them?
4. How will the burdens of financing them be distributed?
5. How will the power and control of those services be distributed?

A sixth question would sharpen and extend number five:

6. Who will be allowed to profit from delivering them?

These questions give content to the idea of justice in health care. They go beyond a claim that all persons ought to be treated fairly, to a charge to specify how fairness can be tested.

Integrity

Integrity can be defined as "the personal commitment to be honest and trustworthy in evaluating and demonstrating one's own skills and abilities" (American Board 1984). Integrity as a virtue can be extended to truth-telling and promise-keeping. It characterizes the disposition to being a whole person who lives out of a deeply held set of values. In the delivery of health services the person of integrity would demonstrate the quality of caring.

Respect

Respect can be defined as "the personal commitment to honor others' choices and rights regarding themselves and their medical care (American Board 1984)." Respect, then, is closely alligned to principle of autonomy. It is respect for the dignity of other persons that involves honoring their

values, preferences, beliefs as well as being willing to compromise one's own values, preferences, and beliefs in order to accommodate other persons. Respect implies cultural competence.

Compassion

Compassion can be defined as "an appreciation that suffering and illness engender special needs for comfort and help without evoking excessive emotional involvement that could undermine professional responsibility for the patient (American Board 1984)." The capacity to appreciate the internal state of a sick person is a virtue that separates professional from unprofessional behavior. This is a special capacity for empathy.

Goals

Maximizing Human Flourishing

It is axiomatic that the goal of medicine is to maximize human flourishing (Nordenfelt 1987). How one determines which medical intervention actually maximizes human flourishing would appear to be a matter of good experimental design and adequate interpretation of the gathered clinical data. Just what constitutes health and flourishing has not reached a consensus point in most cultures. In a pluralistic society, there can be a wide spectrum of definitions of what specifically constitutes health and human flourishing. Quality of life studies are difficult to conduct and equally difficult to interpret for individual life situations. Quality of life for an individual can best be determined by that individual and not as an application of a statistical profile.

Despite the problems of functionally defining flourishing in human health, there is a compelling rationality that whatever intervention promotes flourishing is also the most ethically justified. An ethically justifiable goal of medicine is to promote flourishing in human health, and asking if any project of medicine supports that goal is relevant to an ethical analysis.

Minimizing Human Suffering

Eric Cassel has provided some clarity to the goal of minimizing human suffering (Cassell 1991). What ever means are necessary to relieve human suffering need to be considered as an appropriate function of medicine. This does not mean that all methods of dealing with suffering are appropriate, nor that all methods are in the domain of medicine. Some kinds of human suffering are psychosocial, economic, and political. How far the reach of medical intervention should extend to relieve suffering is not clear. Furthermore, there are means to reduce suffering, for example, physician-assisted suicide, that may challenge some value systems.

The treatment method that shows the most empirical power to minimize suffering through the prevention or treatment of disease should be considered as being the most ethical to apply. This empirical power must be balanced with the patient's preference since not all patients may want the "best" treatment even if it does have the strongest empirical support for minimizing suffering.

The Framework for Bioethical Analysis

The simplest approach to any issue was suggested by H. Richard Niebuhr's two ethical questions: "What is going on here?" and, "What is the fitting response to what is going on?" (Niebuhr 1963) To fully explore the complexity of any situation requires a set of questions such as those that comprise the bioethics analysis grid. This grid is flexible enough to be expanded in a variety of directions and accomplish specific analytic goals. Any one of several principles, virtues, goals or combinations of these elements can be added.

But questions of how to use this framework still exist. Should the questions for each system be compared and judged for adequacy? Is each system to be graded? Is the system with the best grade to be preferred? Should a more sophisticated system from the philosophy of science be used to determine which system of thought might be more progressive or acceptable?

Once a system is devised, the person who applies the questions to real situations needs to be determined. Should it be the scientific community, public policy makers, governmental bodies, regulatory agencies, purchasers of medical

services, insurance companies, cultural thought leaders, or a consensus of citizens (Bulger 1995)? The most sophisticated application at this time is the patient rights and organizational ethics standards of the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission 1997).

The method commonly used in society is a group of virtuously motivated citizens petition a governmental agency. The group presents an idea that is actualized through a process of bringing interested parties together to build a program that will serve the needs of the public. Professional opinion generally has precedence over public opinion. The input of the public is usually considered but is not the deciding factor.

Public values and ethical positions are made more complex by the pluralistic structure of our society. The ambiguity produced by pluralism stalls ethical discourse, making it difficult to agree on the values that will count as standards of judgment. A blending of several methods might facilitate this level of decision making, but such a method for reaching a public judgment is an unfinished task for our democratic society (Yankelovich 1991).

Specific questions that should be asked of alternative medicine are the same ethical questions thatshould be asked of any system of medicine:

1. Is it patient centered?
2. Does it respect autonomy?
3. Does it avoid doing harm?
4. Does it provide the good?
5. Does it promote justice?
6. Do its providers possess the virtue of integrity?
7. Do its providers possess the virtue of respect?
8. Do its providers possess the virtue of compassion?
9. Does it maximize human flourishing?
10. Does it minimize human suffering?

The answers to these questions become the content of the bioethical analysis of an issue or a project. After briefly describing the development of a natural medicine clinic integrated into a conventional medicine system, these questions will be answered in a preliminary way in order to conclude with a provisional evaluation of this project from a bioethical perspective.

Integration of Natural and Conventional Medicine in a Clinic Setting

In 1995, the Metropolitan King County Council (Seattle, Washington area) created a natural medicine clinic with the following purpose: ". . . to integrate natural medicine with conventional medicine to achieve the highest quality health care at the most affordable cost" (Council 1995).

The motion defines natural medicine as the "cure or prevention of disease through the use of vitamins, minerals, amino acids, enzymes, herbs, and other natural substances, or the use of nonsurgical, drugless approaches, such as acupuncture, that support the body's own healing processes" (Council 1995). In this essay, natural medicine and alternative medicine are consider to be synonomous.

The natural medicine clinic grew out of several factors: consumers have become become more health conscious and are seeking care that is cost-effective, noninvasive, and prevention-focused (Pavek 1995); there is an increasing acceptance of natural medicine by traditional institutions and practitioners (Ernst 1995); and the local council was responsive to offering citizens the choice to seek natural medicine in conjunction with conventional medicine to enhance health, maximize treatment options, and prevent illness.

The Seattle King County Department of Public Health (SKCDPH) formed an internal workgroup team consisting of epidemiologists, medical doctors, nurses, clinic managers, and administrative staff to plan the project.

The partnership of Bastyr University, Commu-

nity Health Centers of King County (CHC), Statistics and Epidemiology Research Corporation (SERC), and the City of Kent was selected to carry out the project according to the following criteria:

- evidenced ability to bring together experienced natural medicine providers and conventional primary care providers in a collaborative effort to offer integrated services;
- ability to offer a well-defined scope of natural medicine services;
- ability to offer high-quality services to low-income, culturally diverse populations, expecially immigrants and refugees, at an affordable cost;
- provision of natural medicine services with a prevention focus;
- ability to operate a program that is financially viable;
- evidenced intention to select and collaborate with an unaffiliated research entity to conduct one or more outcome research projects;
- willingness to provide updates and present findings to a natural medicine clinic advisory board and other policy-making bodies;
- be responsive to priorities and data needs of the SKCDPH and the selected research entity (Update 1996).

The clinic is expected to treat between 100 and 130 patients a day, providing a full complement of community-oriented primary health care with an integration of both natural and conventional health services. Providers include a medical doctor, two naturopathic physicians, resident naturopathic physicians in training, an acupuncturist, and a nutritionist. A chiropractor, massage therapist, and health educator will be phased into the clinic in a few months. The clinic will offer both conventional and natural therapies, as well as lifestyle, nutrition, and mental health counseling.

At the heart of this integrated model of care is informed choice regarding avenues of health care. The exception to this pertains to patients with conditions seen first by conventional providers and considered medical emergencies or requiring hospitalization (for example, fracture, stroke, acute respiratory distress, pregnancy). The patient may still choose to see a natural medicine provider after the initial visit with the medical doctor.

If the patient is unaware of the availability of natural medicine services at the clinic and is presenting symptoms determined to be best attended by the natural medicine provider, the patient is asked to see the natural medicine personnel, be educated on natural medicine services and conventional medicine services, and is given the opportunity to ask questions.

At the heart of this integrated model of care is informed choice regarding avenues of health care.

After being fully informed, the patient chooses the provider he or she feels is most appropriate. Both natural and conventional providers cross-refer as appropriate for optimizing patient health. Patients have one chart that is accessible to all providers.

Education is provided for practitioners to maximize mutual understanding. Programs include seminars, monthly joint case review, co-management of specific presenting symptoms, and joint training sessions, having the following objectives:

- familiarize natural and conventional medicine providers about the ways in which they each provide medical services and the reasons for choosing various diagnostic and treatment methodologies;
- to discuss openly and objectively the differences in approaches to diagnosis and treatment;

- to discuss the commonalities and differences between the services planned for the Natural Medicine Clinic and Community Health Center's other primary care clinics;
- to conduct problem solving as the integrated approach is implemented.

Research and development will be conducted to determine whether or not the clinic will be continued.

The Natural Medicine Clinic is seen by its designers as a "revolution" in health care, piloting an enhanced model of health care where natural and conventional medicine are fully blended, patient choice and education are primary, and low-cost, noninvasive services are emphasized.

Applying Ethical Analysis To an Integrated Medical Clinic

For the purposes of demonstration, we will use the Natural Medicine Clinic as a health care institution to which ethical analysis can be applied. Such analysis is necessary for the reasons that any health care issue or activity is evaluated: ethical issues are at the heart of the quality of human action. All human activity should be evaluated for its quality in regard to its consequence for those who are involved in the activity either as agents or patrons. This analysis is an example of preventive ethics in which the relevant questions are probed before some crisis or conflict erupts.

If there is one justification that motivates the enquiry, it is the fact that the dominant ideology of medicine is being partnered with an "alternative" ideology of medicine. The potential for such an ideological interchange to produce ethical consequences that affect patients is significant and ought to be monitored.

In general, alternative or natural medicine satisfies the bioethical, analytic questions. When integrated, both systems of medicine should be studied intensely for their contribution to an ethical approach to the whole person. The main criticism in this regard is that there is no clear evidence that the clinic has been formed with a conscious ethical dimension. For example, there is no policy adopting a patient rights statement or the establishment of an ethics committee, although there is an oversight committee to judge whether or not the experimental protocol is being observed. It is not clear whether this committee functions according to the federal rules of an Institutional Review Board.

It would be advisable to create an ethics mechanism to oversee patient rights and organizational ethics in anticipation of conflicts and dilemmas that arise in ordinary clinic operations. Moreover, making bioethics as important to health care decision making as clinical data, financial issues, and legal concerns would further distinguish the clinic.

The clinic demonstrates respect for patient autonomy as freedom of choice and has set up a mechanism for choice that has few rigid requirements restricting patient freedom. There are specific situations that require a conventional provider's attention, regardless of patient choice. The specific issue of informed consent to participate in this clinic should be addressed by those responsible for the experimental design. Issues of informed consent, however, are easily glossed over in the daily routine of clinical conduct if there are not strong safeguards in place. How well the clinic adheres to a code of ethical behavior in this regard must be monitored carefully.

In regard to doing no harm it is clear that the naturalist offers interventions with the less harmful side effects. Some critics argue that there is no therapeutic effect at all, while others point out the harm done by using ineffective interventions in pathologically progressing conditions. The accumulation of empirical data is currently underway to sort out effective from ineffective interventions. Until clinical outcome studies provide better discriminatory evidence, each provider and patient is free to negotiate which intervention is used.

Promoting the good is the objective of the providers in the natural medicine clinic. What is good is defined by a calculus of the provider, the patient, and the community. In a community where

alternative medicine techniques are widely used, it is likely that a natural medicine clinic will be perceived as promoting the good for patients. While this negotiated agreement does not meet the objective criteria of empirically-based medicine, it remains the standard method of reaching clinical judgment in most situations.

The clinic's intention to make the services affordable to low income persons serves the issue of justice. Distributive justice is the bioethical principle that has not been attended by most health reform efforts. Without a strong central method of service access, distributive justice will not be served. The clear mandate of the integrated clinic to make its multilayered services accessible to those in low income status is strong evidence for intention to promote justice.

The effort to honor cultural diversity is also evidence for a wider understanding of justice. The willingness to respect differing points of view and to treat each person fairly within the requirements of personal cultural viewpoints is evidence that a liberal pluralism is operating at the core of the organization. This indicates that the organization is operating according to a code of ethical behavior.

Integrity is implemented in a practical way in the structure of the integrated clinic by arranging for the professionals to work openly with one another, and dealing honestly with the patients on the issue of choice. Whether or not providers from the two ideologies are being authentically open to one another needs to be assessed carefully. The most compelling test of integrity may occur if it becomes evident that one ideological group will have to give up a cherished belief when challenged by strong empirical evidence.

Respect for the patient appears to be foremost in the design of the clinic so that patient choice is the highest value. Honoring each patient's cultural preference is an extension of choice. This appears to be the point at the which the integrated clinic design is at its ethical apex. Maintaining this virtue in daily practice will be the ethical challenge to which all agents of the organization will have to be dedicated.

Compassion for the individual patient is an assumption applied to all health care organizations. How the policies are carried out on a daily basis is the most critical test of compassion. Without monitoring systems in place, this central virtue can be slighted as the pressures of clinic schedules, conficts of interest, and frustration in dealing with unsolvable human situations all wear away at the benevolence of the staff. Periodic, informal group sessions should be planned for the purpose of talking about the experiences of moral distress that inevitability occur.

The promotion of human flourishing is emphasized by the attention given to preventive medicine and wellness. To the extent that a natural medicine ideology is able to carry out a program of maintaining and maximizing health, it is maximizing human flourishing. It is anticipated that the reciprocal motivation for prevention and wellness that will flow from one ideology to the other will raise this goal of human flourishing beyond what either group could do separately. The measurement of patient satisfaction and the quantification of an improved quality of life are difficult to achieve. In order to move beyond anecdotal levels of evidence, there must be a strong ethical drive to measure and assess objective data to evaluate the clinical outcome.

The amelioration of suffering by providing for symptom relief as well as curative intervention is a sign that natural medicine attends to this goal of medicine. By combining the powers of natural and conventional medicine, the goal of minimizing human suffering may be optimized. The same demand for careful measurement and assessment of objective data regarding clinical outcomes applies to the evaluation of the goal of minimizing suffering. All of this comes under the function of quality of performance improvement.

Conclusion

The Integrated Medicine Clinic is an experiment that tests whether or not two philosophies of medicine can closely interact for the benefit of patients. According to a constructed framework for

bioethical analysis, a preliminary investigation concludes that this experiment has the potential for meeting a high ethical standard. It is strongly suggested that bioethics be an intentional aspect of the clinic's self-observation by establishing an ethics mechanism as an integral part of the plan.

References

American Board of Internal Medicine Subcommittee on Evaluation of Humanistic Qualities in the Internist. 1983. "Evaluation of Humanistic Qualities in the Internist." *Annals of Internal Medicine* 99:720-724.

Beauchamp, Tom and James Childress. 1994. *Principles of Biomedical Ethics*, 4th ed. Boston: Oxford University Press.

Becker, Lawrence. 1973. *On Justifying Moral Judgments*. London: Routledge & Kegan Paul.

Berman, B., B. Singh, L. Lao, K. Fernete, and S. Hartnoll. 1995. "Physician Attitudes Towards Complementary or Alternative Medicine; A Regional Survey." *Journal of American Board of Family Practitioners* 8:361-366.

Blumberg, D., S. Hendricks, M. Dewan, C. Kamps, and W. Grant. 1995. "The Physicians and Unconventional Medicine." *Alternative Therapies* 3:31-35.

Bulger, Ruth E., Elizabeth M. Bobby, and Harvey V. Fineberg, eds. 1995. *Society's Choices: Social and Ethical Decision Making in Biomedicine*. Washington, D.C.: National Academy Press.

Cassell, Eric. 1991. *The Nature of Suffering and the Goals of Medicine*. New York: Oxford University Press.

Clark, C. 1992. "Alternative Medicine." *CQ Researcher* 2:73-96.

Daniels, Norman. 1985. *Just Health Care*. New York: Cambridge University Press. p. 2.

DuBose, Edwin, Ronald Hamel, and Laurence O'Connell, eds. 1994. *A Matter of Principles?: Ferment in U.S. Bioethics*. Valley Forge: Trinity Press International.

Eisenberg, D., Kessler, R., Foster, C., Norlock, F., Calkins, D., DelBanco, T., 1993. "Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use." *The New England Journal of Medicine* 328:246-252.

Ernst, Edzard, Karl-Ludwig Resch, and Adrian R. White. 1995. "Complementary Medicine: What Physicians Think of It: A Meta-Analysis." *Archives of Internal Medicine* 155:2405-2408.

Frankena, William. 1973. *Ethics*. 2nd ed. Englewood Cliffs: Prentice-Hall, Inc.

Frohock, Fred. 1992. *Healing Powers: Alternative Medicine, Spiritual Communities, and the State*. Chicago: University of Chicago Press.

Gerteis, Margaret, Susan Edgman-Levitan, Jennifer Daley, and Thomas L. Delmanco, eds. 1993. *Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care*. San Francisco: Jossey-Bass Publishers.

Joint Commision on Accreditation of Healthcare Organizations, 1997 Standards, Oakbrook Terrace, IL.

Lock, Margaret and Deborah Gordon. 1988. *Biomedicine Examined*. Boston: Kluwer Academic Publishers.

Metropolitan King County Council Minutes. 1995. Motion #9491 in minutes for February 22.

Niebuhr, Richard. 1963. *The Responsible Self*. New York: Harper & Row.

Nordenfelt, Lennart. 1987. *On the Nature of Health: An Action-Theoretic Approach*. Boston: D. Reidel Publishing Company.

Pavek, Richard R. and Alan I. Trachtenberg. 1995. "Current Status of Alternative Health Practices in the United States." *Contemporary Internal Medicine* 7:61-71.

Pellegrino, Edmund and David C. Thomasma. 1981. *A Philosophical Basis of Medical Practice*. New York: Oxford University Press.

_____ 1988. *For the Patient's Good: The Restoration of Beneficence in Health Care* New York: Oxford University Press.

_____ 1993. *The Virtues in Medical Practice*. New York: Oxford University Press.

Potter, Robert. 1991 "Current Trends in the Philosophy of Medicine." *Zygon* 26(2):259-276.

Sabatino, F. 1993. "Mind and Body Medicine; A New Paradigm." *Hospitals*. 66-71.

Sale, D. 1995. *Overview of Legislative Developments Concerning Alternative Health Care in the United States*. Kalamazoo, MI: the John E. Fetzer Institute.

Seattle King County Department of Public Health. 1995. *Final Report: Plan for Natural Medicine Clinic*. Seattle, WA: Administrative Office.

Seattle King County Department of Public Health. 1995. *Natural Medicine Clinic Update* . 1(4).

Seattle King County Department of Public Health. 1996. *Natural Medicine Clinic Update*. 1(5).

Wulff, Henrik, Stig Pedersen, and Raben Rosenberg. 1986. *Philosophy of Medicine* . London: Blackwell Scientific Publications.

Yankelovich, Daniel. 1991. *Coming to Public Judgment: Making Democracy Work in a Complex World*. Syracuse, NY: Syracuse University Press.