AM
Rivista della Società italiana di antropologia medica / 19-20, ottobre 2005, pp. 127-138

2.1 *The domestication of "Wild medicine". Complementary and Alternative medicines (CAM): organisational strategies for their supply and institutional processes for their official recognition*

Enrico Petrangeli

Fondazione Angelo Celli per una cultura della salute (Perugia)
[petrangeli@antropologiamedica.it]

The Unconventional Universe and the "Seven Sisters"

Similarly to what has been happening in Europe and in the rest of the West for the last two to three decades, the diffusion of complementary and alternative medicines (CAM) is also increasing in Italy. According to the latest statistics available (1), more than nine million Italians had recourse to complementary and alternative medicines between 1999 and 2000. Becoming increasingly aware of the various courses of treatment open to them as different individuals, they appear to turn above all to homeopathy, acupuncture, phytotherapy and manual therapies. More and more people have borrowed and reshaped the notions of personal health and well-being that are conceived in cultural situations that develop a so-called "alternative" logic, compared with those that dominate the social system and that are typical of the health services of wealthy societies. More or less consciously and coherently, through their behaviour these people criticise the uniqueness of a medicine considered as standardized and make a case for medical pluralism and freedom of choice among the different options for the handling of health/illness processes (2).

The decision to carry out a medical anthropological research project matured in this socio-cultural context. It was characterized by the epistemological cognition that in-depth research conducted during a circumscribed period and in a circumscribed area, being a "particular case of the possible" (3), would bring interesting cognitive details to light that might facilitate the comprehension of the phenomenon. In order to explore the

prospect of an integration of medical systems, we decided to transcribe what we learned in a health sector action planning policy tool (the *Piano Sanitario Regionale della Regione dell'Umbria* [The Umbrian Regional Health Plan]).

The Fondazione Angelo Celli per una cultura della salute, in collaboration with the Umbria Region and the Sezione antropologica del Dipartimento Uomo & Territorio, Università di Perugia [Anthropological Section of the Man & Land Department, University of Perugia], has conducted a study entitled *Terapie non convenzionali: indagine descrittiva sulle offerte e sull'utenza nella Regione dell'Umbria* [Complementary and alternative therapies: descriptive research on supply and users in the Umbria Region] (4), which focuses on the CAM phenomenon from a medical anthropology approach. The research programme, which developed between August 2000 and August 2002, concentrated on the geographical area under the administration of the Umbria Region. Within this area, in-depth study was conducted in districts that are representative of the diverse geographical contexts: Valnerina, Foligno-Spoleto, Eugubina, the Higher Tiber Valley, Perugia, Lake Trasimeno, Orvieto-Tuderte and Terni.

Open questionnaires, forms of participative observation, forms for the reconstruction of therapeutic itineraries and case studies were addressed to the professionals and the persons who have recourse to complementary and alternative medicines. The main characteristics considered as regards the professionals were the following: their educational careers, cognitive horizons, fields of activity, catchment areas and finally the way they work. The qualitative approach adopted towards those who avail themselves of complementary and alternative medicines aimed at identifying the reasons for their decision, their relative levels of satisfaction and their attitude towards "official" health services. This approach also intended to rebuild fragments of life stories, narrations of illness experiences, "self-healing" episodes and therapeutic itineraries.

Altogether the study produced 200 in-depth interviews in the seven areas of the region, 500 hours of surveying-recording, 2,500 hours of analysis and processing and 5,000 pages of documentation.

Among the interesting achievements of the study – the results will be soon available since its publication is imminent – we would like to point out the number of the different kinds of complementary and alternative medicines recorded: 59. This data is still more significant if we consider that the Umbria Region – which has an area of 8,456 km² for a population of under 805,000 inhabitants – is one of the smallest regions in Italy.

The table below recapitulates the different kinds of complementary and alternative therapies counted and surveyed in the context of our research and puts them into relation with the various categories of healers identified. The table provides information on the professionals who work in the field of complementary and alternative medicines and practices in Umbria. At this point we confine ourselves to making an observation concerning the category that we have called "modern healers". Under this category we find operators who are not medical graduates but who have followed training courses and belong to different cultural and ideological horizons that syncretize various medical systems.

Category of professional	Complementary and alternative therapy practised
Traditional healers	Clairvoyance, Exorcism, Love potions, Phytotherapy, Pranic healing, Radiesthesia, Tarot card reading, Divining
Modern healers	Aromatherapy, Aura reading, Channelling, Chelation (aura clearing), Chromopuncture, Chromotherapy, Craniosacral therapy, Crystal therapy, Dance therapy, Egyptian shamanic and energy healing, Energy reading, Fasting therapy, Flower therapy, Foot reflexology, Holistic (Ayurvedic) massage, Humoralism, Iridology, Kinesiology, Knowledge of previous lives, Lymphodrainage, Macrobiotics, Mediumistic contact with the dead, Music therapy, NAET (Nambudripad's Allergy Elimination Technique), Naturopathy, Osteopathy, Postural re-education methods (Feldenkrais, Souchard, Mézières methods), Pranic healing, Pyramidology, Reflexology, Reiki, Shiatsu, Watsu, Yoga
Graduated in medicine	Anthroposophical medicine, Ayurvedic medicine, Chinese medicine (Acupuncture, Fire cupping, Moxibustion, Phytotherapy), Chiropractice, Flower therapy, Homeopathy, Homotoxicology, Iridology, Microchiniopuntura, NAET (Nambudripad's Allergy Elimination Technique), Ozone therapy, Phytotherapy, Reflexotherapeutic manipulative medicine.

By coincidence or by chance – if we really do not want to recognize the social characteristics of history – the FNOMCEO [Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiatri (Italian Federation of Councils of Physicians and Dentists)] Convention (Terni, 17 May 2002) "La professione medica e le medicine non convenzionali: rischi e opportunità" [The medical profession and complementary and alternative medicines: risks and opportunities] took place during the same period and once more in Umbria. This Convention can be seen as the expression of the recognition that the medical establishment is ready to give to complementary and alternative medicines as well as to the phenomenon of its

diffusion. On that occasion, the chairpersons of the 103 Provincial Italian Medical Councils existing in Italy drew up a document representing the FNOMCEO guidelines on complementary and alternative medicines and practices. This document, approved on 18 May 2002 by the FNOMCEO National Council [5], is the medical profession's reference for CAM. From our point of view there are at least four remarkable elements in the text: the reasons for its having been drawn up, the list of the complementary and alternative practices, the attribution of the category "medical act" and the measure of protection to be adopted. The reasons for the drawing up of these complementary and alternative medicines and practices guidelines lie first in two European Community Resolutions (Resolution 75 of the European Parliament, 29 May 1996, Resolution 1206 of the Council of Europe, 4 November 1999) and secondly in Europeans' general and more and more frequent recourse to complementary and alternative medicines. The same line of argument is used to enumerate the seven medicines and the two practices called "complementary and alternative" (acupuncture, phytotherapy, Ayurvedic medicine, anthroposophical medicine, homeopathy, traditional Chinese medicine, homotoxicology, osteopathy and chiropractice) that are clearly defined as medical acts. These medicines correspond to the definition of a medical act since they can exclusively be practised or handled by a doctor or a dentist, who are the only persons legitimised to make a diagnosis, to organize a treatment plan and to ensure that it is carried out on the patient. The reference to the medical act is essential to state the need for sanctions against every person who, though not being a doctor, practises complementary and alternative medicines or treatments; the necessity of regulated training paths and finally the need to adopt a minimum rate for health care services.

There is a significant gap between, on one hand, the results from the field research on the supply that responds to the demand for individual health and, on the other hand, what is admitted and recognized as a medical act by the professional medical organizations. Indeed, the universe of complementary and alternative medicines and practices is particularly heterogeneous in Umbria as well. This heterogeneity is due to the residues of traditional medicines, the products of heretical deviations from official medicine, the practices of alternative naturopathy medicine, the derivations from the New Age paradigm, charismatic rituals, the reflections of the major Chinese and Ayurvedic systems and the fragments of African and Afro-American therapeutic rituals. The FNOMCEO document on the recognition of the "seven sisters" appears to be the partial concession, subject to restrictions, made by a now monopolistic body that is tending to

remove the political advantages, the social reasons and the historical stages thanks to which it has succeeded in playing this role, and is sweeping away the basic and persistent polarisation of medicine both in the direction of science and in that of art.

Well-being versus Evidence-based Medicine

Over the last decades, in Italy as well as in the rest of Europe and the so-called industrialised West, individuals' attention to the issues related to their own health has significantly increased. In a general manner, the aspects that are not directly curative and that have to do with health promotion and disease prevention have become more important and are receiving more attention; "life styles" are not eclectic products of a literary élite any longer, but rather behaviours deriving from health-conscious attitudes towards every daily detail that constitutes the life cycle; the medical humanities – to stay in the "conventional" field – are acquiring recognition and academic space. The intellectual superstructures that define the characteristics of the "health care needs in the post-modern era", into which the health/illness representations from diverse medical systems are syncretically intertwining, are based on the evolution of epidemiological frameworks, on changes in the dominant diseases inside pathocenosis [(6)], on raising life expectancy and, paradoxically, on the outcomes of 19th and 20th century biomedicine [(7)]. We have moved from the conception of health as the condition of the absence of disease to a conception of health as a procedural reality in a psycho-physical general well-being that biomedicine and its health bureaucracy do not seem to welcome easily, while complementary and alternative therapies appear readier to encourage it.

The representation of health that we have previously defined as post-modern can easily be traced back to the protest movements of the system that have introduced into Western society the revaluation of creative thought, the taste for the transgression of norms, an ecological sensitivity, emancipation from the roles imposed by age or gender, spiritual research outside the Catholic tradition and the enchantment of exoticism. This framework encourages the "aesthetics of health" that accompanies the recourse to complementary and alternative medicines. Once the characteristics of militant "counter-culture" and political commitment were lost, the movements of the late sixties and the seventies impregnated individuals' intimate dimension, induced the pursuit of originality in the definition of one's own identity and found a favoured field of expression in the shift involved in the con-

sideration of the body from a mechanistic device to a place of meanings [8]. The detailed record and the sociological characterization of the users and the practitioners of complementary and alternative medicines allow us to note the depth and the cross-cutting character of the cultural sedimentations determined by this conception of the body and these aesthetics of health.

The research in the Umbria Region conducted by the Fondazione Angelo Celli enabled what has been affirmed up to this point to be specified with reference to ethnography. First of all, we must emphasize that recourse to complementary and alternative therapies does not exclude recourse to biomedicine. It is complementary to it. The CAM patient is often the actor in an individual itinerary through the diverse medical systems, whose efficacy he is disposed to bear witness to, as well as to become a builder of cosmologies. In general, he starts from the search for solutions to pathologies that conventional medicine fails to consider or for which it does not succeed in structuring either diagnostic references or adequate therapeutic settings. Once a pharmacological therapy has been tried, the patient is moved by the desire to avoid their undesirable effects and heads towards complementary and alternative medicines, relying on credible witnesses to their efficacy in order to find his bearings. Sometimes, too, the patient is moved by mere curiosity.

The framework of the various motivations peculiar to a person who has recourse to CAM that we have just reconstructed has many points in common with the itineraries of the graduate doctors who practise complementary and alternative therapies. The reasons why they come to CAM may be family heritage, the influence of esteemed colleagues or personal experience as a CAM patient. These practitioners are those who express their dissatisfaction with the biomedical system, its organization, the way it works and its efficacy in a more circumstantial and well-argued manner. Doctors who practise CAM criticize the too invasive forms of treatment, the de-personalized doctor/patient relationship that penalizes the patient and reduces him to a passive subject in an asymmetrical communication relationship and the excessively bureaucratic and alienating environment. They also mention their own disappointment with the medical profession practised "conventionally" (nowadays, we call conventional a system based on scientific research and on the acquisition of knowledge, while an unconventional system means traditional medical knowledge. The meaning of the adjective is far removed from the concrete reality).

It is interesting to see how spaces in the market are opened up for all these reasons: chemists, another of the targets of the study *Complementary and*

alternative therapies: descriptive research on supply and users in Umbria all build up the same picture from this point of view. They turned to CAM in the early eighties, a period that we could certainly characterize in many different ways connected with the social dimensions of history but that coincides above all with the change from the protesters of the decade before to consumers, who have good purchasing power even if they are niche market customers. Laboratory preparations made in the back shop the way apothecaries used to do it, following criteria of aseptically anonymous packaging, were quickly replaced by industrial and para-industrial products on offer from counter dispensers, whose packaging is conceived to convey a sense of ancient alchemic knowledge to customers imbued with their freshly acquired health consciousness.

As far as the genesis and the supply of preparations are concerned, we can easily compare the case of the herbalist workshops to the case of pharmacies.

In this context, we can cite another aspect that was ethnographically confirmed in the Fondazione Angelo Celli study: the substantial loss of importance of both the traditional iatric activities and the figures of the operators who practiced these activities. An area called Valnerina was selected in the planning phase of the study owing to its conservative reputation for the traditional medical practices largely widespread in Umbria until some years ago. The significant downsizing of rural society due to the changes in the organization of the agricultural sector in Umbria and to the consequent migratory flows led to the disappearance of the so-called "medicine of our women". We can still find some remaining forms of this medicine in developed areas on the outskirts of towns [(9)].

Our outline of some of the characteristics of the health needs in the post-modern era was made possible by the combination of aspects such as international trends and ethnographic reports, globalization dynamics and local changes. This demand for healthcare is the result of population migrations and/or world conceptions related to the new worldwide social structures, the manifestations of hegemony that express themselves in the body's conceptions and the forms of resistance against these manifestations.

In the post-modern era, health needs are expressed by the educated and the well-to-do classes. On one hand, this encourages the diffusion of complementary and alternative medicines. On the other hand, however, this provokes an apparently defensive reaction on the part of biomedicine and its management and administration apparatus, which invokes the question of efficacy as a defence. Efficacy can only be measured through proto-

cols developed within biomedicine, which imposes, through its organisations, the levels of healthcare, the Essential Levels of Health Care (ELHC) provisions, which are now the constant parameter common to all policy planning documents in the health sector. Nonetheless, the planning of the Health Services policies based on the ELHC can not be measured with the aesthetics of health/illness that goes with the diffusion of complementary and alternative medicines. The professional bureaucracy that has developed inside the institutions of biomedicine is responsible for the lack of dialogue between the worlds of biomedicine and of CAM. Indeed, the professional bureaucracy, in order to follow a conduct of presumed scientific rigour, underlines only the ratiocinating aspects of the *arte medica*. As a consequence, it does not recognize that medicine, apart from being science, is also art. Medicine is science and art and should include the evidences of experimentation laboratories as well as the individual variables of human organisms. Epistemologically, we can define medicine as a practice able to make use of scientific knowledge and technological equipment that could start a constructive dialogue with CAM. The motivation should not be the presumed absolute truth of its beliefs but rather its capacity to organize its expertise and make it available.

The Doctor, the Judge and the Anthropologist

The spreading of complementary and alternative medicines, in its reasons, its forms, its pervasiveness and the consensus that surrounds it, is an essential phenomenon for the understanding of the backgrounds of the building of health/illness representations that form the basis for citizens' health needs. The official medical system should take it into account; research centres as well as professional bureaucracies should act in order to understand and to provide services in the light of a perspective of integration of the various medical systems.

The scientific paradigm that has been structured in the West is able to overcome the contrasts between biomedical or energetic metaphysics and the methodological aporiai deriving from the evaluation of efficacy. Moreover, it is conscious of the necessity of turning to the criticism available thanks to the historical reconstructions of its background and the other backgrounds. Finally, it also knows how to structure open research programmes. There are favourable conditions for an integration of the various medical systems that would have interesting repercussions on the interpretation, diagnosis and treatment of illness and, in general, on the

redefinition of the relationship between humanity's biological and social aspects.

From this point of view, we are the Third World. In fact China, Nepal and Korea have developed, both in professional training and therapeutic practice, an integration of medical systems that constitute an interesting development of the medical pluralism that we are still far from having achieved in Europe [10]. The legislative and organizational approaches to complementary and alternative medicines commonly found in Europe are substantially of three types [11]. First, there are the "monopolistic" systems that exclusively recognize conventional medicine as lawful, considering every other form of unconventional medicine as an abusive exercise of the medical profession. These systems are widespread in Southern Europe, France, Austria, Luxembourg, Iceland and Poland. Secondly, we find the "tolerant" systems that, though the only form they explicitly recognize is the conventional medicine, allow unconventional therapists to practise. This is the case in Germany, Great Britain and Ireland. Third, there are the "mixed" systems in which some medical acts, established by the law, are restricted to conventional medicine while other medical practices are freely admitted. We find these "mixed systems" in Belgium, Netherlands, Portugal and the Nordic countries. It is worth noting that attempts at EU legislation governing complementary and alternative medicines have been hampered by the medical traditions of the different countries (the recognition of the *heilpraktiker* or of anthroposophical medicine in Germany and the discipline of herbal remedies in Great Britain, to name but the most well-known cases). These difficulties have thrown into sharp new relief the questions connected with medical pluralism, which, at last, is no longer considered an anthropological and cultural notion associated with exotic countries. We should also stress the European Community's desire, prompted by the pressure of public opinion, to establish general norms in the field of complementary and alternative medicines. The difficult relationship between the demands expressed by public opinion and the building of a popular consensus on one hand and scientific research and administrative policies on the other hand is becoming obvious and emphasizes the fact that complementary and alternative medicines can be considered as the "critical consciousness" of our health organization.

The Italian legislative approach to health care is such that it must be considered as falling under the category that we have previously defined as monopolistic. Indeed, in Italy, only the practice of conventional medicine is recognized as lawful. From the legal point of view, the Italian health system is still based on two articles of law. The first is Article 2229 of the

Civil Code, which allows the practice of the intellectual professions only to persons that have notions and a level of education previously established by the State. The second is Article 348 of the Civil Code, which represents its criminal law equivalent and punishes the abusive exercise of all professions [12]. It is worth noting that these two laws apply to all the intellectual professions. These norms appear to be the expression of a political and philosophical concept on the basis of which the State punishes abuses in the sense that it is the sole supervisor of the production and the transmission of culture through school and university administration. It should also be noted that the Italian legislative system is another illustration of the correspondence between bureaucratic State centralisation and the unequivocal medical knowledge that, according to Foucault, represents the genetic conditions of the modern clinic. In accordance with this, the health professions (doctors, veterinaries and chemists) were instituted by a Royal Decree, namely the 1934 Consolidated Health Act. After this, health professions that were considered "auxiliary" until 1999 were instituted. Fourteen figures have been established by as many decrees issued by the Health Minister from September 1994 to March 1995 (the chiropodist, the speech and language therapist, the orthoptist, the dietician, etc.).

It should also be noted that the notions of medical profession and medical act – calibrated by the legislator to the characteristics of curative medicine operators – that provide the basis for the Italian legislation are not adequate to cover the whole sector of preventive medicine and health promotion. Moreover, if we consider the effect that complementary and alternative medicines have on the conceptions of well-being in the broad sense of the term, it is easy to understand the difficulties in the application of the system of sanctions.

In any event, during the 14th legislature (from June 2001 to October 2002) eighteen bills were presented to the Chamber of Deputies and three to the Senate. This is a noteworthy production, to which parliamentarians from every political party contributed and which can be considered as an example of the cross-cutting approach (a trendy expression in the political field) to questions related to the non-conventional medicines. But it can also be interpreted as a manifestation of a legislative will that is perhaps too dependent on and sensitive to movements representing public opinion. At this point it might be of interest to make an overall evaluation of this legislative production. First of all, we appreciate that the recent proposals are no longer characterized by a concern to stigmatize and by the desire to inflict penalties, which shows the legislator's more mature knowledge of complementary and alternative medicines. Moreover, the principles of "sci-

entific pluralism" and of therapeutic freedom of choice have spread, not problematically but rather with a connotation connected with the Italian social context in which they are inserted. In general, we note the attempt to overcome the Health Ministry's bureaucratic centralism. Nevertheless, the individual's right to freedom of choice concerning the most suitable type of treatment is established with difficulty. Recognition is easier in the case of associations or lobbies that have established themselves as corporatist CAM groupings.

We wish to conclude this article with an important and hopeful consideration: the fact that legislative activity seems to be in the course of offering the prospect of integrated medicine, inspired by Article 33 of the Italian Constitution. This Article lays down the freedom of art and science and the legislative power that has been recently granted to the Regions, some of which (Piedmont, Tuscany, Valle d'Aosta, Umbria) have already made interesting experiments in this field.

Notes

(1) ISTITUTO NAZIONALE DI STATISTICA, *Condizioni di salute e ricorso ai servizi sanitari, Indagine Multiscopo 1999-2000*, ISTAT, Roma, 2001. This Italian Statistical Institute survey concerned a sample of 30,000 families. Though Italy occupies a low position in the European ranking, the number of people who have recourse to complementary and alternative medicines has doubled between 1991 and 1999 in this country. MEP Paul Lannoye has mentioned, in his Report on the status of the complementary and alternative medicines to the Committee for the Environment, Public Health and Food Safety of the European Union, that between 20% and 50% of the European population have recourse to complementary and alternative therapies.

(2) For further information, see: CAVICCHI Ivan, *Pluralismo o Babele medica? Chi, come e che cosa scegliere per curarsi*, pp. 63-84 in *Medicina e multiculturalismo. Dilemmi epistemologici ed etici nelle politiche sanitarie*, preface by Sebastiano MAFFETTONE, Apèiron, Bologna, 2000. For a systematic picture of the question, see: G.P., *Salute/malattia*, pp. 394-427, vol. XII, in *Enciclopedia*, 16 voll., Einaudi, Torino, 1977-1984.

(3) BOURDIEU Pierre (1995 [1994]), *Spazio sociale e spazio simbolico*, in BOURDIEU Pierre, *Ragioni pratiche*, translated from the French by Roberta FERRARA, Il Mulino, Bologna [original edition: *Raisons pratiques. Sur la théorie de l'action*, Éditions du Seuil, Paris, 1994 / original edition of the essay: *Espace social et espace symbolique*, conference held in the University of Todaiji, October 1989].

(4) FONDAZIONE ANGELO CELLI PER UNA CULTURA DELLA SALUTE, *Terapie non convenzionali: indagine descrittiva sulle offerte e sull'utenza nella Regione dell'Umbria*, in collaboration with the Umbria Region and the Section of Anthropology of the Dipartimento Uomo & Territorio at the University of Perugia.

(5) The document can be found on www.fnomceo.it.

(6) For the definition of dominant diseases and pathocenosis, see: GRMEK Mirko D. - SOURNIA Jean-Charles, *Le malattie dominanti*, pp. 417-450, vol. III. *Dall'età romantica alla medicina moderna*, in GRMEK Mirko D. (editor), *Storia del pensiero medico occidentale*, 3 voll., Laterza, Roma-Bari, 1993-1998.

(7) For a conceptual framework and its contextualization in a medical anthropological work perspective, see: Seppilli Tullio, *Antropologia medica: fondamenti per una strategia*, "AM. Rivista della Società italiana di antropologia medica", no. 1-2, October 1996, pp. 7-22.

(8) On this subject, see the various essays in: Colombo Enzo - Rebughini Paola, *La medicina che cambia. Le terapie non convenzionali in Italia*, Il Mulino, Bologna, 2003.

(9) For a presentation of traditional medicine in Umbria, see: Falteri Paola, *La medicina popolare/ Umbria*, pp. 160-165, in Seppilli Tullio (editor), *Le tradizioni popolari in Italia. Medicine e magie*, Electa, Milano, 1983. The sentence in italics in the text refers to the work of a general practitioner from Perugia. He worked in the Umbrian countryside and was interested in folklore, especially medical folklore: Zanetti Zeno, *La medicina delle nostre donne*, anastatic reprint by M.R. Trabalza, with an essay by A.M. Cirese, Foligno, 1978 [original edition: Zanetti Zeno, *La medicina delle nostre donne*, a folklore study that was awarded a prize by the *Società di antropologia*, including a letter by Paolo Mantegazza, Città di Castello, 1892]. This book is to be considered as one of the most famous treatises on the studies of popular culture of the late 19th century.

(10) The legislative approaches to this matter have been classified into "monopolistic", "tolerant", "mixed", "inclusive" and "integrated" by Stepan J., *Traditional and Alternative Systems of Medicine: A Comparative View of Legislation*, "International Digest of Health Legislation", vol. 36, no. 2, 1985.

(11) We are referring here to: Dei Fabio, *Normative europee sulle medicine non convenzionali, uno sguardo antropologico*, an intervention during the Congress on *Medicine non convenzionali. Esiti della ricerca in Umbria e percorsi per l'integrazione nel Servizio Sanitario Regionale* (Perugia, 5 December 2002), organized by the Fondazione Angelo Celli per una cultura della salute, the III Permanent Umbria Region Committee and the Umbria Region Department for Health Protection and Healthcare, in the context of the research project *Terapie non convenzionali: indagine descrittiva sulle offerte e sull'utenza nella Regione dell'Umbria*". Acts still being printed.

(12) Renzo Michele, *Professione medica e medicine non convenzionali: linee costitutive e problemi aperti della normativa italiana* and Crocella Carlo, *Analisi delle proposte di legge presentate al Parlamento alla luce di alcuni principi sui diritti del cittadino malato*, interventions during the Congress on *Medicine non convenzionali. Esiti della ricerca in Umbria e percorsi per l'integrazione nel Servizio Sanitario Regionale* (Perugia, 5 December 2002), organized by the Fondazione Angelo Celli per una cultura della salute, the III Permanent Umbria Region Committee and the Umbria Region Department for Health Protection and Healthcare, in the context of the research project *Terapie non convenzionali: indagine descrittiva sulle offerte e sull'utenza nella Regione dell'Umbria*". Acts still being printed.