



Introduction

Ruth Trickey with Sofie Mikosza

Women, Hormones and the Menstrual Cycle is now recognised as an essential text for the undergraduate and graduate natural therapist, and for practitioners with an interest in the treatment of women. This text is in its third re-write and with each edition has evolved to accommodate the changing needs of practitioners. It covers the major health issues that affect women from adolescence to older age and has been comprehensively expanded to incorporate the latest research as well as new sections on conditions associated with ageing and breast and gynaecological cancers. Herbal medicine has been intimately associated with the treatment of women over the ages and is the primary treatment modality discussed in this book. The practice of gynaecology, the use of herbs and the role of women in medicine have been simultaneously and independently shaped by complex social, political and philosophical influences. Thus we begin with a discussion of past beliefs, traditions and the role of women as health care providers, and conclude with a discussion of collaborative medicine which is the basic premise of this book.

Attitudes to menstruation

Women in the developed world today have a very different experience of menstruation and the menstrual cycle than their ancestors. Earlier menarche, better nutrition, fewer pregnancies and a longer life expectancy mean that women will have many more menstrual cycles than in previous centuries. The 'average' Australian woman can expect to menstruate from the age of 12 or 13 until she is somewhere between 25 and 35 years old. She

is then likely to become pregnant two or three times about every two years, and then breastfeed for about three to nine months. Following her pregnancies, she can expect her cycle to remain fairly regular until she is about 50, when it is likely she will become menopausal. Thus the average woman will have about 30 years of regular menstruation, totalling around 360 to 400 periods. This represents a tenfold increase in menstrual incidence when compared to the women during the eighteenth century, and similarly represents the opportunity for a significant increase in the incidence of menstrual problems and menstrual cycle irregularities.

By contrast, women of earlier eras were usually described as beginning to menstruate from between 14 and 15 years old and were frequently married soon after. Childbearing began at an earlier age and it was common for women to give birth many times if their fertility was not affected by sexually transmitted diseases, poor nutrition, or if they didn't die during childbirth. Contraception was not as reliable as it is today, and the spacing between pregnancies was influenced by breastfeeding—both because breastfeeding naturally reduced fertility, and because it was commonly held that a breastfeeding woman should abstain from sex. (Sex was believed to bring on a woman's period, and the return of the period was thought to deprive the baby of sustenance by diverting the breast milk—the 'white blood'—from the breasts to the womb.) So, for most of their fertile years, women were likely to be either pregnant or breastfeeding, and had an average of only 40 periods during their lifetime.





Introduction

A woman's menstrual cycle has been the subject of many myths and taboos. Around the second century AD, Pliny made his enduring contribution to the understanding of menstruation and its effects. He believed a menstruating woman could sour wine, make vines wither, cause fruit to drop from trees, kill bees, blunt knives, discolour mirrors and make dogs rabid. He was by no means the first. Around the fourth century BC, Democritus wrote that 'a girl in her first menstruation should be led three times around the garden beds so that any caterpillars there would instantly fall and die...'¹

The prevailing belief was that menstrual blood was extremely poisonous and toxic, not only to the menstruating woman but to anyone in her vicinity. It was even thought to be the origin of period pain, as its toxicity caused pain by harming the tissues it touched. Having sex with a menstruating woman was forbidden on pain of death, either by contact with the blood itself, or by Church decree. At any rate, a child born from such an act would be deformed, leprous, have red hair or be a girl!

For centuries scholars wrote of the inherent weakness and toxicity of women, especially menstruating women. Irrefutable evidence of woman's weakness could be found simply by comparing the male and female anatomy: the male was the 'normal' standard, the female his inferior 'other half'. This could be seen in the anatomy of the male and female genitals—the male perfect and complete with genitals turned outward; the female imperfect, incomplete and with genitals turned inward.

The origin of menstrual blood was comfortably accommodated within the philosophies of the Humoral theory, which described bodily excretions as the means by which an individual retained homeostasis. Hippocratic physicians (first century BC), thought of women as *colder* and *moister* than men. Women, therefore, did not sweat or grow hair on their face or body (both signs of greater body *heat*—animals grew horns instead) and had to menstruate to rid their bodies of 'unprofitable *blood*'. This was supposedly substantiated by the observation that women labourers (who sweated) and 'coarse' women (who grew hair and probably had polycystic ovarian syndrome) had lighter periods or did not menstruate at all.

Another somewhat contradictory theory was put forward by Galen, in the second century AD. He suggested that women, being weaker than men, could not use all of the *blood* that they concocted from food, and menstruated regularly

to rid themselves of the 'plethora' (excess of *blood*). He observed that women who ate rich and *moist* food bled more than women who ate coarse and difficult-to-digest foods. Hunger, he noticed, also affected menstruation, and women who were starving didn't menstruate at all.

Believing as they did that menstruation was necessary to purify the *blood*, not menstruating was viewed with grave concern—a condition requiring prompt action. Popular medical texts of the Middle Ages were crammed with remedies for 'stopped menstruation', with a variety of causes: the *blood* might be too thick to flow easily, or the uterine muscle too 'tough' to let the *blood* pass. The unknown author of the *Medieval Woman's Guide to Health* listed diet, stress and overwork among the causes of failing to menstruate: 'being awake too much, thinking too much, being too angry or too sad, or eating too little.'²

Stoppage of the menses was believed to have frightening consequences: the humoral imbalance created noxious vapours that rose to the head and caused melancholia, suicidal thoughts and insanity, or 'mother fits', a type of epilepsy ('mother' was the word for the uterus). The cure was blood-letting, which must have been worse than useless when the cause was anaemia, as it often was. Still, menstruating or at least some form of *blood* purgative was considered necessary for a woman's health, and so blood-letting or leeches were used as treatments until the start of the 19th century.

With all of the beliefs about amenorrhoea, imagine the difficulty when a woman became menopausal. Deprived of the necessary monthly loss, she was believed to become so poisonous that just by looking into the cradle she could damage the baby's eyes. Menopausal women were often called witches and deemed capable of extraordinary feats.

Unusual theories about menstruation prevailed into the 19th century. A medical professor at Harvard University wrote in 1873 that although he believed women had the right to do anything they were physically capable of, they should not study. The female reproductive system, he said, was incapable of normal development while a woman was engaged in academic pursuits, because the female body was incapable of doing two things well at the same time. This argument was used to deny higher education to women who wanted it.³

Myths persist today. Some religions still isolate or ban women from places of worship during menstruation, and chefs have been known to





prevent women from entering their kitchen in case they were menstruating and curdled a sauce or a soufflé because of their presence. In the 1970s and 1980s, a number of books on natural therapies advocated the long-term use of the 'pure' fruit and vegetable-only diet. One of the benefits of this diet, the authors claimed, was that women who stayed on it long enough stopped menstruating—and menstruation was only necessary when a woman's body needed purification. As late as 1993, an American scientist put forward the (new) theory that menstruation was necessary to cleanse the body and remove sperm-borne pathogens.⁴

Women's health and natural medicine: a historical and contemporary overview

The role of women in health care

Since antiquity, when the earth was worshipped as the Great Mother, women have ministered in times of birth and death, and were intimately responsible for home, hearth and healing. The woman healer was as integral to the administration and teaching of health care as was her male counterpart. Ancient Egypt, far in advance of other cultures in the practice of medicine, was a land of specialists: '... some of the eye, some of the teeth, some of what pertains to the belly, and some of the hidden disease.'⁵ Women were treated by other women for all complaints, but especially during childbirth and for menstrual disorders.

The history and legends of ancient Greece describe a rich pageant of women healers including Helen of Troy; Gaia, the Earth Goddess; Panacea, who gave her name to the panacea, the curer of all things; and Hygeia, who became associated with the concept of hygiene. Panacea and Hygeia were the daughters of Aesculapius, deified father of medicine. Other healers were Persephone, the goddess of teeth and eye diseases; Athena who could cure blindness; and Leto the surgeon. However, Greek women healers gradually lost their influential role in medicine and by the 3rd or 4th century BC it was illegal for women to practise medicine 'on pain of death'.

The Roman Empire also produced some great women healers, including Olympias; Octavia, who was Mark Anthony's first wife; and Fabiola, physician to the poor of Rome who established hospitals and became famous and well-loved. Sadly, during the next era of history, so aptly called The Dark Ages, much of this knowledge was suppressed or temporarily lost and it is not until the 11th and

12th centuries that practitioners of note rose to prominence again.

The 11th, 12th and 13th centuries were times of excitement and diversity for women healers. Domestic medicine continued to be practised, even though the methods that survived the Dark Ages were of questionable value. The socio-political developments and the still-fluid religious tone allowed women to practice the healing arts with extraordinary freedom compared to the immediate past and future. The culture allowed an unheard-of emergence of women as physicians and ecclesiastics.⁶ Two women who made an enduring impact were Trotula and Hildegard of Bingen.

De Mulerium Passionibus (On the Suffering of Women) was written by Trotula in the 11th century. She is remembered either as an old crone or as a celebrated and enlightened midwife, who worked and taught in Salerno, Italy, one of the few places in Europe where women practitioners flourished. *On the Suffering of Women* was a compilation of the work of the Roman, Greek and Arab physicians of her time and was translated and used across Europe for the next 300 years. Trotula discussed sexual abstinence, which she claimed caused 'suffocation of the womb'; menstruation and the nourishing of the embryo; the *liver's* role in the production of menstrual blood (still taught in Chinese Medicine); various aspects of anatomy and physiology; and how to 'restore' virginity with raw egg white!⁷

Hildegard of Bingen (1098–1179), abbess of the Benedictine monastery on Mount St Rupert in the German Rhineland, was a spiritual leader, physician, artist and writer. Largely ignored by historians while her male contemporaries (Francis Bacon and Thomas Aquinas) were revered, her contribution was nevertheless significant. As her biographer Matthew Fox has said, 'If Hildegard was a man, she would be well known as one of the greatest artists and intellectuals the world has ever seen.'⁸ Her text *Causae et Curae* was one of the important medical works of its time. It discusses many aspects of health and disease including the humours and their relation to health; childbirth, menstruation and sexuality; the current philosophies of gender determination ('if the man's seed is strong a male will be born, if weak, a female'); the treatment of gynaecological complaints; and the correct time to conceive.⁹

The midwives

During the Middle Ages, the delivery of a child was one of the most hazardous and difficult times in



a woman's life. Traditionally, the delivery and the 'lying-in' period were entirely controlled by women and a few close and trusted friends who would be present to provide help and support. Some of these women, by virtue of the number of births they had attended and the consequent experience they had gathered, gained the reputation of midwife. The midwife's position of authority was earned rather than learned from formal training, and until the end of the 17th century, personal experience of childbirth was considered an essential requirement for midwifery practice.¹⁰

The term 'gossip', which referred to the women attending the birth, is quite revealing of the context in which childbirth took place: originally it meant a formal witness to the birth, but by the 17th century it was used to describe 'a woman's circle of close female friends'. After the birth, the gossips took over the household chores for a few weeks, thus providing the mother with an opportunity to 'lie in', to recuperate while she devoted herself to the care of her new child.¹¹

Here was a group of women practitioners who wielded a great deal of influence in the matters of daily life. They were intimately involved in birth and death; in the moral questions of paternity and the religious office of baptism. They were asked to procure abortions and would know about cases of infanticide. The Catholic Church was keen to be involved in the activities of this group, and not only because of the midwives' obvious role in social and moral affairs. There was also the fear of the practice of witchcraft and midwives were made to take an oath that they would not invoke these darker powers.

The problem for the midwives was education. During the 14th through to the 17th century, medical practitioners were middle- to upper-class, university-trained men. Women were excluded from the formal study and practice of medicine. They continued to practice midwifery and administer health care as lay physicians, and did so predominantly to the peasant population, while trained medical practitioners catered largely to the wealthy. The persecution of these women healers not only resulted in a loss of valuable medicinal knowledge, but deprived the peasant class of health care, as many could not afford the more expensive licensed practitioners.

However, while women were forbidden from attaining formal training, they were also admonished for not having done so. The Catholic

Church in general, and the inquisitors Kraemer and Sprenger in particular, were quite clear on this point: to cure without appropriate education was evidence of the work of the devil. The manual *Malleus Maleficarum* (Hammer of Witches) was written by the two inquisitors in 1484 and deemed that, 'If a woman dare to cure without having studied she is a witch and must die'.¹² The *Malleus* expressed the prevailing feeling: 'No one does more harm to the Catholic Church than midwives'.¹³

Another grave event occurred for midwives in the 16th century: England's 1512 law which restricted the use of medicine and surgery to licensed practitioners. Around this time the English physicians petitioned parliament specifically to prevent women from practising (those 'worthless and presumptuous women who usurped the profession'¹⁴) and to ban unlicensed practitioners from practising the 'Fisyk' (medicine).

Parliament passed a bill which decreed that the licensing of practitioners was to be established under the auspices of the Bishops. This eventually led to a midwifery licence, also under ecclesiastical control, which required the midwife to report cases of infanticide, to baptise the baby in an emergency and to certify its paternity. This law spelt the beginning of the end for midwives as primary care practitioners.

Administered from home

During the 17th century in Europe and America, women who managed large houses, were titled, or were married to churchmen, saw it among their duties to provide basic health care. For these women, it was their religious and social responsibility to attend not only to their families and household members, but also to their neighbours and the local villagers. The apothecaries were often quite a distance away, and the services of a physician were expensive and not always available.

Some women took to their role as the home herbalist with vigour and enthusiasm. This was, after all, one of the few pursuits other than housewife open to women, and many were obviously talented and became well respected. Some had extensive 'still-rooms'; the rooms where they extracted herbal vinegars and wines, made ointments, dried their herbs, distilled oils and made their perfumes, pomades and household goods.

'A good reliable herbal—like a sound basic cookery book—was the first essential of the young housewife.'¹⁵ These herbals were used to identify the plants and their uses and to assist with the preparation of herbal creams, extracts, syrups



and poultices. Eventually, books were compiled from the collected recipes and advice of some of the more famous of these women, and some books became bestsellers. Usually, no distinction was made between books for culinary and medical advice and the manuals written for housewives included mixtures of medical and cookery recipes. *The English House-wife*¹⁶ included advice on common ailments such as toothache, anaemia or 'green sickness', jaundice, epilepsy, diarrhoea, skin diseases and hernias alongside recipes for custards, jams and potted meatloaf.

This tradition was continued in Australia, initially with books published overseas, such as *The Family Doctor*,¹⁷ but eventually local titles were produced by Australian publishing houses. John Broadbent, 'practical medical herbalist' of Melbourne, wrote two for the general market: *The Australian Botanic Guide* (1887)¹⁸ and *Botanic Multim in Parvo* (1899). Although not general household books, both reflected the trend for home treatment which had been employed in the English households.

Many of the books gave a wide variety of advice on cookery, hygiene and herbal or other remedies for a surprising range of conditions.¹⁹ Mrs Lance Rawson's book, *Australian Enquiry Book of Household and General Information* (1910),²⁰ in the tradition of *The English House-wife*, encompassed cookery, preserving, embroidery, swimming lessons, farming tips, building and decorating, as well as health and hygiene. Even as late as 1939, the *Ladies Handbook of Home Treatment*²¹ gave advice on diet, convalescence, douches and instruction for personal hygiene, although by this time, the use of herbal and other natural remedies had disappeared, to be replaced by a more chemical approach (the use of mercury, lead, arsenic and copper had become increasingly popular since the late 1500s).

These books are excellent chronicles of the fading tradition of tending to family and friends in the home. Australian women settlers, probably because of their isolation, seem to have been keen advocates of this tradition; utilising common household remedies to make, amongst other things, their own cough medicines, cold and flu remedies or chest poultices. Today, the possibility of treating complaints with common and natural ingredients contributes to the popularity of natural medicine. These remedies, rather than being passed over as 'old wives' tales', are proving to be effective and safe and enable people to once again be involved in their own health care at a fundamental level.

The practice of gynaecology

Evidence for the practice of gynaecology as a discrete discipline prior to the 1800s is not extensive, although it is obvious that women's health was attended to by a wide variety of practitioners, each having differing skills and training. The prevailing groups of licensed practitioners by this time were the members of the College of Physicians, the surgeons from the Company of Barber-Surgeons, and the midwives. The affluence of the individual was a major deciding factor in the choice of practitioner and so many of the general public continued to rely on information and ministrations from members of their family, priests, neighbours, from unlicensed male practitioners and from wise women who had neither recognition from the Church nor from the civic bodies.

From as early as the 12th and 13th centuries, physicians were guided by a code of ethics: 'Enter a home without injuring or corrupting it. Beware lest your medicines bring death to anyone. Do not allow women to persuade you to give abortives, and do not be a party to any such plan, but keep yourself without blemish and undefiled. Keep yourself free from carnal relations with the maid-servants, children, married women, virgins and widows, And whatever you hear in the course of your treatment, unless it is something that ought to be reported and judged, keep secret.'²² Although these guidelines are sound and remain relevant today, early surgical procedures seem to have fallen outside this sphere of genteel behaviour and many procedures were highly controversial.

Of all of the therapeutic gynaecological interventions introduced during the 19th century, the removal of the ovaries met with the greatest condemnation. The first oophorectomy was reported to have been performed in 1809 by an American surgeon, Ephraim McDowell. Anaesthetics not being available, his patient is said to have 'supported herself by singing hymns'. The operation lasted 25 minutes and as a testament to her vigour, the woman was up and about in five days and lived for another 30 years.²³ Others were not so lucky. Thomas Spencer Wells performed 50 operations for the removal of ovaries in five years. In all, 33 women died from the procedure.

By the 1870s and 1880s oophorectomies were performed in larger numbers. Some surgeons, who performed the procedure for nervous complaints, believed that the ovaries were diseased, even when there was no evidence of pathology. Ovaries were also removed to cure fibroids, and to treat dysmen-



orrhoea and 'menstrual epilepsy', a condition believed to originate from continued ovarian pain during the period.

The word 'hysteria' came from the Greek word *hysteria*, meaning womb. Doctors from Greco-Roman times believed 'hysteria' or a woman's irrational, neurotic or mad behaviour came from a detached womb that wandered freely and violently through the body. This perplexing understanding of the uterus and the female psyche prevailed until the early 19th century.²⁴

Hysterectomies, the surgical removal of the uterus were commonplace in the 19th century and undeniable advances meant that the lot of women was generally improved, but to undergo surgery meant a horrendous ordeal without an anaesthetic, often accompanied by a mortality rate of more than 50 per cent. The introduction of reliable anaesthetics after the mid-1800s meant that surgery could advance from the minor procedures—removal of polyps, the excision of hypertrophied clitoris and the incision of the imperforate hymen—to more complex operations such as hysterectomy and removal of the pregnant uterus.

The history of speculum use in gynaecology is similarly riddled with controversy. First known during the Greco-Roman period, its use lapsed until the beginning of the 19th century, largely because of the prevailing view that it was indecent to see the inner private parts. It was even referred to as an 'instrumental rape' in some circles²⁵ and examination with a speculum was commonly believed to be sought by women who were seeking sexual gratification.²⁶

Fortunately the field of gynaecology has evolved and our knowledge of human anatomy and anaesthesia is sufficient to provide for the large part, safe and much less painful surgery. Women were finally accepted into medical schools and professions in the early 1900s and female gynaecologists offered women an opportunity to choose the gender of a practitioner with whom they felt more comfortable. Looking at early gynaecology however, does provide an interesting insight into how for many centuries the dominant understanding of women's bodies, and the methods to treat these bodies, were written and controlled by men.

The history of natural medicine

The early traditions

Throughout the centuries, every culture and civilisation has developed its own system of medicine

that reflects its cultural understanding of the body in health and disease. Medicine has always been an endeavour to cure sickness and illness and bring about health, and can be seen as a dynamic, constantly evolving discipline. Many early traditions of medicine can be compared in their similar philosophical underpinnings, particularly in relation to the belief in a vital force and the influence of the natural elements of earth, water, air, fire and metal.

The concept of vital force has played a pivotal role in the philosophy, religion and medicine of ancient cultures. This idea of vital force, or a life-giving principle, can be seen in ancient Greek, Egyptian, Chinese and Eastern philosophies, as well as Judaeo-Christian belief. Ancient Egyptians recognised *Chu* as a 'divine spark' whose function was to give life to the body. Eastern philosophies and the practice of Ayurvedic medicine dating back 4000 years to 2000 BC, recognised PRANA as life and vitality: 'PRANA in the body of the individual is part of the cosmic breath of the universal spirit'.²⁷ Chinese medicine, over 3000 centuries old, recognises *Qi* as the fundamental substance that makes up the universe. It constitutes the vital energy or life force that flows through the organism.²⁸ The origin of man in the Book of Genesis teaches that God breathed into man and made him a living being, the basis of the Judaeo-Christian belief. One of the greatest Greek philosophers, Aristotle, spoke of the 'soul' as 'the vital principle'. Paracelsus postulated that actions of external influences on *Archaeus* (the active living spiritual agent in man) produce certain kinds of living diseases.²⁹

This concept of vital force is integral to the school of 'vitalism', which is in direct contrast to the school of 'mechanism'. As it has been applied throughout the ages, vitalism adheres to the philosophy that the body in health and disease has to be seen as an integrated whole. A unique complexity as demonstrated by its ability to grow and develop, respond to stimuli, reproduce and repair itself that distinguishes itself from the inanimate. Mechanism on the other hand looks at the body from a reductionist viewpoint, where the body can be explained as a complex series of chemical and physical reactions, without any special quality that distinguishes it from the inanimate. Contemporary natural medicine draws on the philosophy of vitalism, while the scientific biomedical model is firmly rooted in the mechanistic or reductionist view of the body.



In addition to this concept of vital force, many early medical systems believed that the natural environment had powerful influences over an individual's health. Ayurvedic medicine of India, Traditional Chinese Medicine, and Greco-Roman medicine believed that the elements of earth, fire, water and metal seen in nature also existed in man. An excess of *fire* in a person may manifest as an excess of *heat* and anger, or *water* as an increase in fluid retention and bodily secretions: each element needing to be balanced where there were signs of excess or deficiency. These concepts are fundamental to the development of the humoral theory of medicine.

The medicine of early cultures was based on observation. Groups of symptoms were seen to form repetitive patterns, and these were related to observed phenomena in the universe. These patterns were associated with environmental factors, and as the philosophies evolved, greater complexity was introduced which described the workings of a vital force, *Qi* or PRANA.

Despite many differences and complexities between early medical systems, some of the common beliefs can be broadly summarised as follows:

- The belief in a vital force as the living and generative energy in the body. The vital force generates *heat*, circulates throughout the body, and is necessary for life and procreation.
- Deficiencies of the vital force are associated with poor health, slow recovery from illness and early death.
- Incorporated within this understanding is a wider concept, that the macrocosm (the world) reflects the microcosm (the individual).
- The elements *Earth, Air, Fire, Water* and (in the Chinese system) *Metal* and *Wood* are described as being the constituents of all life forms.
- Ill-health is influenced by the relative preponderance of one or more of the elements.
- All life forms are made of identical 'elements' and are subject to the same universal laws, celestial influences and patterns of change.
- Each of these life forms, as part of the greater whole, is in no way superior to any other life form.
- Extremes in environmental factors, such as exposure to extreme cold, can cause or aggravate many diseases.

Table 1 The three major medical systems from antiquity

System	Vital energy	Element	Season or quality	Organ system or constitutional type
Greco-Roman	Pneuma	Air	<i>hot</i> and <i>moist</i> /Spring	Sanguine
		Fire	<i>hot</i> and <i>dry</i> /Summer	Choleric
		Water	<i>cold</i> and <i>moist</i> /Autumn	Phlegmatic
		Earth	<i>cold</i> and <i>dry</i> /Winter	Melancholic
Chinese	<i>Qi</i>	Wood	<i>Wind</i> /Spring	<i>Liver</i>
		Fire	<i>Heat</i> /Summer	<i>Heart</i>
		Earth	<i>Damp</i> /Late Summer	<i>Spleen</i>
		Metal	<i>Dry</i> /Autumn	<i>Lung</i>
		Water	<i>Cold</i> /Winter	<i>Kidney</i>
Ayurvedic	PRANA	Air	DRY/Autumn	VATA
		Fire/Water	HOT/MOIST Spring/Summer	PITTA
		Water/Earth	MOIST/HEAVY Winter/Spring	KAPHA



Humoral theory

Humoral theory originated from the Hippocratic school of thought as laid out in the Hippocratic Corpus (around 400 BC). However it was not until the 2nd century AD that Galen systemised and formalised ancient Greek thought on humours to what became known as Galenic medicine. Galenic medicine and the humoral theory dominated European medical thought until the 17th century.³⁰ Galenic medicine was also adopted into Islamic medicine, still practised today as Unani-Tibb.³¹ Interestingly, the Yin/Yang theory of Chinese medicine, which has many similarities to humoral theory, was being refined at around the same time in the Song dynasty of China (960–1279 AD).

In health, the humours were present in a state of relative balance while in ill-health one of the humours became relatively more dominant.

The four elements of *earth*, *air*, *fire* and *water* together were related to the four qualities of *hot*, *cold*, *moist* and *dry*, which represented an overall picture of the humoral balance of the individual. The *earth* element was seen as ‘cold and dry’; *air* was ‘hot and moist’; *fire* was ‘hot and dry’; *water* was ‘cold and moist’ (see table 1). The nature or temperament was believed to be directly influenced by the dominant element. A predominance of *air* was related to *blood* and the *sanguine* (cheerful) temperament; *fire* to *yellow bile* and the *choleric* (irritable) temperament; *water* to *phlegm* and the *phlegmatic* (even or

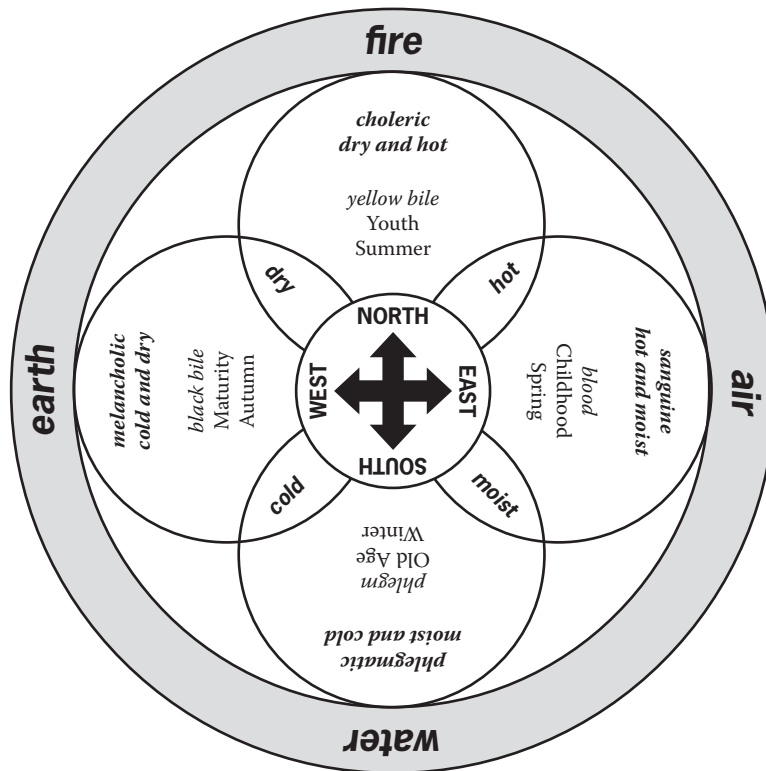


Figure 1 The humoral theory

‘Humoral’ refers to the semi-gaseous fluids or ‘humours’ and is sometimes translated to mean ‘body fluids’. However, humours cannot be equated to any scientifically identified body constituent.

unexcitable) temperament; and *earth* to *black bile* and the *melancholic* temperament.

The elements were also present in food and drink, which were made of varying combinations



of *air, earth, fire* and *water*. Everything taken into the body would contribute to the humoral balance because digestion transformed the elements into the appropriate humours. A diet lacking in balance would contribute to disease by affecting the humoral balance. When other factors had initiated the humoral imbalance, the diet could be manipulated to regain health.

Astrology was also intimately connected with the humoral laws: an individual's physiology and outer anatomy was believed to be continually influenced by the constellations of the zodiac. The humoral fluids, like the ocean tides, were under the dominion of the planets and the moon. Disease, regarded primarily in terms of disturbance of the humoral balance, was caused by a change in the body fluids and could be related either to the positions of the planets or moon, the quality of the diet, or to a loss of body fluids, such as sweat, menstrual blood or urine.

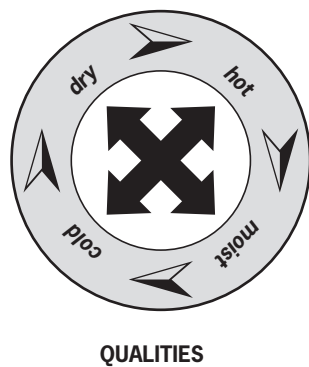


Figure 2 The qualities

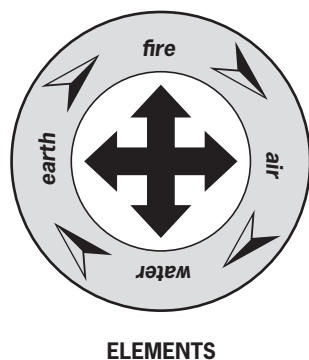


Figure 3 The elements

When it came to recognising and treating illness, a diagnosis was made by closely observing the individual for combinations of signs and symptoms. A correlation was made between observed phenomena in the universe and the patterns of disharmony in the person. For example, the observation that fats and oils became thick or hardened with increasing cold was taken as an indication that *cold* would cause the body fluids to become thick and movement to be difficult. To treat this condition, *hot* remedies were used to counterbalance the *cold*. Other observations associated *hot* with redness, and *cold* with a purplish discolouration. This led to the association of bright red blood with *hot*, and purplish, dark or maroon blood with *cold*. (See Appendix 1 for further details of the qualities, the elements, the temperaments and physiology according to the Humoral Theory.)

Choosing and categorising herbs occurred in much the same way. Plants that had a pungent and spicy taste were believed to be *heating* as well as *drying* because heat was seen in nature to dry more efficiently than cold. If a plant grew close to water like the willow, it was believed to be *cooling* and *moistening*. On the basis of this observation, willow was used for colds, fevers and inflammatory joint problems, to alleviate fever and reduce inflammation in the joints. Today we know that willow is indeed anti-inflammatory, and can reduce temperatures because of its ability to yield salicylate after ingestion.

Herbs: the earliest medicine

Herbal medicine is as old as humanity itself. Evidence that plants may have been used as medicines from as early as 60,000 years ago came from the discovery of the pollens of common plant medicines at the burial site of a Neanderthal man in a cave in Iraq. Marshmallow, grape hyacinth, yarrow, ephedra, all in use today, were placed beside him, perhaps as decorative offerings, or perhaps for his journey to the afterlife.³²

According to available knowledge, virtually all peoples throughout the world have used some form of plant medicine. Of those societies which still use herbal remedies as their source of medicine, many seem to share common traits. Almost all have an individual to whom the knowledge of specific plants is entrusted and who will pass on the information only to selected initiates. Many make a distinction between men's and women's knowledge and use of medicines.

Over centuries, careful observation revealed that there were optimum times to pick plants and



administer medicines according to the phases of the moon, seasons or times of day; and that some parts of the plant were more effective than others. It soon became clear that different plants were more effective when administered in certain ways. Gradually the doctoring and supply of herbs developed into recognised professions: the physician became the early doctor and the apothecary became the pharmacist.

The first recorded herbal text was written in ancient Greece, in the 4th century BC, by Diocles of Carystius, a pupil of Aristotle. Herbals were initially probably written for apothecaries. In the 1st century AD, Dioscorides wrote his famous *De Materia Medica*. The selection of plants, many of them previously unknown, and the precise way he wrote his text made the work so popular that it is still copied and quoted today.

Sufficient numbers of the valuable texts from the Arabs, Greeks, Romans and Egyptians have survived to give a good indication of the practice of herbal medicine by the scholarly and educated. However, much of the early practice of women's medicine was continued as an oral tradition. It was either passed on from one initiate to another by the priestesses and wise women, to be used in strict accordance with the current law; or in the case of the common and everyday remedies, passed on from mother to daughter. This seems to have been especially true of contraceptive practices.

Birth control, or the absence of, has always had important consequences for women so it is highly likely that women have always sought to control their fertility. Certainly there is evidence that reproduction rates have been limited by one means or another since as early as 200 BC.³³ Restrictions in sexual activity and barrier contraceptives were used, and there is also evidence for the use of herbal remedies as contraceptives and abortifacients as early as the first Egyptian medical documents.

One of the most compelling written pieces of evidence comes from Soranus, a Greek writer on gynaecology around 100 AD. He distinguishes between a contraceptive, which 'does not let conception take place', and an abortive, which 'destroys what has been conceived', and comments that 'it is safer to prevent conception from taking place than to destroy the foetus'. A number of common plants including pomegranate (*Punica granatum*), the giant fennel (*Ferula opopanax*), rue (*Ruta graveolens*), juniper (*Juniperus communis*) and asafoetida (*Ferula asafoetida*) were all

mentioned as being in common use in Europe.

But while some writers mention the use of these agents, there is little clear advice on the correct dosage, times of administration or even the way to take the remedies. Were they, for instance, to be used as pessaries, or taken orally? John Riddle, Professor of History at North Carolina State University, who has studied these issues extensively, has a possible explanation:

...ancient physicians, all those cited thus far being male, did not fully understand the procedures for taking the anti-fertility agents. In no account, medical or non-medical, is there sufficient detail to permit efficient administration... Thus knowledge of anti-fertility plants, and how and when to take them, appears from the evidence - scant though it is - to belong to a female culture. Some of the medicinal plants were also salad plants. The implication...is that women were eating plants, such as rue and dill, from the same bowl as men who may not even have been aware of what was going on. One must suppose women knew what to eat, when and how often, and they would appear not to have learned this through books.³⁴

Science and medicine have remained sceptical of the effectiveness of plants for contraceptive purposes. In recent times, scientists have found that the seeds of Queen Anne's lace (*Daucus carota*) have contraceptive qualities and stop implantation of the embryo, as well as inhibit progesterone production. The regular consumption of the common pea, *Pisum sativum*, is reportedly responsible for the low birth rate in Tibet.³⁵

What was once common knowledge about herbal contraception, passed on through word of mouth, is lost to today's herbalist. Early writings and current use both support the view that herbs taken as contraceptives seem efficient, and may even be relatively safe. Further investigation into their mode of action, the correct dosage and timing of administration may yet provide enough information to enable their confident prescription.

In sharp contrast to contraception, fever management was an important aspect of treatment for the early physicians and a vast body of instruction can be found in the literature. Infectious diseases were a cause of high mortality for all, but particularly for the young and the infirm, and prior to the use of antibiotics, even minor conditions had the potential to cause death.



Elaborate systems for the differentiation of febrile conditions were developed, based on removing the offending environmental agent, and stimulating the individual's vitality.

Traditional practices for the management of colds, viruses and flus are still recommended by herbalists: acute illness with high temperatures where the person feels cold are treated with Hot herbs and fluids to encourage a subjective sense of heat and to allow the 'fever to break'. This is in direct opposition to the recommended 'take an aspirin and go to bed' advice commonly given today. Herbalists believe that the body attempts to generate heat to overcome viral or bacterial invasion and that assisting this process may shorten the course of the illness.

All traditional medicine has developed a specific language and philosophy on which to base its diagnostic and treatment rationales. Lack of vitality, catarrhal complaints, lymphatic congestion, toxicity or Liverishness are all characteristic of herbal medicine, but are often understood by the public: for example, most of us know about being Liverish and have an idea of what it means to lack vitality. In many cultures these concepts become so entwined with the language and a common understanding of health and disease that only a thin line exists between 'commonsense' and the practitioner's knowledge. As a result, these concepts become difficult to articulate; they are just 'known' and may not be taught or even conceptualised as concise and recurring syndromes:

Constitutional [Holistic] Herb Therapy is widely practised in China, Tibet, India, Japan, and Southeast Asia; its theories and methods have been written about in various Asian languages. The concept is so ingrained in everyday Asian life that herbalists there have not concerned themselves with comparing Constitutional Therapy with other kinds of therapy. As a result, it is not easy to find a book devoted to this subject even in the cultures where it is practised.³⁶

Over the past 50 years, herbal medicine in the West has changed its focus from the individual to specific constituents of herbs and their impact on diseases. Detailed information is now available on the outcomes of a herbal medicine and it is possible to prescribe precisely for a number of complaints. Partly, this has been related to the increasing use of herbal remedies by medical practitioners in Europe

and Japan, but it has also been associated with a lapse in the traditional language and philosophy of herbal medicine on which its rationale for diagnosing and treating disease was originally based.

One of the most basic tenets of the natural practitioner is the focus on the individual; on why there is disease, rather than what disease; on the vitality and constitutional type rather than the strain of bacteria, the type of cancer, the exact level of some blood component. It is vital that herbalists retain and use their traditional understanding of patho-physiology. To do anything less is to betray those people who have turned to herbal medicine for a more holistic solution to their health care.

Holistic philosophy and health

'Holistic', when that adjective is properly applied to health care, refers to a qualitatively different approach, one that respects the interaction of mind, body and environment. Beyond the allopathic approach of treating the disease and the symptoms of disease, it seeks to correct the underlying disharmony causing the problem.³⁷

'Holism' derives from the Greek word for whole, *holos*. The word 'Holism' was coined by Jan Smuts in 1926, who described it as 'the tendency in nature to form wholes that are greater than the sum of the parts through creative evolution'.³⁸ Essentially treating holistically is recognising that each person is complex and unique. It is an understanding that every individual has a myriad of influences that include genetics, physiology, the social, psychological, spiritual and environmental aspects, which are all equally important, and impact upon their health and well-being. Hippocrates (460–377 BC) is famously quoted as stating that, 'It is more important to know what sort of person has a disease, than to know what sort of disease a person has'. Similarly holism recognises that we are more than just our disease or the sum of our physical parts.

One of the key differences between holistic health philosophy compared to a more mechanistic or reductionist biomedical paradigm is the importance of the role of the pathogen in disease. The biomedical model focuses on the pathological factors such as bacteria, viruses and toxins in the causation of disease. From a holistic view, what predisposed the person to being vulnerable to the pathogen, and why the immune system is unable to cope with such a stressor, is of more importance.



Introduction

For example, while a large number of people may be exposed to a virus or bacteria, such as the common cold, not everyone will become sick. Clearly there are situations where pandemics or epidemics arise and a virulent strain of pathogen or toxin can overwhelm any immune system, but for a large majority of illnesses or diseases this is not the case. A holistic model of health will focus on what makes an individual susceptible to infection in the first place and why the body's various defence mechanisms were not able to ward off this infection.

Louis Pasteur revolutionised medicine and is considered the 'father of germ theory'; he developed the process of 'pasteurisation' which is the heating of liquids like milk to kill most of the bacteria and moulds within them. With such focus on the germ, it is interesting that on his death bed he is reported to have said, 'the germ is nothing, the terrain is everything'. Holistic medical philosophy is similarly concerned with the body's terrain, of how well the body processes are working to maintain homeostasis and health.

Integral to the holistic philosophy of health is that the mind and body are not seen as separate entities, but rather as part of a continuum. What we think and feel has very real physiological consequences in our body. Likewise the health of our body can directly impact on our thought processes. Emotions such as anxiety, hate and anger can affect the body by impairing digestion, hormonal balance and blood flow and other physiological aspects. Chronic pain can also have the effect of creating states of depression and anxiety. The separation of the mind from the body stems from the work of René Descartes, who held that the mind and material body are separate (Cartesian dualism). Much of the development of biomedicine continued with this assumption, as it led to great advances in surgery by freeing medicine from religious constraints, which believed the body to be sacred. It was not until the early 1970s that the inter-relatedness of the mind and body was acknowledged in the field of 'psychoneuroimmunology'. Candace Pert, a research scientist and biochemist, conducted pioneering work in the area of neuropeptides and neurotransmitters that led to the discovery of opiate receptors. She describes the old adage 'the power of the mind over the body' as inaccurate, and that it should be: 'Mind doesn't dominate body, it *becomes* body—body and mind are one.' And '...when we explore the role that emotions play in the body, as expressed through the neuropeptide molecules, it

will become clear how emotions can be seen as a key to the understanding of disease'.³⁹

Naturopathy is just one example of how holistic philosophy can be incorporated into the practice of health care. Naturopathic medicine has been defined as 'a distinct system of primary health care—an art, science, philosophy and practice of diagnosis, treatment and prevention of illness.' The philosophy of naturopathic medicine is based on six principles:⁴⁰

- *First do no harm (primum non nocere)*; physicians at all times act to use methods and substances that minimise harm
- *The healing power of nature (vis medicatrix naturae)*; which recognises that the body is intelligent and self-healing, and that treatment should identify and remove obstacles to healing, while supporting the body's own healing mechanisms
- *Identify and treat the cause (tolle causam)*; physicians should seek to find the underlying cause of ill health and not merely provide symptomatic relief
- *Doctor as teacher (Docere)*; naturopathic physicians educate their patients and encourage self-awareness and responsibility for health
- *Treat the whole person*; take into account all aspects of an individual's life and;
- *Prevention*; to assess risk factors, heredity and susceptibility to disease and make appropriate interventions to prevent illness.

The holistic philosophy recognises that health is more than the absence of disease and views health as the sense of positive wellness in conjunction with the absence of disease (see Box: Signs of Health). The World Health Organisation clearly embraces this definition of health by stating that; 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.⁴¹

Complementary medicine/natural medicine

Defining 'what is complementary medicine' has been a contentious issue. For a while, all medical care that did not fall within the dominant Western biomedical model was 'alternative' medicine. The term 'alternative' became synonymous with 'fringe' and 'unorthodox' and was seen as a part of a counter-culture that was inherently unscientific. The issue with 'alternative medicine' is that it implies that it is a practice of medicine that is used instead of, or



Signs of Health

Being healthy is not the absence of disease or illness, but rather the presence of signs of balance, harmony, happiness and wellness.

- The stature is erect and held with ease
- The skin is clear, smooth and lustrous. To the touch it is warm, firm and slightly moist
- The individual is within the normal weight range for their age, build and height
- The normal body processes such as digestion, evacuation of the bowels, urination and menstruation proceed normally and occur without excessive discomfort
- The bodily excretions such as sweat, urine, faeces, menstrual blood and saliva are of normal consistency, colour and do not have unusually strong or unpleasant odours
- The appetite is normal and there is hunger in the mornings
- The desire for fluids is balanced: it increases in hot weather and with exercise, and the preference is for fluids which are neither too hot nor too cold
- The emotions are balanced and even. There is neither too much anger, joy, fear, boldness, impulsiveness nor procrastination, and the emotions are maintained in a state of equilibrium
- Sleep is balanced with wakefulness, and is not interrupted by excessive or disturbing dreaming. Dreams that occur are pleasant, uplifting and filled with optimism
- The mind is quick, alert and imaginative; the memory is good
- The limbs move easily, with strength and precision
- The blood vessels can be seen in the flesh and are neither too deep, nor do they bulge out
- The hair is lustrous and is neither too thin nor too coarse. It grows in the correct places and does not grey or fall out prematurely

as an 'alternative to' Western medicine. The reality is that a lot of so called 'alternative' medicines were, and are, being utilised quite harmoniously with biomedicine, and practitioners did not consider their medicines mutually exclusive. The phrase CAM or 'complementary and alternative medicine' was later adopted and more recently 'complementary medicine' alone has become the term of reference employed to refer to such therapies. This definition is also not necessarily ideal, as 'complementary' assumes a role that is an 'adjunct to', rather than all disciplines being able to complement each other. 'Natural medicine', while a broad term, may better convey the role and field of medicine that involves natural non-drug based medical treatment.

Complementary medicine (CM) generally refers to a wide range of health care practices that do not use drugs or invasive techniques. Treatments may include herbal medicines, homoeopathic medicines or nutritional and other supplements. In Australia, the common complementary therapies practiced are: naturopathy, herbal medicine, homoeopathy, acupuncture and Chinese Medicine, aromatherapy, all of the massage therapies, osteopathy and chiropractic (see Table 2). These disciplines generally share a common belief in the holistic philosophy of health, and the principles associated with this.

Table 1.2 gives a brief description of the most common disciplines practised in Australia.



Table 2 The most common natural medicine disciplines practised in Australia and New Zealand

Discipline	Definition
Naturopathy	The use of any or all of the techniques listed below, including dietary advice and nutritional supplementation, usually within a holistic framework
Herbal medicine	The prescription of herbs for the treatment of complaints Prescriptions are usually based on the philosophical doctrine of medical herbalism rather than being used as a substitute for drugs
Homoeopathy	Based on the law of the minimum dose and 'like cures like', homoeopathy is the treatment of disease by minute doses of remedies that in healthy persons would produce symptoms like those of the disease
Acupuncture	The insertion of specialised acupuncture needles to regulate and stimulate the body's energy flow or <i>Qi</i>
Chinese Medicine	The use of acupuncture and herbs, and the manipulation of the flow of <i>Qi</i> with massage and specific exercises
Aromatherapy	The use of 'essential oils' as therapeutic agents either orally, in an oil burner or applied to the skin
Massage	Massages may be relaxing or 'therapeutic' A therapeutic massage involves deep-tissue massage for the relief of injury, muscular spasm and tension A relaxation massage is usually more gentle and is designed to relieve stress
Shiatsu	Pressure-point massage working along specific channels to stimulate energy or <i>Qi</i>
Chiropractic and osteopathy	The mobilisation and manipulation of the skeletal structures along with the strengthening and stretching of the muscular components of the body
Mind-body	Techniques such as meditation which emphasise awareness of the connection between mind and body

Naturopathy is not made up of a specified group of disciplines and each of the colleges or universities may train their students differently. A practitioner who uses a multi-disciplinary approach has usually trained as a naturopath. Naturopaths may be predominantly herbalists, homoeopaths or nutritionists, or a combination of these.

The quality of training is extremely varied and at present there are no regulations in Australia governing the practice of natural therapies. Currently the issues of regulation and educational standards are under review by a variety of state and Commonwealth government-initiated processes. Although registration has not been established in Australia yet, a recent Victorian government review of the practice of Western herbal medicine and naturopathy, concluded in favour of registration of practitioners.⁴² Registration of the naturopathic profession would lead to greater integration of

naturopaths into mainstream health care, as well as ensure a minimum standard of education of practitioners. Many practitioners are concerned with the lack of regulation and belong to professional associations as a way of indicating their standard of education and to demonstrate their commitment to improving the status of their profession.

Towards integration

Complementary medicine (CM) in health care is becoming increasingly popular. A large number of health care funds now cover for the use of CM. A study in 2000 found that around 57 per cent of the Australian population used some form of complementary therapy, and that public spending on complementary medicines far exceeded total patient contribution for all pharmaceutical medicines (A\$2.3 billion).⁴³ A follow-up survey in 2004 reported that while spending had decreased on complementary medicines (A\$1.8 billion), visits to complementary



therapists had increased by around 26 per cent.⁴⁴ So it is clear that public use and spending on complementary medicines, and practitioners, is increasing and represents a significant proportion of health care.

In recent years there has been greater recognition by the Australian government of the need for research and regulation of CM. In 1999 the federal government established a regulatory framework for complementary medicine, with the 'Office of Complementary Medicine' within the Therapeutic Goods Administration (TGA). As a result there is now greater regulation over the control, safety and quality of manufactured complementary medicines. CM has become more widely accepted by the medical profession in Australia. The current position statement of the Australian Medical Association (AMA) 'acknowledges the growing use of complementary medicines and therapies by the Australian population' and states that 'evidence based aspects of Complementary Medicine are part of the repertoire of patient care and may have a role in mainstream medical practice.'⁴⁵ In 2005 the Royal Australian College of General Practitioners (RACGP) and the Australasian Integrative Medicine Association (AIMA) put forward a joint position paper on complementary medicine which further endorsed the AMA's position statement.⁴⁶

Use of complementary medicines by GPs also appears to be increasing and aspects of complementary medicine are now being taught in a number of medical undergraduate courses. Surveys have found that around 30–40 per cent of Australian GPs practise some form of CM, while 75 per cent formally refer their patients to such therapies.⁴⁷ However, a recent survey found that it was the non-medicinal and non-manipulative therapies such as acupuncture, hypnosis, meditation, massage and yoga that were considered to be the safest and most effective, while osteopathy, homoeopathy and herbal and nutritional medicines were seen as potentially more harmful than beneficial.⁴⁸ Furthermore, GPs saw the risks associated with CM result from incorrect, inadequate or delayed diagnosis and the interactions between complementary medications and pharmaceuticals.⁴⁹

Obstacles to integration still remain and there is still a lack of understanding and clear communication between the orthodox and allied health professions. Of particular concern is the fact that while most people use complementary medicine as an adjunct to orthodox medicine,⁵⁰ many are reluctant to inform their doctors that they are doing so.⁵¹ This is a significant concern. Awareness is growing as to

the potentially dangerous interactions between a number of herbal and nutritional supplements and pharmaceutical medications. A recent survey of surgical patients in hospitals highlighted this issue. It was found that while 46 per cent of the patients had taken complementary medicine in the two weeks prior to surgery; only 58 per cent disclosed this to hospital staff.⁵² The most common reason cited for non-disclosure was that they were not asked (80 per cent). It is known that there are a number of nutritional supplements and herbal medicines such as vitamin E, garlic, ginger and fish oils that can increase bleeding time.⁵³ The fact that this is not paid due attention has the potential to result in patient harm.

Collaborative model of health care

In a collaborative model of health care, orthodox and complementary health professions work together in providing the most effective patient care. It is unlikely that a patient's individual medical needs can be met by only one practitioner. In a collaborative model of health care there is recognition of the scope and limitations of any one practitioner, an awareness of other available health care services, and a referral to these services where appropriate, ensuring that the patient's best interests are always placed first.

A well-established referral system is integral to a collaborative model of health. Although complementary therapists are trained in various types of diagnosis according to their discipline, some diagnostic procedures or investigations are outside the sphere of complementary therapies. Examples of examinations that require referral to GPs and specialists include:

- Routine screening procedures such as breast examination and Pap smears. Cervical screening for dysplasia or cervical cancer will also detect sexually transmitted infections as well as vaginal infections
- Gynaecological examinations that are performed vaginally and involve internal palpation of the pelvic organs
- Pathology tests such as blood tests, swabs and some urine tests; and radiological examinations such as ultrasounds and X-rays



Orthodox or biomedicine is undeniably the first line of treatment in cases of acute and emergency medical situations. However, this is only a small percentage of medical issues. Often medical cases are complex and chronic and require ongoing management in both treatment and prevention. Naturopathic medicine has a strong emphasis on prevention and is particularly effective in the treatment of chronic diseases. Naturopathic physicians often receive referrals when a detailed dietary history and specific nutritional advice may be required, for example where there are suspected food intolerances, chronic skin conditions, or digestive health issues. Functional disorders are another common type of medical referral to naturopaths. A functional disorder is a disorder that exists despite no diagnosable pathology, such as in the case of irritable bowel syndrome (IBS). Reproductive issues such as infertility, and gynaecological disorders such as premenstrual tension, are other examples of where there may be a number of underlying causes and a holistic approach is effective in restoring health and function.

A collaborative model of health care may involve the combined use of biomedical and complementary health care. Endometriosis may be treated in some cases both with the oral contraceptive pill to alleviate pain and control growth of endometrial cells, as well as herbal and nutritional support that aims to improve uterine tone and reduce inflammation in the body. Likewise in cancer therapy, a patient may undergo surgery, radiation or chemotherapy, and can also benefit from complementary care that optimises nutrition and assists in minimising and alleviating drug and treatment side effects.

Within the collaborative health model, patient treatment is individualised and interactive. An interactive consultation involves the patient being part of the decision-making process. This may involve listing possible treatment options, both from biomedical and complementary health care perspectives. It also involves the patient in the understanding of treatment strategies, a process which not only improves compliance, but also assists in positive outcomes and allows people to intervene on their own behalf when or if the condition arises again.

Effective treatment is also individualised. We are each unique in our genetics, environmental exposures and various medical conditions, and as such are our nutrient requirements and reactions to medicines will be different. Research from the Human Genome Project in the field of nutrige-

nomics and pharmacogenetics has shed new light on the importance of individualised treatment approaches. These research areas emphasise the individualised response to medicines and nutrients as well as the role of dietary and genetic interactions. There is no one system of intervention that will work for every person; neither is it reasonable to expect that a condition will always respond favourably to a treatment, even if this has been the case for other individuals many times in the past.

Complementary medicine is continuing to grow in its public use, research and government funding. Research into nutritional and herbal medicines is expanding the knowledge basis and scientific validity of complementary health care. Integration of complementary medicine with biomedicine is slowly but surely becoming part of mainstream health care. In order for a collaborative health care model to be effective, practitioners need to be aware of the limitations of their area of expertise with referrals being made across disciplines where appropriate. Practitioners must also be aware of what medicines their patients are taking and the potential interactions between nutritional, herbal and pharmaceutical medications. It is clear that for a collaborative model of health care to be viable there must be informed and open communication between patients and their practitioners, as well as between health care professionals.

This book is a guide for treatment of gynaecological complaints from a natural therapist's perspective. The information in this book is intended for practical application by herbalists and allied health-care practitioners, and may also be of value for those engaged in research and study. Although this book has a self-care focus it is not intended as a substitute for competent advice and guidance by a qualified practitioner.

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Introduction

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