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# Social medicalization and alternative and complementary medicine: the pluralization of health services in the Brazilian Unified Health System

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## ABSTRACT

Social medicalization transforms people's habits, discourages them from finding their own solutions to certain health problems and places an excess demand on the Unified Health System. With regard to healthcare provision, an alternative to social medicalization is the pluralization of treatment provided by health institutions namely through the recognition and provision of alternative and complementary practices and medicines. The objective of the article was to analyze the potentials and difficulties of alternative and complementary practices and medicines based on clinical and institutional experiences and on the specialist literature. The research concludes that the potential of such a strategy to "demedicalize" is limited and should be included in the remit of the Unified Health System. The article highlights that the Biosciences retain a political and epistemological hegemony over medicine and that the area of healthcare is dominated by market principles, whereby there is a trend towards the transformation of any kind of knowledge or structured practice related to health-illness processes into goods or procedures to be consumed, and this only reinforces heteronomy and medicalization.

**DESCRIPTORS:** Social Medicine. Health Services Needs and Demand. Complementary Therapies, utilization. Single Health System. Health Services. Health Knowledge, Attitudes, Practice.

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## INTRODUCTION

Social medicalization is a complex phenomenon that carries different meanings depending on the focus of studies that investigate the term.<sup>20</sup> It is associated with wide-ranging socio-cultural, political and scientific transformations related to both the incorporation into wider society of behavioral norms with a biomedical origin,<sup>8</sup> and to the redefining of human experiences as medical problems.<sup>10</sup> Medicalization is thus related to the ways in which healthcare and treatment have been legitimized, formalized and professionalized in modernity, and this process has been led by biomedicine.

While this process cannot be attributed solely to the field of medicine, the forms of interpretation and action that are prevalent in biomedicine tend to contribute further to medicalization.<sup>22</sup> There is a tendency to attribute illnesses to problems that relate to the "human machine" and that will be resolved by chemical or surgical technology (or, when that is not the case, to problems that require the adoption of a "healthy lifestyle"). There has been an increase in the number of professional, diagnostic and therapeutic procedures that are unnecessary and

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Received: 11/27/2007

Reviewed: 3/27/2008

Approved: 4/8/2008

therefore harmful. At the same time, there has been a reduction in therapeutic perspectives with a devaluation of approaches concerned with ways of life, values and of subjective and social factors that are related to the health-illness process.<sup>22</sup>

For Santos,<sup>21</sup> biomedicine is indispensable and necessary while at the same time it is inadequate and dangerous. The social practice of biomedicine, which is relatively homogenous, acts within medicalization through what Illich<sup>10</sup> calls “cultural iatrogenesis”: a diffuse and harmful effect of biomedical activities that diminishes people’s personal ability to deal autonomously with situations that involve suffering, infirmity, pain and death.

Parallel to social medicalization, there has been, across a range of social sectors in the West, a growing interest in so-called complementary and alternative medicine (CAM). CAM has gained in popularity as a result of the frustrations, dissatisfactions and limitations experienced with biomedicine (and difficulties relating to access and cost), but also on account of its own merits.<sup>1,5</sup> This recognition has been acknowledged in public health around the world<sup>a</sup> and in Brazil it has been further acknowledged through the current National Policy on Integrated and Complementary Practices.<sup>b</sup>

The aim of the present article was to discuss the hypothesis that CAM may represent a fertile strategy to minimize the process of social medicalization in the context of healthcare. The article presents reasons for re-evaluating CAM from a socio-anthropological perspective and observations relating to the potential limitations and difficulties of such a strategy.

### Recognizing the value of CAM

It is common to find readings of CAM that are reductionist or prejudiced and which consider CAM to be a form of mystical primitivism. As such, they fail to recognize that CAM has made an important contribution towards developing knowledge about health care and cures. From this perspective, the growth of biomedicine should be accompanied by the disappearance or reduction of CAM. However, the opposite has in fact happened.<sup>12</sup>

Such a reading is often associated with a perspective that considers science to be constantly under threat from the specter of irrationality, which is related to its historic battle against religious or traditional authorities. This would suggest that the rise of CAM is considered as a call to abandon scientific knowledge in favor of a return to a supposed past marked by obscurity, magic and oppression. It is not necessary to point out that the current challenges to healthcare, the crises of medicine

and public health, economic globalization, scientific expansion across the world and social medicalization support and demand that this fear be overcome.

On the other hand, there are those that take up a defensive posture and argue that Western civilization is superior and should simply be imposed on others. One of the related reasons for this vision is ignorance, in so far as those who defend this position have no idea of the concrete achievements made by other civilizations, and spread rumors about the excellence of science and the dubious qualities of everything else. Yet another reason comes from immunization equipment which make the distinction between basic science and its applications, so that if there is some kind of problem or disaster, the equipment can be blamed. There is also the argument that non-scientific traditions have had their chance, that they did not survive the battle with science and any attempt to resuscitate them would be irrational and unnecessary. Ask yourself if these traditions were eliminated for rational reasons or because of military, political and economic pressures. Since the answer is almost invariably the latter,<sup>6</sup> these arguments do not merit any credit.

As a result, many traditions are in extinction or under transformation, making it difficult to recuperate them. However, this does not mean that one cannot learn from the ideas, values and methods that remain. In addition, from the 1980s, the notion of complementary medicine matured, whereby the decision stopped being alternative, with a choice between “one or other” and became additional, with the composition of “one and the other”. That which is complementary is not *a priori* in opposition, thus making it possible to have both “this and that”.<sup>2</sup>

Historical-epistemological and socio-anthropological studies of the sciences questioned a positivism and scientificism that are inductive to a vision of scientific knowledge as a truthful but asymptomatic description of reality; a vision that gives rise to epistemological mistrust of all that is not science. From these studies, one notes that scientific production is a sophisticated tradition concerned with the production of knowledge and practices, connected by specific forces, social networks, interests and cultural and socio-political values.<sup>6-8,10</sup>

The “green revolution” was a success in terms of the industrialization of agriculture, but a failure for agricultural communities who value their autonomy, ecological sustainability and certain traditions that connect them to the cycles and rhythms of nature. The same can be applied to the health-illness relationship: scientific technologies and knowledge can be marvelous or inadequate, depending on the situation, and on the subjects and values that are involved. It has to do with debates and decisions that are not only scientific but existential.<sup>6</sup>

<sup>a</sup> Organización Mundial de la Salud. Estrategia de la OMS sobre medicina tradicional 2002-2005. Geneva; 2002.

<sup>b</sup> Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Práticas Integrativas e Complementares no SUS - PNPIC-SUS. Brasília; 2006. (Série B - Textos Básicos de Saúde)

## Classifying Complementary and Alternative Medicines

CAM can be defined as a group of medical and healthcare systems, practices and products that are not at present considered to be part of biomedicine. This group can be organized in: alternative medical systems (homeopathy, ayurvedic medicine and others); body-mind interventions (meditations, orations); biological therapies (based on natural products that are not scientifically recognized); methods for manipulating the body and those based on the body (massage, exercise); and energetic therapies (reiki and ch'i gong among others). When these practices are used alongside biomedical practices, they are known as complementary; when they are used instead of biomedicine, they are considered alternative; and when they are used together based on good quality scientific evaluations of their safety and effectiveness, they are called integrated.<sup>17</sup>

The World Health Organization (WHO)<sup>a</sup> associates CAM with "traditional medicine", understood to mean "diverse sanitary practices, focuses, knowledges and beliefs that incorporate medicines based on plants, animals and or minerals, spiritual therapies, manual techniques and exercises". These descriptions define CAM vaguely as what they are not and include heterogeneous practices within the same definition.

The first students of types of healthcare and thus of CAM themselves were anthropologists. Metcalf et al,<sup>15</sup> adapting a schematization that came from American medical anthropology, divided healthcare in Brazil into three sectors: so called popular or informal medicine (care of family members, friends, neighbors, mutual assistance in churches or self-help groups); the formal system (biomedicine); and CAM and traditional medicine (homeopathy, acupuncture, popular and traditional specialists). Laplantine & Rabeyron<sup>11</sup> proposed four bipolar axes for defining the characteristics of CAM: social legitimacy, the traditional dimension, constitution in a theoretical *corpus* (popular or erudite) and medicinal functionality (diagnostics and/or therapeutics).

Luz<sup>14</sup> devised a powerful analytical-classifying schematic of CAM, by categorizing their medical rationality. This categorization is made up of: human morphology (anatomy, in biomedicine), vital dynamics (physiology), diagnostic system, therapeutic system and medical doctrine (explanation about illnesses and cures), based on an implicit or explicit cosmology. These dimensions characterize a medical rationality, which allows for distinctions between complex medical systems such as biomedicine or ayurvedic medicine for therapies or diagnostic methods such as Bach flower remedies, iridology and reiki among others.

According to Fleck's epistemology,<sup>7</sup> CAM can be analysed through their styles of thinking which bring together conceptions, values, knowledge and practices of thought groups with specialized training, interests and activities. These groups are organized in hierarchical socio-epistemological circles, as follows: central esoteric circles, made up of specialist knowledge producers (in biomedicine these are the scientists); intermediary circles of those who reproduce and practice this knowledge (healers, clinical doctors); and more peripheral and exoteric circles, made up of lay people who use techniques and knowledge passed on by those who have preceded them (the sick).

According to this vision, medicines that are sufficiently structured include specialized layers that are more or less esoteric; and the classification of healing systems can be organized according to the characteristics of their epistemological design. Thus, a medical rationale can be understood as composed of intermediary and esoteric knowledge and techniques from a specialized way of thinking about health-illness, with their own structured methods, pedagogy and knowledge.

### CAM in the field of healthcare

For Bourdieu,<sup>3</sup> a field of study is defined, among other things, by its issues of dispute. Since all societies are interested in minimizing infirmities, disputes exist between the different forms of care, each of which seeks social recognition, symbolic importance and economic and technical resources.

Principally from the 1960s, knowledge of scientific medical rationality began to be relativized, particularly as its technological arsenal creates interlocations between the therapist and patient. The long-standing relationship between the therapist and patient began to rupture, breaking the standard of meanings that were historically shared and incorporated as symbols, by means of which people communicate and carry out their activities and livelihoods.<sup>2</sup>

The debates concerned with this rupture lead to, on the one hand, the questioning of the hegemony of the medical discourse, with the proposal of multi-professional healthcare teams, which require a new professional identity for doctors, and, on the other hand, the possibility of opening up, or giving recognition to, new models of healthcare with social credibility.

For Geertz,<sup>9</sup> collective symbols can be used to represent any object, act, relationship, collection of notions or occurrence. They can be symbolic systems that function as a model drawn from and for social realities. It is possible to conceive of a model for an alternative/complementary reality that seeks out a lifestyle that is more independent from consumer society, and is based on ecological awareness, spirituality, and on the idea of

<sup>a</sup> Organización Mundial de la Salud. Estrategia de la OMS sobre medicina tradicional 2002-2005. Geneva; 2002

holistic and not dualistic health. Such a model for reality, based on applying complementary and alternative practices for health, allows for new power structures and relations to be constructed, with new roles and incentives for professionals and patients. These models are the fruit of various factors that stem from Western culture itself, including counter-cultural movements from the 1960s, the popularization of concepts from psychoanalysis and the support given by the WHO to traditional medicine.

The symbolic system that supports complementary/alternative culture gives meaning to new issues, such as perplexity in the face of a practice that is no longer technically nor symbolically satisfactory, the experience of suffering and the ethical paradox. In so far as the biomechanical model progressively incorporates high technologies, it creates barriers in the process of anamnesis and the clinical exam, interfering in the relationship between the professional and the patient. This interference changes the nature of working with human suffering, in particular by hiding it. To experience it as nuclear element of the human condition, it is appropriate and perhaps necessary to develop non-biomedical practices that re-humanize suffering, as a basis of the gnosis of the health and illness process.

The perceptions that arise from the perplexity and the experience with suffering create a need for certain other concepts in the health-illness process, such as intuition, vital energy and holism among others, making it necessary to rethink the practice within a “new” ethical space.

In the care and cure ritual, with the application of alternative and complementary techniques and positive solutions, the conviction arises that the grounding concepts and the directives are correct. In this way, a social perception about the CAM develops, recognizing its effectiveness and necessity: firstly, recognizing the association between integrated health and physical, mental, social and spiritual well-being; secondly, encouraging the subject to assume his or her responsibility for his or her own health-illness, thereby increasing the sense of autonomy; thirdly, supporting the fact that professionals see themselves as equals in the process of orientating the patient about attitudes, beliefs and habits; fourthly, valuing not only biomedical notions but also emotional, spiritual, social and other elements; and fifthly, creating a model for the practice of CAM that places an emphasis on natural techniques, and on medication and procedures that are harmonizing and stimulate the individual’s own ability and potential to return to equilibrium.<sup>2</sup>

Thus, through this different ways born from and relating to their practice, the CAM have come to be widely recognized as possible mediators in the movement for reconstructing collective symbols, which transcend the simple dispute about the forms of care and cure in the field of healthcare.

### Contributions made by CAM

Generally, CAM are innovative in a series of ways: they consider the ill patient to be the center of the medical paradigm; in the restructuring of the healer-patient relationship as the element that is fundamental to treatment; in the search for simple forms of therapy that are less dependent on hard scientific technology, less expensive and, nonetheless, are equally or more effective in situations involving more general and common illnesses; in the construction of a form of medicine that seeks to increase the patient’s autonomy; and in the affirmation of a knowledge/ practice that has, as its central tenet, health and not illness.<sup>13</sup>

One practical contribution made by these medicines is the interpretive and therapeutic enrichment of the clinic: many “unclassifiable” illnesses, that persist after fruitless consultations with specialists and complementary exams, are made understandable through a CAM reading, which can lead to treatment that may be effective and accessible. They can thus help to expand the clinic. Cunha,<sup>4</sup> for example, argues that homeopathy and acupuncture should be included as therapeutic tools used by primary healthcare professionals in the Brazilian Unified Health System, the SUS.

Some CAM, notably those that draw on medical groundings, are relatively integrated in their approaches, vis-à-vis biomedicine and thus are possible treatments that could be offered to SUS users. In some ways, this integrality, which is greater in esoteric circles, extends to intermediary and exoteric circles, thus leading to the recommendation that they too should be included in health care.<sup>23</sup>

Another reason that supports the potential demedicalization of CAM is based on an analogy with a harm reduction policy. It would appear to be less iatrogenic and more enriching within the health-illness culture of SUS users, including people who receive homeopathy, acupuncture, yoga, meditation or phytotherapy, among others, than the general medicalized population who demand chemical and surgical interventions from the SUS, with benefits for the participants.<sup>16</sup>

However, legitimizing other kinds of practices and knowledge would require that other social actors be legitimized and that the criteria for social validation be multiplied; that is to say, to act upon decisions that are of a political and existential nature, while avoiding that they become “epistemologized” and “scientificised”.<sup>6</sup> In this regard, some CAM that have been studied scientifically using methodologies that do or do not respect their theoretical and technical characteristics, are appropriately relevant. This has helped some non-biomedical techniques to become slowly institutionalized within biomedicine itself. However, discussions about the effectiveness of CAM using scientific standards

are methodologically complex and have shown few results that are consensual and reliable, although many are promising.<sup>5</sup>

In terms of the inclusion of different medical and therapeutic rationalities in health care, Luz<sup>14</sup> argues that there are insurmountable theoretical-epistemological and political difficulties and overcoming the contradictions between medical systems is closer to the art of healing than to the science of illness. In this way, some integration has occurred slowly in pioneering biomedical health services that allow for CAM spaces, in which professionals and users experience a therapeutic syncretism or complementary micro-environments.

There are municipal and local experiences involving regulating, negotiating and implementing CAM in the SUS. Contestations of these initiatives are, as a general rule, limited to those that fall into the medical or associated category. It is worthy of note that practices such as *lian gong*, yoga, tai chi chuan, therapeutic touch and reiki among others, have come to be accepted by professionals and users.<sup>a</sup>

This popular<sup>16</sup> acceptance expresses the interaction between concepts used within CAM and those used by users of the SUS, the health culture of which is a kaleidoscope of different representations about humans and their illnesses. In spite of the progressive medicalization, perhaps in this context psychic, religious, traditional and vitalist ideas still predominate. In turn, the CAM cosmologies have a number of similarities, in spite of their diversity. Luz<sup>14</sup> attributed a “vitalist paradigm” to the rationalities of homeopathy, traditional Chinese medicine and ayurvedic medicine. For him, notions such as energy, breath, energetic body, individual imbalances, natural and ‘super-natural’ forces have an important existence and role to play, integrating nature and man in a perspective of macro and micro universes. This leads one to consider illness as a break from one’s internal (in the micro-universe) and simultaneously relational equilibrium. These aspects allow those who practice these CAM a greater symbolic flow in relation to their illnesses, as well as an easier emotional rediscovery of meaning and support for the changes and new lessons learnt that arise from experience and the illness and, in this way, a potential demedicalizer.

Such characteristics also support an approach involving what could be called “spiritual” aspects of the health-illness-cure process for various CAM. For Vasconcelos,<sup>24</sup> these elements and their relevance are gradually becoming clearer to science and to health professionals, just as they always were to the general population.

Furthermore, some CAM, that are more closely based on medical rationales, involve knowledge and technologies that specifically promote health. The training of traditional Chinese and ayurvedic healers in a traditional setting, for example, involves learning and understanding these promotional techniques, and encourages a real potential for communication and pedagogy in these healers.<sup>b</sup> From this internal characteristic of some CAM, one can consider them to be potentially enriching to healthcare in the SUS, from clinical and health promoting perspectives.

### Limitations of the CAM

Illich<sup>10</sup> was pessimistic in relation to the potential for CAM to act as an instrument for managing medicalization. He believed it to be a political remedy that was ambiguous and had little use, since he considered medicalization to be independent from medical rationality: “the more different theories with the power to diagnose and define a treatment that exist, the more reasons there are to renounce responsibility for transforming what, in the environment, causes illness [...] and the more illness becomes depoliticized” (p.113).

Foucault<sup>8</sup> appeared not to pose this question, since biomedical norms were widely accepted in Western societies. Illich and Foucault are essential for a critical analysis of medicalization, but are not enough to come to conclusions about “therapeutics”.

Advances in debates about autonomy and self-treatment in biomedicine and in contemporary culture was also considered, in the subsequent work of Illich, to be part of a pathologic and medicalizing movement.<sup>19</sup> Nogueira<sup>18</sup> labels the obsession with health in a globalized culture a “hygiomania”, which has led to an intensification in the consumption of practices, products and services for self-treatment and preventive treatment. He argues that it forms part of a blame seeking and individualistic paranoia that has negative political and social repercussions, under the same signs of autonomy and responsibility. Further, the appearance of the entification and treatment of risks represents a new form of “re-medicalization”, now as a function of the future.

The boom of New Age culture and of the consumption of complementary techniques and treatments within the logic of the market, medicalization and ‘hygiomania’ are arguments against the use of CAM as a demedicalizing strategy. In this way, attracted by a contemporary culture that is reductionist in its treatment of meanings, forms and contents of healing practices, CAM can also impoverish the richness of experiences and meanings of the health-illness spectrum, leading to heteronomy

<sup>a</sup> Simoni CL. Ginástica terapêutica chinesa Lian Gong: estudo de caso da inserção no SUS [master’s dissertation]. Salvador: Instituto de Saúde Coletiva da Universidade Federal da Bahia; 2005.

<sup>b</sup> Tesser CD. Epistemologia contemporânea e saúde: a luta pela verdade e as práticas terapêuticas [doctorate thesis]. Campinas: Faculdade de Ciências Médicas da Unicamp; 2004 [cited 2007 Jul 01]. Available from: <http://libdigi.unicamp.br/document/?code=vtls000317960>

and ‘hygiomania’. In addition, the inclusion of some of its techniques within biomedicine equally shows a trend in this direction.

## FINAL CONSIDERATIONS

As a political and democratic directive, the supply of CAM by the SUS is an incontestable given. Across the local, municipal and national levels, there is a unanimous show of political will among civil society and user groups, and in Brazilian health councils and conferences, with regard to the supply of CAM within the SUS.

In general, their intrinsic virtues are entirely relevant, the risk is relatively low and the potential would seem to point to a “demedicalizing” strategy within the SUS. Such a way forward is not itself a panacea and it points to a cultural domain and to a field of practices that are tense. Just as with any practice in contemporary healthcare, its exercise is subject to a reductive review of meaning, whether it be medicalizing or ‘hygiomaniac’.<sup>18</sup> In this way, it is necessary to encourage, for collective health and for the SUS, CAM practices that contribute towards solidarity, that are less market-focused and that are more enriching of the experience of the health-illness-cure process.

One could say, as Cunha<sup>4</sup> does that the SUS should devise a policy that avoids “allowing therapeutic plurality for the rich (outside of the SUS), while for the poor the rigor (and limits) of Cartesian science will remain (p.148)”. For this, there should begin a long process of

bringing together the social actors, institutions and professionals that are involved with CAM, with its various difficulties, such as the history of the health councils within the SUS. Councils and councilors did not exist, but little by little they are appearing on the scene and the same could happen with those who practice CAM, their traditions and institutions, assuming a similar political investment occurs, which is currently not the case.<sup>24</sup>

To move forward with this strategy, confrontations between corporations and political pressures will become more intense within the field of healthcare. Epistemological complexities, operational difficulties and political disputes exist and will increase, once there are more and different questions, such as: the proliferation of “complementary” specialists; negotiation about their training and capacity building; the inclusion of the CAM in their (esoteric) epistemological complexity, in their intermediary and simplified (exoteric) forms, or in all their forms, which would be more desirable; the democratization of CAM by middle and senior professionals, or their limitation to doctors or specialists; the priority supply of primary healthcare, which is justified as the central *locus* of healthcare within the SUS, and also in hospitals and emergency units.

In spite of these difficulties, the supply of CAM within the SUS should be defended as a support for sustainable “democracy and ecological epistemology” and the strategy for managing medicalization in the construction of universality, equality and integrated care within the SUS, all of which are required to guarantee quality healthcare.

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Article based on the following works presented to the Departamento de Medicina Preventiva e Social of Universidade de Campinas: Barros NF [master's dissertation, 1997 and doctorate thesis, 2002] and Tesser CD [master's dissertation, 1999 and doctorate thesis, 2004].