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ON THE DEFINITION OF COMPLEMENTARY, ALTERNATIVE, AND INTEGRATIVE MEDICINE: SOCIETAL MEGA-STEREOTYPES VS. THE PATIENTS' PERSPECTIVES

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Much confusion exists regarding the definitions of complementary, alternative, and integrative medicine. Whereas 'complementary and alternative medicine' (CAM) is used to describe a variable set of diagnostic and therapeutic modalities considered as non-conventional, 'integrative medicine' is commonly used to describe the combination of allopathy and CAM. CAM, however, is nothing more than a categorical label that subsumes numerous therapeutic modalities generally sharing few commonalities. Creating a unique category out of such diversity has led to misunderstanding and skepticism. From the physician's standpoint, this can generate numerous stereotypes, prejudices, and misconceptions that may compromise the therapeutic relationship, impede compliance, and lead to treatment failure. To help avoid this dangerous pitfall, we propose a distinctly new operational definition for CAM; one that shifts the focus from the traditional, population-based approach to a definition that focuses on the individual. This paper outlines various definitions of CAM and discusses their relative strengths and weaknesses for the 21st century practice of medicine. It is our conclusion that individual patients, rather than society, should be the frame of reference and defining source for what constitutes integrative medicine and CAM. (Altern Ther Health Med. 2003;9(5):58-62)

If patients were powerful rather than powerless, if they were viewed as interesting individuals rather than diagnostic entities, if they were socially significant rather than social lepers, if their anguish truly and wholly compelled our sympathies and concerns,

would we not seek contact with them, despite the availability of medications? Perhaps for the pleasure of it all.¹

—Rosenhan DL

Much confusion exists regarding the definition and meaning of Complementary, Alternative, and Integrative Medicine. Are they synonyms or separate components of the medical armamentarium? Is there overlap among their various approaches to a given problem or do they represent a continuum of medical treatment? A National Institutes of Health (NIH) panel 2 that convened to define Complementary and Alternative Medicine (CAM) acknowledged, "Boundaries within CAM and between CAM and the domain of the dominant system are not always sharp or fixed." Fulder³ concluded, "It would be unrealistic to attempt an exact definition of those therapies which are outside mainstream conventional medicine." The multiple classification systems for CAM⁴ suggest, as others have noted, that CAM as a field is significantly problematic in terms of categorization.⁵ Thus, the purpose of this commentary is not to deal with taxonomy per se, but rather to operationally delineate and characterize the meaning and implications of these various terms in the context of modern health care practice and public health.

WHAT IS CAM? PUTTING CAM INTO CONTEXT

CAM is used to describe a variable set of diagnostic and therapeutic modalities that are considered to be non-conventional.^{6,7} In the past these disciplines were mainly provided as an alternative to conventional health care and hence became known collectively as "alternative medicine." The term "complementary medicine" developed as these two systems began to be utilized alongside each other.⁸ Even though the terms "alternative" and "complementary" are neither linguistically nor conceptually synonymous, they are often used interchangeably by practitioners and patients alike. Differences do exist, however. Complementary medicine emphasizes adjunctive use of treatments integrated with conventional medical practices and not used as an alternative to them.⁹⁻¹⁰ Different surveys across various health conditions and cultures indicate that only a minority of patient/users view CAM as "alternative". The clear majority of those who use CAM takes an "inte-

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grative” approach to their health care, one that naturally incorporates CAM and mainstream allopathic medicine into a blueprint for healing and prevention.¹¹⁻¹³

To better understand the evolution and incorporation of these terms into the medical lexicon, it is important to remember that substantial changes in the common use of professional terms often parallel changes in societal and cultural attitudes. The CAM domain seems to be a good case in point. In 1992, as a response to the increasing interest in non-conventional medical practices among a large segment of the population, the US Congress instructed the NIH to create the Office of Unconventional Medical Practices. The name of this NIH branch was later changed to the Office of Alternative Medicine (OAM) and most recently to the National Center for Complementary and Alternative Medicine (NCCAM). As societal attitudes have continued to change, the funding for this center has grown from an initial \$3 million in 1993 to more than \$100 million today.¹⁴⁻¹⁵ Indeed, CAM is no longer a term used by the medical fringe but has entered the mainstream.^{11,16-18}

CAM as a label

CAM is, in fact, a categorical term under which hundreds of therapeutic modalities, generally sharing few commonalities, are lumped together.¹⁹ To illustrate the fallacy of this categorization, consider an analogy to a high-rise apartment building. The many residents of such a skyscraper have one thing in common; their street address, but may vary tremendously in terms of many other characteristics. Similarly, although included under the umbrella of “CAM,” practices such as acupuncture, chiropractic, and iridology have almost nothing in common from a theoretical perspective. One reflection of this heterogeneity and diversity is the National Library of Medicine (NLM) scope note for alternative medicine, which describes the field as “an unrelated group of non-orthodox therapeutic practices.”²⁰

Some might claim that different CAM practices share an emphasis on “holism.” Indeed, another overlapping but unique term in this arena is “holistic medicine.” The goals of holistic medicine converge on the “optimal attainment of the physical, mental, emotional, social, and spiritual aspects of health,”²¹ goals to which many CAM or integrative medicine providers would subscribe. Holistic practice involves “all safe and appropriate modalities of diagnosis and treatment.”²² As noted above, the mechanics of different modalities themselves may focus on treatment interventions in only one physical subsystem of the individual, eg, colon hydrotherapy, or on a conceptualization of person as an indivisible body-mind-spirit system, eg, classical homeopathy or traditional Chinese medicine, as the means to the same end. Thus, even in terms of how the practitioner thinks about a given treatment and the way in which healthier outcomes might evolve in the person may differ dramatically between CAM modalities.

Furthermore, although some CAM modalities, eg, traditional Chinese medicine or classical homeopathy, and some definitions of “holism”²² espouse vitalistic notions of an invisible vital force or energy enlivening the whole person, many other CAM modalities do not, eg, functional medicine with individually-tailored nutritional interventions. Recent conceptual work, even in those systems

with vitalistic philosophical roots, has been seeking to reframe the terminology in terms of self-organizing complex systems theory, an approach at the cutting edge of modern science.²³⁻²⁴ Many, but not all CAM interventions expect that, wherever their point of entry into the person as a system, the effects are ultimately non-specific and system-wide in strengthening of the host, rather than fighting disease in an end-organ. However, many other CAM interventions rely on allopathic diagnosis and, like pharmaceutical drugs, target the biological disease process, eg, antineoplastins for cancer or neurotherapy for particular EEG changes in attention deficit disorder, purportedly with greater safety. Thus, different CAM practices may or may not identify holism as a goal, and labeling all such interventions as “holistic” or “vitalistic” is also inaccurate and misleading.

Therefore, we think, alternative medicine is nothing more than a label; an abstract socio-cultural construct that serves the establishment and much less so the patient. As just one example of how fallible and arbitrary this labeling process is, the NCCAM²⁵ and the NIH Office of Dietary Supplements²⁶ consider vitamin use as part of CAM, yet in the 1999 National Health Interview Survey, conducted by the National Center for Health Statistics, daily supplemental vitamin use was excluded since it was not considered CAM therapy.¹³ Likewise, Teramoto²⁷ showed that many Japanese doctors who prescribe Chinese herbal medicine (Kampo) do not recognize it as CAM. Their definitions and attitudes toward CAM depended upon whether they were university- or private hospital-affiliated. Furthermore, Furnham, who conducted a factor analytic study of how lay people classify various CAM therapies, concluded that “it seems as if lay peoples’ perception of CAM therapies is as much a function of knowledge based on media interest as their understanding of the philosophy or method underlying these therapies. Experts tend to classify CAM therapies as structural, biomechanical, or psychological, while lay people seem equally happy to classify them in terms of familiarity and perceived effectiveness.”²⁵

Labeling and stereotypes

We fear that creating a unique category out of such diversity can lead to misunderstanding and skepticism. This in turn may give rise to numerous stereotypes, prejudices, and misconceptions related to the art and science of these modalities. Classifications based on race and ethnicity, practices predicated on social acceptance, or behaviors categorized solely on subjective impressions, run the risk of appearing racist, prejudiced, and discriminatory. Indeed, most societies have learned to value and respect individuals despite differences in their belief systems and rituals. Much social upheaval can be tied to attempts to categorize as “alternative” religious and other practices not conforming to the mainstream.

Our discourse on the contemporary societal viewpoint of CAM does not criticize cognitive schemas and mental categories per se but rather their undesirable consequences. Indeed, when viewed as a heuristic device, these schemas and categories aid in learning and utilize self-education techniques that result in personal discovery and problem solving. Our concern, however, stems from schema research that shows the danger of oversimplification. By storing knowledge at a molar, inclusive level, rather than squir-

relying away, one-by-one, all the original individual experiences in their raw forms, schemas can lead to stereotypes, which preclude the pure data-driven processing inherent in traditional medical thinking, especially in fields where specific occurrences and processes are still presumed to be part of distinct and separate categories.²⁸ Furthermore, subtle schemas may often resemble objectivity, thus severely compromising one's ability to relate to fact rather than fiction.²⁹

Medicine in its ideal form not only listens to and respects the individual but also makes them a partner in the healing process. The practice of medicine requires good rapport and mutual respect between patient and practitioner so that an alliance may be forged around a common agenda. Support for these propositions comes from the Institute of Medicine (IOM) in its quest to redesign the U.S. health care system for the 21st century. Their position states that "care should be based on continuous healing relationships... should be customized according to the patient needs and values, and that the patient should be the source of control."³⁰⁻³¹ This is virtually impossible when a practitioner is judgmental and critical which only stifles patient inquiry and partnership.

We believe that practitioners must assess patients as unique individuals while diagnosing and treating their diseases. Assessing health practices (broadly defined) requires placing them in context. Labeling a health practice "alternative" may be misleading if it is integrated within one's life as normal practice. What may be "alternative" for one individual could be mainstream for another. For example, for many patients, routine use of mind-body practices such as meditating is not alternative at all. To avoid this false labeling process the health care system must adopt the IOM call for a patient centered approach ie, "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."³⁰⁻³¹ Not to do so may compromise the therapeutic relationship, impede compliance, and lead to treatment failure.³²

Bringing in the patients' perspectives

It is therefore our contention that the operational definition of CAM should be individualized and should serve as a basis for an open discussion between health care provider and consumer. This approach differs from a population-based approach to medicine, which focuses on patterns and aggregates. Accordingly, we propose a distinctive new *operational* definition for CAM; one that shifts the focus from society to individuals:

Complimentary and alternative medicine includes those systems and modalities of health care that define and solve health problems in a context that is *not* congruent with the patient's rationale, life-world, and identity, regardless of societal and medical conventions.

To clarify what we mean, consider the following example. A patient, who believes in homeopathy as a whole system of care, develops fever due to acute non-life threatening infection, eg, flu. The patient decides to use a homeopathic remedy to help the body fight back the infection, rather than "conventional" over-the-counter antipyretics that would only relieve the symptom. Now,

from a societal standpoint homeopathy along with its underlying principles is foreign to the way much of society looks at disease and healing. But we suggest that this societal viewpoint may be irrelevant since in modern health care, the patient is the ultimate arbiter of what is alternative and what is not. This counter-orthodox viewpoint is consistent with the IOM "Crossing The Quality Chasm" manifesto which states, "Patients should be given the necessary information and opportunity to exercise the degree of control they choose over health care decisions that affect them. The system should be able to accommodate differences in patient preferences and encourage shared decision making."³⁰⁻³¹ Thus, to go back to our example, it is likely that the patient would not consider homeopathy as alternative medicine, contrary to societal and the medical establishment conventions.

Our proposed definition differs fundamentally from other existing definitions of CAM because of our individual versus social-based and relativistic approach. For example, in their seminal article, Eisenberg et al., championed the common social theme that alternative medicine consists of "...medical interventions not taught widely at U.S. medical schools or generally available at US hospitals."³³ These reference criteria, however, are changing rapidly and are not consistent across the world. Presently in the US, CAM is not only commonly taught in medical schools but also is increasingly integrated into the health care system.³⁴ Similarly, Eskinazi's definition of CAM, "...[treatments that] pose challenges to diverse societal beliefs and practices (cultural, economic, scientific, medical, and educational.)"³⁵ is largely societal-based and regionally dependent. Others look at CAM as an add-on to mainstream medicine ("diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole, by satisfying a demand not met by orthodoxy or by diversifying the conceptual frameworks of medicine").³⁶ Whereas this viewpoint may be true for many patients, it is by no means true for others for whom mainstream medicine is, in fact, added on to CAM.³⁷

Our definition, rather than focusing on society as the authority for defining CAM modalities, asserts that CAM should be delineated with the individual goals, objectives, and beliefs of the consumer, as the defining source. We believe that all forms of Medicine are ethnomedicines, which, given the perspective of globalization and the process of hybridization, are variable resources that patients may appropriate for a variety of purposes. Therefore, it is important for practitioners to understand patients' reasons for using or refusing particular healing protocols and for identifying specific modalities as either central or peripheral to their lives. This requires the practitioner to understand the patient's perceptions of disease and health and the entire scope of therapeutics that they consider part of their medical armamentarium.³⁸

Of particular interest is the definition proposed by the NIH Panel on Definition and Description, CAM Research Methodology Conference,² which was later adopted by the Cochrane Collaboration: "CAM is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or

culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within CAM and between CAM and the domain of the dominant system are not always sharp or fixed.”

At face value, this definition includes both the societal and the individual perspectives, yet the user's perspective is somewhat problematic. Is buying aspirin over the counter considered CAM? How about regular exercise? Or a low-fat diet? According to this definition, these and other common practices, which are often self-prescribed, can definitely be regarded as CAM since they all can be said to be “preventing or treating illness or promoting health and well-being.” Thus, we agree with the “self-defined” component of that definition, yet our definition sets forward a different criterion, ie, the incongruity between one's belief system and the nature of the intervention.

Is Integrative Medicine the same as CAM?

Integrative Medicine is a term first coined in the early 1990s in response to the need to shift the orientation of medicine to one of healing rather than one of disease.³⁹ Integrative practitioners do so by engaging the mind, spirit, and community, as well as the body, based on an uncompromised commitment to the practice of good medicine, whether its origins are conventional or alternative. Integrative medicine recognizes that good medicine is inquiry-driven and open to new paradigms and that it neither rejects conventional medicine nor uncritically accepts alternative practices.^{37,39} From this perspective, integrative medicine is a new, comprehensive system of medicine, not only in techniques, but also in conceptual foundation, different from the classical science perspective on health as the absence of physical disease. By putting the patient at the center of the therapeutic relationship, integrative medicine illustrates the advantage of valuing the patient's viewpoint of health and disease, consistent with what we strongly argue for in this commentary. Recent epidemiological surveys that examine the reasons why patients chose healing oriented practices support this claim.^{12,40}

Unfortunately, the term integrative medicine is often regarded as “combination medicine,” which is nothing more than a shotgun approach to patient care.⁴¹ The patient is not seen as an individual but rather as a disease requiring formulaic or predetermined combinations of therapies. Integrative medicine recognizes patient individuality and the need to develop approaches unique to the individual. This method takes into account the patient's point of view as well as physician experience. We propose that combination medicine (conventional plus CAM) is not integrative medicine.¹⁸ Integrative medicine is a structure for care that considers health (or disease) as an inherent property of the individual in a coherent system. Furthermore, one must be vigilant against the danger of fragmenting this system into component parts (CAM and conventional practices) lest we fall back into the old paradigm of viewing health as the absence of disease.³⁸

Implications

Establishing trust and productive communication between practitioners and patients are two cornerstones of the therapeutic

relationship. Yet, when it comes to “alternative practices,” only a minority of patients has open communication with their care providers.¹⁷ Sadly, the fear of being marginalized by what may sometimes seem an intimidating medical establishment that has limited tolerance for alternatives outside of mainstream practices only reinforces this communication breakdown.⁴² This grim reality stands in sharp contrast to the emergent approach of patient-centered care that emphasizes the exploration of experience and expectations of disease and illness, the understanding of the whole person, the finding of common ground regarding management and partnership, and the enhancement of the doctor-patient relationship.⁴³ A recent observational study showed that patients desire a patient-centered approach over a biomedical one.⁴⁴ Furthermore, Stewart et al,⁴⁵ were able to demonstrate that patients' perceptions of their role in the therapeutic relationship was a strong predictor not only of health outcomes but also of efficacy of health care. If practitioners hold prejudicial or stereotypical attitudes toward patients' therapeutic preferences (whether CAM or others), the therapeutic alliance may be severely compromised.

The practice of good medicine requires more than just “objective” evidence since “evidence does not make decisions, people do.”⁴⁶ Global evidence still needs localized decision-making.⁴⁷ As the late Dr John Eisenberg put it “worldwide access to evidence-based clinical decision making must coexist with respect for individual decision making shaped by local culture and circumstances. This is the balance between globalizing the evidence and localizing the decisions that will improve delivery of health care worldwide.”⁴⁸

We believe that our newly proposed operational definition of complementary and alternative medicine promises new horizons for the integration of CAM into the current health care system. We therefore propose putting aside all societal schemas and mega-stereotypes regarding CAM and make the implicit explicit. Whereas there might be alternative options for diagnosis and treatment, there are no alternative patients!

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