Introduction – Taking stock of integrative medicine: Broadening biomedicine or co-option of complementary and alternative medicine?

In response to the emergence of the holistic health movement in the early 1970s and the rising popularity of complementary and alternative therapies, a growing number of biomedical physicians and institutions have embraced complementary and alternative medicine (CAM), often under the guise of integrative medicine. Whereas alternative medicine is often defined as functioning outside biomedicine and complementary medicine beside it; integrative medicine purports to combine the best of both biomedicine and CAM. Some social scientists have argued biomedicine has become more holistic as a result of this development, whereas others suggest it has embarked upon a subtle process of absorbing or co-opting CAM. This special issue consists of six articles that address changes in the health care sectors of four Anglophone societies, namely the United States, Great Britain, Australia, and New Zealand, associated with the adoption of integrative medicine or CAM. The authors examine some of the causes and consequences of this development. Is this a reframing of biomedicine itself, an erosion of medicine’s political, economic, and social authority, a response to managerialism and the demands of consumers or market pressures, an expression of rising legitimacy for CAM, or a new professional strategy for biomedicine? And finally, where might the push for evidence-based medicine fit into this equation?

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From ‘holistic health’ and ‘complementary and alternative medicine’ to ‘integrative medicine’

New medical systems or synthetic ensembles of therapies (such as the hygiene movement in the nineteenth century), emerged as popular health movements that often undergo a process of professionalisation and may in time even be absorbed by biomedicine (Baer 2001). The holistic health movement began to emerge on the US West Coast, especially the San Francisco Bay Area, in the early 1970s (Baer 2001). It quickly spread to other parts of the United States and also to other, especially Anglophone, countries (Canada, the UK, Australia, and New Zealand), as well as to Western European countries, such as Germany, the Netherlands, and Denmark. It began as a medical revitalisation movement that in various ways challenged the bureaucratic, high-tech, and iatrogenic dimensions of biomedicine. The holistic health movement was by no means a monolithic phenomenon, and varied considerably from society to society where it emerged. It encompassed numerous heterodox or alternative medical systems (such as homeopathy,
herbalism, naturopathy, chiropractic, osteopathy and bodywork), with often divergent philosophical premises and therapies. Although it appeared to have its strongest expression in Western societies, it also drew heavily from various Eastern medical systems, such as Traditional Chinese Medicine, Ayurveda, and Tibetan Medicine. To a large extent, the holistic health movement overlapped with the New Age movement that also became very popular in Western societies. Like the holistic health movement, New Ageism focuses upon a balance in the interaction of mind, body and spirit in its attempts to achieve experiential health and well-being. New Ageism also incorporates many therapeutic techniques and practices, including meditation, guided visualisation, channelling, psychic healing, and neo-shamanism.

Starting in the late 1970s, an increasing number of biomedical physicians, osteopathic physicians (in the case of the US, where they enjoy full practice rights in all 50 states and the District of Columbia), and nurses in various countries, began to recognise the limitations of their conventional approach to illness and acknowledge the loss of many of their more affluent patients to alternative practitioners of various sorts. A group of MDs and DOs (Doctors of Osteopathy) established the American Holistic Medical Association in 1978. Nurses in particular, given their strong person-orientation, expressed interest in holistic health and formed the American Holistic Nurses Association, which in 1995 created the American Holistic Nurses Certification Corporation in order to offer programs in aromatherapy, therapeutic touch, Amma therapy and imagery.

Ironically, but not surprisingly, holistic health as a popular movement has by and large evolved into complementary and alternative medicine (CAM), or even more recently, into integrative medicine or integrated medicine, depending upon the national setting. In various Anglophone countries, terms that have been used to refer to CAM have included unorthodox medicine, unconventional medicine, alternative medicine and complementary medicine. Until relatively recently, the term conventional medicine was commonplace in the UK (Fulder and Munro 1982; Sharma 1995; Vincent and Furnham 1997). The Office of Alternative Medicine, which was established under Congressional mandate in 1992 as a branch of the US National Institutes of Health, became the National Center for Complementary and Alternative Medicine in 1999. Indeed, a panel convened by the Office of Alternative Medicine in 1995 defined complementary and alternative medicine as follows:

"Complementary and alternative medicine (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 well-being. Boundaries within CAM and between the CAM domain and the domain of the dominant system are not always sharp or fixed."


As this definition indicates, CAM is both an amorphous category and a biomedical construction: one which has entered the sociological and anthropological literature. It also appears to have emerged as a political compromise between American alternative medicine and the European complementary medicine. Over the past decade or so, numerous biomedical physicians and nurses have written overviews of CAM and even called for an ‘evidence-approached approach’, at least in the case of the former (Jonas and Levin 1999; Novey 2000; Micozzi 2001; Diamond 2001; Yuan et al 2006; Snyder and Lindquist 2006). Wolpe (2002:165) argues that CAM is ‘what sociologists refer to as a residual category’ in that it is ‘defined not by its internal coherence but by its exclusion from other categories of medicine’. Conversely, while there is a tendency to speak of CAM in the North American and British contexts, there is a tendency to simply speak of complementary medicine in Australia and complementary and alternative health in New Zealand (Robson 2003; Di Stefano 2006). Conversely, various scholars
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in the past and even more recently prefer the term *alternative medicine* to *complementary medicine* to refer to the CAM scenario in Australia (Wiesner 1989; Martyr 2002).

In time, more and more biomedical and nursing schools began to offer courses on alternative therapies. This is a process that has occurred in the US, Canada, the UK, Australia and other developed countries. In 2002, at least 81 of the 125 biomedical schools in the US offered instruction. In contrast to North America and the UK, Australian biomedical schools have moved slowly in the adoption of CAM familiarisation courses. Nevertheless, as Brooks reports:

*Some Australian medical schools are in the process of revising their curricula, with several considering the addition of a CAM component. CAM may be taught as an independent elective, within another unit such as 'society, health and health psychology,' or in the teaching of ethics* (Brooks 2004:275).

Many US nursing schools have established programs in *holistic nursing*. The *New York University Advanced Practice Holistic Graduate Program* (est. 1998) offers a master’s degree as a holistic nurse practitioner and teaches meditation, therapeutic touch, and homeopathy (Dean 2001). The *University of Washington School of Nursing* offers instruction in CAM with input from Basytr University, a naturopathic institution (Sierpina 2003). Nursing schools in various parts of Australia train their students in various complementary therapies, such as aromatherapy, massage, and Therapeutic Touch (Jacka 1998:161). The nursing school at the *University of Southern Queensland* has included naturopathy into its curriculum (Eastwood 1997:20). Until recently, the *La Trobe University* in Melbourne offered a combined nursing–naturopathy degree program. (Students took their nursing courses at the La Trobe-Bundoora campus and their naturopathic courses at the private *Southern School of Natural Therapies*.)

In many cases, the terms *integrative medicine* or *integrated medicine* have supplanted CAM or complementary medicine. Andrew Weil, a Harvard-trained MD and a renowned holistic health guru, is often credited with inventing the term *integrative medicine*. Weil established the *Program in Integrative Medicine at the University of Arizona* in 1994. This offered one-year fellowships to family practitioners and internists in order to teach them ‘how to combine the best ideas and practitioners of conventional and alternative medicine, with a strong emphasis on healing, natural healing, mind–body interactions, etc’. (quoted in Redwood 1995:2). Weil also established the journal *Integrative Medicine: Integrating Conventional and Alternative Medicine* in 1998.

Coulter (2003:107) delineates the following items distinguishing CAM and integrative medicine:

1. the addition of CAM to largely hospital-based programs;
2. the inclusion of CAM practitioners into biomedical clinical settings, particularly chiropractors, naturopathic physicians, acupuncturists, and massage therapists;
3. the increasing trend for health insurance companies to provide at least partial coverage for CAM treatment; and
4. initiatives on the part of patients to obtain integrative care.

Elsewhere, Mann, Gaylord, and Norton (2004:157-164) delineate seven models of integrative care:

1. the informed clinician who communicates his or her knowledge about CAM to patients;
2. the informed, networking clinician who adds ‘referral networks with CAM practitioners’ to his or her knowledge of CAM therapies;
3. the informed, CAM-trained clinician who incorporates specific CAM therapies into his or her practice;
4. the multidisciplinary integrative groups practice where ‘practitioners provide both conventional and complementary therapies in a partnership’;
5. the interdisciplinary integrative group practice ‘in which care providers in multiple disciplines see patients together as a team’;
6. hospital-based integration; and
7. integrative medicine in an academic medical centre.

Diamond (2001:14) argues that the terms *alternative* and *complementary* are divisive and should be discarded and replaced by *integrative*
or integrated medicine. In *Integrated Health Care: Complementary and Alternative Therapies for the Whole Person*, Victor Sierpina (2001:3) delineates eight aspects of integrative health care:

1. Patient-centred care;
2. Encouragement of personal responsibility for health;
3. Recognition of the interaction of mind, body, and spirit in health and healing;
4. Emphasis on wellness;
5. ‘Collaborative partnerships involving interdisciplinary teams of health-care providers and the patient’;
6. Openness to CAM therapies which ‘have a record of safety and efficacy but are outside of the conventional biomedical model’;
7. Reliance on evidence-based scientific thinking when integrating biomedical and CAM therapies; and
8. Recognition of the fact that health and healing are individualistic processes.

Other than the emphasis on evidence-based science and reliance on safety and efficacy studies; Sierpina’s model of integrative health care closely resembles the old holistic health model, thus suggesting that integrative medicine is nothing more than ‘new wine in old wineskins’. Others however, might argue that integrative medicine constitutes a genuine paradigm shift within biomedicine because it has prompted it to adopt holistic concepts, adopt CAM therapies, and even collaborate with CAM practitioners. Conversely, Fulder (2005:775) asserts that while holism is a worthy ideal, in reality ‘it has been eclipsed by a new word for therapeutic inclusiveness, namely integration [which refers to] the combined used of therapies’. Nurses have also embraced integrative medicine. Halcon et al (2001:128) assert: ‘Nursing science, grounded in both holism and biomedicine, can provide a critical link in the establishment of a truly integrative health care system’, and describe efforts at the University of Minnesota School of Nursing to achieve this goal. Many CAM practitioners have also adopted the integrative medical model. For example, the *Southwest College of Naturopathic Medicine* in Tempe, Arizona:

... provides students with an integrative approach to the delivery of health care. While encompassing natural therapy philosophies and emphasising the practical information necessary to establish a successful practice. ND students gain experience in private practice offices and in local health care and hospital settings under the supervision of naturopathic, allopathic, or osteopathic licensed physicians (Poorman et al 2001:106-107).

**An overview of the contributions to the special issue**

This special issue consists of six articles addressing changes in the health care sector associated with the adoption of integrative medicine in five ‘Anglophone’ societies, namely the United States, Canada, the UK, Australia, and New Zealand. Of all the contributors to this special issue, Kevin Willison appears to be the most positive in his assessment of integrative medicine as he indicates in his article on ‘Advancing integrative medicine through interprofessional education’. Willison views the growing popularity of CAM and the increasing emphasis on both CBPR and IPE as powerful countervailing forces to biomedical dominance in health care delivery. He particularly seeks to demonstrate such a trend in the management of chronic diseases.

Conversely, Christopher Fries, in ‘Governing the health of the hybrid self: Integrative medicine, neoliberalism, and the shifting biopolitics of subjectivity’, adopts a more critical view of integrative medicine. Fries views integrative medicine in Foucauldian terms as an expansion of medical surveillance and regulation to not only the biological dimensions of human existence, but also the psychological, sociological, and spiritual dimensions. Although integrative medicine appears to have initially emerged in the US and UK, it has spread to other countries as a ‘consequence of transnational cultural flows’. Rather than viewing the sources of disease or illness as being embedded in various political, economic, and social structural forces, integrative medicine places the onus of responsibility ‘smack onto’ individuals, thus contributing to making health care a commodity consistent with a growing, global, neoliberal agenda.
In addition to the appearance of free-standing integrative medical clinics in many developed countries, various biomedical schools and hospitals have established integrative medical centres. The UCLA Center for East–West Medicine was created in 1993 to merge principles of Chinese medicine and biomedicine (Hui et al 2002). Thomas Jefferson University Hospital in Philadelphia, and George Washington University Medical Center, both operate centres for Integrative Medicine. Shellharbour Private Hospital, south of Sydney, operates a one-stop medical complex offering both complementary and biomedical services and sells natural and biomedical products in a facility adjacent to the hospital (Collyer 2004:89).

While various hospital-based centres of integrative medicine have functioned for well over a decade, others, as Ian Coulter and his colleagues chronicle in ‘Trials, tribulations and troubles on the road to implementing integrative medicine in a hospital setting’, have not fared so well. These authors examine the difficulties of creating an integrative medicine centre in a Los Angeles hospital, despite the presence of a culture which legitimised the development of innovative medical programs. As they indicate, this hospital had failed to implement feed-back mechanisms that may have otherwise prevented it from carrying on with poor managerial decisions. Furthermore, financing the integrative medicine program in the hospital proved to be particularly problematic. Indeed:

Directors of integrative clinics admit ... that their ventures are not money-making enterprises. Nor are many clinic directors actively seeking growth because increased volume requires a concomitant expansion in facility capacity, which requires more funds (Ruggie 2004:197).

Furthermore, the labour intensity the CAM component of integrative medicine also mitigates the capital-intensive nature of much of biomedical care.

While the first three articles in this special issue focus on integrative medicine at the macro, and intermediate levels of health care systems, the last three focus on the implementation of integrative medicine in specific clinical settings. In ‘The problematic nature of conflating use and advocacy in CAM integration: Complexity and differentiation in UK cancer patients’ views’, Philip Tovey and Alex Broom report on their interviews with 80 cancer patients drawn from three National Health Service (NHS) teaching hospitals and one partially NHS-funded hospice in the UK. While the majority of their interviewees were using CAM therapies privately as part of cancer treatment, they supported the idea of integrating CAM therapies into NHS cancer services. Furthermore, most of their interviewees felt that while they did not require scientific validation for the CAM cancer therapies they were utilising, only those CAM cancer therapies which had undergone scientific validation should receive NHS funding.

Kevin Dew and his colleagues in their article “You just got to eat healthy”: The topic of CAM in the general practice consultation’, describe the complex interaction between nine New Zealand general practitioners and 105 patients with respect to the possibility of incorporating CAM into their treatments. For the most part, patients adopted a variety of strategies to have CAM therapies included in their treatment regimen, but had to counterbalance this against a polite but reserved response of the GPs to CAM. Conversely, one of the GPs described himself as a ‘naturopath’, despite the fact that naturopathy enjoys less legitimation and respectability than it does in various other developed societies, including the United States, Canada, and Australia.

In ‘Integrating biomedical and CAM approaches: The experiences of people living with HIV/AIDS’, Rachel Thorpe examines the perceptions of 18 individuals living with HIV/AIDS in Melbourne who are receiving integrative medical care. While these patients found utilisation of complementary therapies to be empowering in coping with a chronic condition, they also found the process of communicating with biomedical physicians and complementary practitioners cumbersome, if not at times exhausting. Interviewees often expressed a desire to receive treatment in a more integrated medical care setting instead of ‘bouncing back and forth’ between representatives of biomedicine and complementary medicine.
Tensions between biomedical and CAM practitioners within the parameters of Integrative Medicine

As the various articles in this special issue indicate, complementary and alternative medical systems, albeit some more than others, have encountered biomedicine full on under the guise of integrative medicine (Baer 2004). Needless to say, many CAM practitioners have embraced this development while others remain sceptical. Conversely, while many biomedical physicians have come to embrace CAM, others remain sceptical, if not hostile to it. Some biomedical physicians even believe they alone are qualified to integrate biomedicine and CAM. Adams (2003) conducted an exploratory study in which he interviewed 25 GPs (14 male and 11 female) practicing CAM in Edinburgh and Glasgow. His subjects tend to regard their incorporation of CAM therapies as ‘complementary’, as opposed to CAM practitioners, whom they regarded as ‘alternative’ and often deficient in their approaches, if not potentially dangerous.

Biomedical practitioners who express openness to integrating CAM therapies often insist they undergo scientific validation within the framework of evidence-based medicine (EBM) (Parker 2007). The Australian Medical Association (2002) has formally stated that the ‘evidence based aspects of complementary medicine are part of the repertoire of patient care and may have a role in mainstream medicine’. Although many CAM practitioners have embraced the call for subjecting CAM therapies to the rigours of evidence-based medicine, others assert that EBM is based upon biomedical philosophical premises and relies excessively on simplistic random, doubled-blinded, efficacy trials and that CAM therapies should be evaluated upon their own therapeutic philosophies and practice styles. Based upon interviews with ten traditional acupuncturists (five male, five female) in the UK, Jackson and Scambler (2007) note that their informants tended to reject biomedical evaluations of acupuncture and called for the development of an alternative scientific approach to testing their therapeutic modality.

While some biomedical physicians are willing to work in integrative medicine settings with CAM practitioners, others choose to engage in their own integrative endeavours. For example, in a study of medical acupuncture in Germany, Frank and Stollberg (2004) delineate the following patterns of medical integration:

1. ‘biomedically dominated coexistence’ in which acupuncture functions as an adjunct therapy;
2. ‘coexistence with heterodox dominance’ in which biomedical physicians blend acupuncture with one or more CAM therapies, such as chiropractic, herbalism, or homeopathy;
3. ‘biomedical incorporation of acupuncture’ in which the efficacy of acupuncture is explained in terms of biomedical concepts rather than those of Chinese medicine; and
4. the ‘great melting pot’ in which biomedical physicians blend acupuncture with several other healing traditions.

Even when biomedical practitioners are open to CAM, they tend to vary in terms of the CAM therapies they accept or reject, and in the degrees to which these are accepted or rejected. Australian general practitioners, for instance, are particularly open to acupuncture, massage, meditation, yoga, and hypnosis (Cohen et al 2005), while nurses often incorporate meditation and yoga in their practices and tend to be more open than biomedical physicians to the adoption of CAM therapies such as relaxation, breathing techniques, Therapeutic Touch, guided imagery, music therapy, aromatherapy, prayer, and indigenous healing (Halcon et al 2001:130).

Historically, biomedicine has often incorporated alternative therapies rather than losing patients en masse to heterodox practitioners. Budd and Sharma (1994:4) assert that ‘[o]fficial medicine tends to colonise “fringe” areas of medicine once they are successful’. Indeed, David Rakel and Andrew Weil (2003:7), both biomedical physicians and staunch proponents of integrative medicine, observe that biomedicine often views CAM as providing ‘tools that are simply added to the curative model, one that attempts to understand healing by studying the tools in the tool box’.
The dominance of biomedicine often becomes apparent in integrative medicine centres. Goldner found this to be the case in her ethnographic observations in an integrative clinic in the San Francisco Bay area:

At the integrative clinic, one practitioner mentioned that the ‘physician here likes to be the physician and wave her title. So I have to be respectful, but not necessarily back down’... On several occasions, members thanked physicians for attending workshops, especially since they were ‘putting themselves out there’ when ‘they don’t have to [do this]’. The alternative practitioners seemed so appreciative that physicians were giving them any level of credibility, that they did not seem to mind differences in power (Goldner 2000:228).

More recently, Hollenberg (2006) conducted ethnographic and document analysis on two integrative health settings in Canada, interviewing thirteen biomedical physicians and eight CAM practitioners. He found that biomedical practitioners exerted their professional dominance by following four strategies: (1) seeking to monopolise patient charting, referrals, and diagnostic tests; (2) appropriating certain CAM therapies from CAM systems; (3) relegating CAM practitioners to specific therapeutic tasks; and (4) using biomedical jargon as the principle vehicle of communication. Conversely, CAM practitioners did not function simply as passive subordinates in these two integrative health settings. Instead, they adopted the following enclosure strategies: (1) using their own ‘esoteric knowledge’ in their interactions with biomedical practitioners and other CAM practitioners; (2) adopting biomedical jargon; (3) enhancing their own professional status by working within the corridors of biomedicine; and (4) referring patients amongst each other. Nevertheless, Hollenberg (2006:742) argues that ‘Western biomedicine continues to maintain its dominance in IHC settings’. Even in the few integrative medical clinics which are run by naturopathic physicians, osteopathic physicians, or even PhDs, biomedical physicians are ‘invariably on the staff’ because it is considered imperative they rule out rule out serious diseases (Ruggie 2004:196).

Based upon her observations in a non-conventional medical (NCM) clinic loosely affiliated with a biomedical hospital in Israel, Judith Fadlon (2005) found that biomedical dominance in the NCM clinic was maintained in that the clinic supervisor was a biomedical physician and all other practitioners, both biomedical and NCM, worked there on a part-time basis. She asserts that in the case of Israel, ‘While NCM may embody countercultural ideologies that lead to differentiation, in practice its major and most successful thrust has been through selective integration and ultimately domestication’ (Fadlon 2005:117). On the surface, sports medicine appears to be one endeavour where the integration of diverse therapeutic specialties has occurred smoothly. However, in interviews with 35 Canadian health professionals, including biomedical physicians, chiropractors, physiotherapists and athletic therapists, Theberge (2008) found that chiropractors managed to gain acceptance on sports teams for two reasons: (1) their willingness to work primarily as ‘manual therapists’ rather than heterodox general practitioners, and (2) their popularity as effective practitioners in the eyes of many athletes.

The US-based, Consortium of Academic Health Centers for Integrative Medicine constitutes perhaps the most explicit example of the biomedical co-option of CAM. In its definition of integrative medicine adopted in May 2004 and edited in May 2005, the Consortium states that it can ‘help transform medicine and healthcare through rigorous scientific studies, new models of clinical care, and innovative educational programs that integrate biomedicine, the complexity of human beings, the intrinsic nature of healing and the rich diversity of therapeutic systems’ (www.ahc.umn.edu/chaicm/about/home.html). Ironically, its membership consists of 41 biomedical academic centres but not a single CAM training institution.

At any rate, in a matter of a few decades, it appears that biomedicine, governments, and various corporate entities have domesticated holistic health as a popular movement and transformed it initially into CAM and more recently integrative medicine, a system in which certain heterodox therapies often
function as adjuncts to the arsenal of high-tech approaches. As CAM therapies are increasingly incorporated into university-based and private integrative clinics directed by biomedical physicians or operated by hospitals, health maintenance organisations and health corporations, they run the risk of functioning as adjuncts to the high-tech, capital-intensive biomedical practices that have come more and more under corporate and governmental dominance.

The challenge for social scientists
The body of work presented in this volume and elsewhere in the literature on both CAM and integrative medicine poses some significant challenges for social scientists. The first challenge is to separate out the rhetoric from the reality. Much is being claimed for IM but little has been empirically demonstrated. While IM claims to be holistic, what holism actually means at the level of practice, and whether most of those claiming holism can actually practice it, remains an empirical question.

The second major question is whether what is occurring between biomedicine and CAM is truly integrative as opposed to co-optation or co-adaptation. By which we mean, is CAM simply being co-opted into the biomedical paradigm at the level of therapy but not at the more philosophical level? Under this approach, integrative medicine turns out to be biomedicine with CAM therapies added. In other words, the vitalist elements of the paradigm are relinquished in this approach. It can be seen in chiropractic, where manipulation is offered for musculoskeletal problems but no mention is made of the innate or universal intelligence which is part of the philosophy of chiropractic. Perhaps this is just another expression of 'when you cannot beat them, join them'. It is telling that until the Wilkes trial in which chiropractors successfully sued the American Medical Association for restricting trade, there was very little effort to integrate chiropractic with biomedicine. In the case of hospitals it was not possible to do so without violating the AMA code of ethics, which in turn was adopted by various accrediting bodies. Since the landmark decision in that case, when the AMA and its affiliated bodies were directed by the court to cease all their activities aimed at restricting, containing or eradicating chiropractic, we have seen the emergence of integrative medicine in which chiropractors are included. In general however, they are still not included in many hospitals even when other CAM groups are, (such as acupuncture), and even where they are included, the degree of integration seems to be variable.

The third issue for social scientists is how much of integrative medicine is being driven by economic factors. As Coulter et al show in their article in this special issue, one of the impacts of the Eisenberg utilisation studies was to establish how much money the public was spending on CAM and whether this was a major factor in the decision of the hospital to develop integrative medicine. The users of CAM tend overwhelmingly to be fee-for-service, cash-paying patients. In a world of health care increasingly dominated by health insurance and a large bureaucracy, CAM appears as an increasing attractive business alternative. This is a question which has been raised elsewhere (e.g. Collyer 2004; Singer and Fisher 2007), but remains critical: to what extent is biomedicine integrating CAM merely because it perceived that there is 'gold in them thar hills'?

The fourth challenge is an analytic one. The term integrative medicine has been developed largely by those who claim to practice it. But if social scientists are to use the term, we have to be assured it is either an accurate descriptive term or provides an analytic distinction which is useful for driving both our theorising and empirical studies. At the moment it does neither. What characteristics do the groups calling themselves integrative medicine, or that social scientists have called integrative medicine, have in common? Analysis indicates they share one characteristic: they all subscribe to vitalism, the belief that the body heals itself and is the expression of some innate spirit, intelligence, or vital spirit. But do the vitalistic elements survive when CAM moves into integrative medicine, particularly in biomedical settings? Is integrative medicine simply an integration of therapies in which the philosophical elements are dropped? What we commonly find is that the manipulation of chiropractic is practised in biomedical hospitals but...
not the concept of ‘Universal Intelligence’. Similarly, the needles of acupuncture, the yoga and meditation of Traditional Chinese Medicine are practiced, but rarely the concept of chi.

The fifth challenge for social scientists is to examine the impact of integrative medicine on the health of those who use it. Is integrative medicine better for your health? Is its holistic approach more effective, and if so, for what kinds of patients, for what kinds of health, and by what kind of providers?

All the above questions pose significant research challenges for social scientists. Much of the information we have about these matters is descriptive but limited. To date, we have an increasing body of data on the utilisation of CAM and integrative medicine that is largely cross-sectional, primarily self-reporting (by patients and providers), and which tells us very little about what actually occurs in the integrative medicine health encounter. How patients make the choice to use integrative medicine during ill-health episodes is unknown. What occurs in the treatment room between the therapist and the patient is equally unknown. Without good ethnographic data on the health encounter we cannot answer even very basic questions, nor design rigorous quantitative studies. As Coulter (2004) has shown in the case of chiropractic, if you compare the research conducted by health services researchers on chiropractic, to that conducted by sociologists and anthropologists (who have observed the health encounter itself and the care given), you might conclude that the two groups have studied totally different health practices. In the case of health services research, we see patients attending for a very narrow range of problems and receiving a very narrow range of therapies. The practice here looks like that of a neuro-musculoskeletal specialist. The observation studies on the other hand, show a broad-based wellness practitioner providing care over a wide range of physical, emotional and lifestyle health problems. Hence the methodologies applied in the study of integrative medicine can have a significant effect on what is learnt.

And last, but not least, without a good descriptive base, theorising seems somewhat premature. As Coulter and Willis note (2007), most of the theorising to date – even about the growth of CAM – is highly speculative. They also note that any explanation for the growth of CAM and integrative medicine must not only explain why greater numbers of patients are choosing it, but why, increasingly, both the state and private insurance companies are covering the costs. In short, therefore, there remains a great deal of work for social scientists to do before we have a coherent account of integrative medicine.

References


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