Integrative Medicine: Combining the practice of Western & Alternative Medicine
To be or not to be...?

This paper will briefly cover the definitions of what constitutes Western Allopathic Medicine (WAM) and Complementary and Alternative Medicine (CAM) as well as the definitions and rationales for Integrative Medicine (IM). It is the contention of this paper that the term 'Integrative Medicine' represents a worldview and agenda that is ultimately and ironically at odds with 'alternative' and 'complementary' forms of medicine, the very forms that it seeks to absorb. Instead, as this paper will endeavour to articulate, it is 'Collaborative Medicine', that should be understood as offering best practice.

This distinction of terminology is and is not a semantic argument. Words hold power. With usage and over time words convey a worldview, they are representative of thought and action. By looking at the definitions and rationales for IM it will be argued that different terminology is the first step in redefining CAM's role within the broader healthcare landscape. Different terminology clears the way for forging new relationships with our own medicine, orthodox medicine, research [Barry, 2005] and ultimately our patients; and ensures that a continued diversity and approach to life, health and wellbeing survives.

So first to definitions of what constitutes WAM and CAM. This is not as easy as it first appears. There is considerable flux in the practices that are generally understood to be western/ allopathic or complementary/alternative due to differing national attitudes, healthcare necessity, political and cultural contexts and incremental changes across time. [Leckridge, 2004; Shuval & Mizrachi, 2004]

WAM is essentially a homogenous medical model; otherwise known as orthodox, biomedical, mainstream, modern and/or conventional medicine, it is firmly located within a scientific, reductive paradigm. [Leckridge, 2004; Kaptchuk & Miller, 2005] In the UK, the British Medical Association defines orthodoxy [WAM] as "treatment delivered by a registered medical practitioner" [Leckridge, 2004] however this is an inadequate definition as many registered medical practitioners are also providers of CAM treatments such as acupuncture, homeopathy and others. [Leckridge, 2004] Given the hierarchies of evidence within the Western Allopathic

paradigm, most of the affirmed and credible knowledge is evidenced by randomized controlled trials (RCT's) as opposed to empirical, anecdotal or anthropological evidence, [Scheid, 2008; Karger, 2007; Barry, 2005] although this wasn't always the case.[Hammerly, 2000]
This commitment to diagnosis and treat patients in the light of current scientific knowledge is according to Kaptchuk and Miller, what makes it "fundamentally distinct from alternative medicine". However the growing requirements for 'evidence-based medicine' across all paradigms of medicine, makes this definition a little less definitive. Essentially though WAM is the "'model of illness based on a central notion that specific diseases exist, that they are produced by biologically aberrant functioning, and that they can be alleviated by clearly defined treatments." These treatments and diseases are underpinned by biology, biochemistry and assumptions of objectivism, determinism and positivism.' [Shuval & Mizrachi, 2004]
CAM therapies on the other hand, also known as "complementary, holistic, natural, unorthodox, fringe and unconventional medicine, principally assert that illness is caused by an imbalance between opposing energy forces and adheres to a holistic orientation as part of their paradigm of healthcare." [Shuval & Mizrachi, 2004]
CAM unlike WAM though, is a heterogeneous medical model and many disciplines are lumped together under the CAM umbrella. [Kaptchuk & Miller, 2005] It is partly because of sometimes quite different systems of thought that it can be so difficult to pin down a definitive statement about what constitutes CAM. Leckridge points out that it is often defined by what it is not rather than what it is and this is in part due to a blurring of the definitions of not only CAM but also orthodoxy. [Leckridge, 2004]
The US based NCCAM (National Center for Complementary and Alternative Medicine) which defines CAM as "...a group of diverse medical and health care systems, practices and products that are not presently considered to be part of conventional medicine" [Leckridge, 2004], for their purposes divide CAM into 5 domains. TCM and naturopathy are considered alternative medical systems; then there are mind-body interventions like Yoga and meditation; biologically based therapies such as homeopathy; manipulative and body based therapies such as osteopathy/chiropractory and massage and lastly energy therapies such as Reiki. [Leckridge, 2004]
How important it really is to create static definitions of what constitute WAM and CAM depends to a large degree on the competing interests that appropriate these definitions. Leckridge suggests that definitions of 'CAM' and by relationship 'orthodoxy' are culturally, historically and politically determined and because the boundaries between the two practices 'are not fixed, a CAM product or service can become redefined as 'orthodox'.' [Leckridge, 2004]
Surely though if the boundaries are not fixed then this redefinition can work to the advantage of CAM? It does and it doesn't. It may be true on an individual level, but it is precisely because there is an inherent power dynamic within which CAM is always 'the other' that suggests redefinition and demarcation would entail at the very least a loss of territorial 'equity' for CAM and at worst a loss of paradigm integrity. WAM as the dominant healthcare paradigm will tend to assimilate and co-opt CAM therapy redefining itself as Integration Medicine (IM), while CAM is unable to do the same. This issue of boundaries and definitions has significant implications for the emerging profession of CAM practitioners at an organisational level, because it undermines their continuing role within the healthcare/wellness landscape. At its heart this redefinition is what co-option is all about.
'Integrative Medicine' is a deceptive term at least for practitioners and supporters of CAM. A strict dictionary meaning of the word 'integrate' means to unite or combine, to meld with and become part of the dominant culture. It is not so much the act of union with the dominant culture that is of most concern, although this is problematic for some , it is the nature of the union that is relevant. 'Integrative Medicine' is an entity that does not have at its core a collaborative or co-operative agenda, despite using a term that might suggest such a relationship. Instead it is about assimilation of particular CAM therapies, in order to maintain its power base – because there is only one worldview within which all other views must fold.
Edzard Ernst has reiterated two definitions of IM. Firstly he calls it is a "comprehensive, primary care system that emphasizes wellness and healing of the whole person...as major goals, above and beyond suppression of a specific somatic disease." [Ernst, 2004] He goes on to say that IM "views patients as whole people with minds and spirits as well as bodies and

includes these dimensions into diagnosis and treatment." [Ernst, 2004] Secondly, "it also means the use of different therapies, including both complementary medicine and conventional medicine and different healthcare agencies and practitioners, in a co-coordinated and mutually supportive programme of care for the greatest benefit of the individual patients." [Ernst, 2004]

IM it should be recognised, symbolizes a new movement of 'holism'; a capturing (and Ernst would say recapturing) of the body-mind-spirit trinity within established medical ranks.

For Australia's own Australasian Integrative Medicine Association (AIMA) their mission statement states that they : "...act as a peak medical body that promotes the integration of holistic and complementary medicine with current mainstream medical practice, in pursuit of a complete whole person care." [AIMA, 1998] This definition at first glance seems reasonable, but what is not immediately apparent is the exclusivity of AIMA. It is "an organisation of individual medical practitioners seeking to provide whole person medical care by integrating evidence-based complementary medicine into mainstream practice." [AIMA, 1998] Full membership to AIMA is open only to registered medical practitioners . Where does that leave the idea that "[n]o single therapy, specialty or discipline can provide everything needed for comprehensive (mind, body, spirit) care"? If we really accept this idea, then the only thing we get from IM is compromised outcomes and poor patient care as a result of the arrogant assumptions that 'Someone can Practice All Medicine' (SPAM) [Hammerly, 2000].

It is no coincidence that with the substantial growth in support for and use of CAM within the last decade [ABS, 2008] interest in 'integration' for the mainstream medical establishment has become of such pressing concern. This interest should be considered a primary internal factor influencing the premise of IM. As Shuval and Mizrachi state, "The changing orientation of major segments of the medical profession need to be seen against the growing threat that consumer demand for alternative practitioners poses to the biomedical establishment, and the need of the latter to maintain its status and hegemony." [Shuval & Mizrachi, 2004] And yet if IM is the mainstream medical fraternity's refocusing of priorities to the social, economic and political pressures that have rapidly gained momentum within the last decade in relation to CAM; and its rationale is purely economic and status quo driven, that is not to say that factors such as patient centred care, best practice, efficacy, safety, quality [Fong, 2002], reliability and sustainability aren't also relevant rationales for working together. Indeed they are, but working together is a different concept and action than assimilating particular therapies such as acupuncture, homeopathy and chiropractory into a general practice.

The growth in CAM services has meant a growing professionalization of CAM, and implicit acceptance of it and its practitioners by the broader medical community. This is an external factor influencing the IM model [Hess, 2004] . There is complicity by CAM in accepting IM and this is due to a diversity of rationales; ranging from the structure of CAM as a more pluralistic community, to the motivations of best practice, efficacy, safety, quality reliability and sustainability which have at their core the patient's wellbeing, to the possibly more self interested concerns of individual practitioner status.

And then there is a third intrinsic factor at work too. Integration, it can be argued, is an organic process . It is most obviously observed in the way subcultures or fringe social movements often with anti-mainstream values; such as organic and biodynamic farming, punk/ grunge music scenes or even (one could argue) feminism, end up becoming part of the mainstream, losing their fringe or alternative status precisely because they have become so successful . This intrinsic factor serves to underline the difference between 'integration' as an ongoing process of life, that part of the equation that is both inevitable and valuable; and IM as a political, economic and social entity attempting to maintain dominance in a landscape of shifting power bases.

But given the external, internal and intrinsic factors at play where then does Best Practice lie? If IM is rejected as being SPAM [Hammerly, 2000] where are the best outcomes for patients, as well as for the (CAM and WAM) professionals who provide a service? The answer is in a redefinition of the common ground and the terms of reference that 'sing up the country'; the healthcare landscape. That redefinition is Collaborative Medicine (CM)

So what is CM and how does it differ from IM? Collaboration is essentially a two way interaction between common interests, it assumes and reinforces equality, it acknowledges

that WAM & CAM have common ground being not only the patient, but the integrity of their own medicine. Collaborative Medicine is a movement, a dynamic, a relationship rather than an entity.
CM requires reappraisal and adjustment of the values that inform care and cure, whether it is valuing the placebo and different hierarchies of evidence , or whether it is maintaining the pluralism of our practices and resisting the desire to obey a fascist logic buried within the nature of 'productivity' . In essence it requires all of these elements.
Diversification, understanding, acceptance and respect for differences, communication, commitment to the patient and the medicine- all these elements engender relationships which lie at the heart of patient-centred medicine. [Leckridge, 2004; Hammerly, 2000] CM is influenced by the Daoist philosophy of balance (Yin/Yang) and the valuing of all elements within the realm. The difference between CM and IM is (respectively); inclusion rather than exclusion, plurality versus uniformity, intention centred in the patient/human/care axis rather than within the money/status/power axis. And there is the trick: CM exists only in the relationships that seek it; it is the antithesis of a static, bureaucratised entity- it is the living word, the divine spark in human engagement.
IM and CM then represent two opposing worldviews, yet both are about union. IM is the absorption of particular aspects of other forms of medicine into a single practice, in an attempt to maintain a position of primary healthcare provision. CM is about keeping the integrity of each medical model; about practitioners working together to provide the patient with opportunities for safe, effective and quality choices.

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