

Australian Journal of Acupuncture and Chinese Medicine

CONTENTS

- 01 Editorial
- 03 Investigating the Reliability of Contemporary Chinese Pulse Diagnosis
K Bilton, N Smith, S Walsh and L Hammer
- 14 The Use of Acupuncture by Chinese Medicine Practitioners in the Australian Workers
Compensation System: Results of a National Survey
B Choy, S Walsh and N Smith
- 26 Integrative Medicine: Combining the Practice of Orthodox and Alternative Medicine –
Inclusive of 'Other' or Just Another Path to Exclusivity?
K Edin
- 31 Acupuncture Point Injection in the Treatment of Midportion Achilles Tendinopathy:
A Case Report
I Murray and D Hall
- 36 Current Research and Clinical Applications
- 40 Research Snapshots
- 45 Book Reviews
- 50 Conference Report
- 52 Upcoming International Conferences

Integrative Medicine: Combining the Practice of Orthodox and Alternative Medicine – Inclusive of 'Other' or Just Another Path to Exclusivity?

Kaitlin Edin* BHSc(TCM)
Private Practice, Sydney, Australia

ABSTRACT

The importance of creating static definitions of what constitutes western allopathic medicine (WAM) and complementary and alternative medicine (CAM) depends to a significant degree on the competing interests that appropriate these definitions. Terminology is and is not a semantic argument. Terminology is a sociological argument too. Words and the way we categorise hold enormous power over the human mind. Through usage and time, words are the matrix of any worldview and as such they are representative of thought, belief, action and collective consequence. What, then, is the definition and rationale behind integrative medicine (IM), is it a new paradigm as it appears to be, and how does it influence the broader healthcare landscape for practitioners of CAM and WAM alike? This article discusses the philosophical consequences of the definition and rationales of IM and suggests that 'integrative medicine' as a term and practice (hence, an entity) represents a worldview and agenda that is ultimately and ironically at odds with 'alternative' and 'complementary' forms of medicine, those very forms that it seeks to absorb. As practitioners of CAM modalities, we have a stake in ensuring that integrative medicine is understood as being a politico-economic entity and not the medical paradigm it suggests itself to be.

KEYWORDS Medicine, integrative, co-option, western allopathic, orthodoxy, CAM, traditional east Asian, narrative.

Introduction

Integrative medicine (IM) is relatively new terminology suggestive of a new medical paradigm. Yet the rationale and the philosophical underpinnings of this purportedly 'new' medicine, it will be argued, are not new. IM speaks of a medicine which combines the best of the western allopathic medicine (WAM) paradigm with the benefits of complementary and alternative medicines (CAM). So, at face value, it presents itself as a layered and holistic,

all-encompassing medical approach; yet closer evaluation suggests a worldview and agenda that is ironically at odds with 'alternative' and 'complementary' forms of medicine, the very forms that it states it integrates. Before discussing and defining integration and IM, however, there must first be clarity about how WAM and CAM are defined; one first must understand what they are independently. These definitions prove useful in providing some surprising insights into what integrative

* Correspondent author; e-mail: practitioner@kaitlinedin.com.au

medicine might actually be offering. A closer examination of the apparent chasm between what integrative medicine is and what it purports to be will also be considered.

Discussion

The distinction of terminology is and *is not* a semantic argument. Terminology is a sociological argument too. Words do hold power. Through usage and time, words are the matrix of any worldview and as such they are representative of thought, belief, action and collective consciousness.

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 and complementary/alternative due to differing societal attitudes, healthcare necessities, political and cultural contexts enacted upon by incremental changes across time.^{1,2}

WAM is effectively understood as a homogenous medical model; otherwise known as 'orthodox', 'biomedical', 'mainstream', 'modern' and/or 'conventional' medicine, and claims to be firmly located within a scientific, reductive paradigm.^{2,3} In the UK, the British Medical Association defines orthodoxy (i.e., WAM) as 'treatment delivered by a registered medical practitioner'²; however, this is an inadequate definition as many registered medical practitioners are also providers of what are considered CAM treatments such as acupuncture and homoeopathy.²

The commitment to diagnose and treat patients in the light of current scientific knowledge is according to Kaptchuk and Miller, what makes it 'fundamentally distinct from alternative medicine'.⁴ Although this is a reasonable definition, the growing requirements for 'evidence-based medicine' across all paradigms of medicine, could make this definition seem a little less definitive. What is problematic with this definition is 'current scientific knowledge' is not well defined, and given that empirical, anecdotal or anthropological evidence^{1,4,5} often provides a wellspring of knowledge that only over time is validated by accepted scientific procedures, it could be that WAM in practice isn't always how it's defined on paper. Indeed, as Hammerly points out, '[t]he recent medical literature is rife with examples of widely used medical therapies which have not been convincingly substantiated by our own standards. Two hundred years of using digoxin for heart failure was finally 'validated' in a 1996 study of 7,788 patients reported at the annual meeting of the American College of Cardiology'.⁶ This definition does somewhat imply that alternative medicine isn't 'scientific' in its approach, and while the premise of the medicine is alternative, it doesn't naturally follow that the medicine itself is not based on firm scientific principles of systematic observation and experimentation. Indeed what if alternative medical practice

and 'facts' contribute to current scientific knowledge? This indeed is borne out by the current scientific and medical frenzy with the biological and psychological health benefits that mindfulness and meditation training practices (such as yoga, qi gong, meditation) provide, now being validated by scientific trials as factually true.⁷

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 ideologically underpinned by biology, biochemistry and assumptions of objectivism, determinism and positivism.^{2,3}

Complementary and alternative medicine (CAM) therapies, on the other hand, are collectively referred to as 'complementary, holistic, natural, unorthodox, fringe and unconventional medicine, [and] principally assert that illness is caused by an imbalance between opposing energy forces and adhere to a holistic orientation as part of their paradigm of healthcare'.³

Quite unlike WAM, CAM is a heterogeneous medical model and many disciplines 'similar and diffuse' are grouped together under the CAM banner.⁴ Indeed, finding the threads that unite such different (and differently perceived) practitioners of disciplines as diverse as massage, yoga, homoeopathy, crystal healing, reiki, acupuncture, herbal medicine and naturopathy, highlights the difficulty of defining what constitutes CAM. As Leckridge points out, it is often defined by what it is *not* rather than what it *is*.²

The US based 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',² for its purposes divides CAM into five domains of related complexity. Chinese medicine and naturopathy are considered alternative medical systems; then there are the mind-body interventions of yoga and meditation; biologically-based therapies such as homoeopathy; the manipulative, body-based therapies such as osteopathy, chiropractic and massage, and lastly energy therapies such as reiki.² It is worth pointing out here that within Australia chiropractic and osteopathy have redefined themselves as 'allied' healthcare providers (being as they are recognised under Medicare) and as such may not be viewed, by themselves or others, any longer as CAM.

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' as well as '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’”.² Surely, though, if the boundaries are not fixed then this redefinition works to the advantage of CAM, too? Well it does and it doesn’t.

In one sense, and somewhat ironically, the alternative medical paradigms of naturopathy and traditional East Asian medicine have (at least in Australia) over time and with continued efficacy and patient/consumer use become more ‘mainstream’. Perhaps their acceptance into ‘orthodoxy’ is only a matter of time, but for the moment they would still be considered CAM therapies, however integrated into the ‘normal’ medical fabric. So in one sense redefinition could well be said to work to the benefit of the aforementioned CAM therapies, in part because redefinition hasn’t meant complete annexation or official prohibition from practice by regulatory authorities. But orthodoxy is a way of thinking, which CAM therapies and practitioners, by their existence, have challenged in the past, and with redefinition have come challenges to paradigm integrity. The alternative medicine paradigms are still part of a vanguard that have demanded a reappraisal and adjustment of the values that inform care and cure,³ the valuing of placebo⁸ and appreciating and respecting different hierarchies of evidence.⁵ But how far does thinking within the CAM communities that have benefitted from this ‘success’ of mainstreaming become orthodox in its own way? And with redefinition and demarcation into ‘orthodoxy’ how does ‘territorial equity’ for CAM practitioners manifest? Are practitioners of CAM, either as a group or as individuals, respected by the established orthodoxy on an equally esteemed footing?

At its heart a redefinition of orthodoxy is what co-option is all about; or put another way, ‘redefinition’ in the interests of co-option *is* orthodoxy. Precisely because WAM is the dominant healthcare paradigm, it will tend to assimilate and co-opt CAM therapies, redefining itself as integrative medicine, while CAM and CAM practitioners are unable to do the same.

It could be argued that CAM does in fact co-opt WAM, and could call itself integrative because many CAM therapies are taught and practised, incorporating western, biomedical and biomechanical knowledge and that in so doing it becomes integrative medicine. However, this is a too literal understanding of IM; integration is after all an organic process. Traditional and alternative medicines and orthodox medical paradigms themselves are not static but have incorporated and adopted materials and skills from each other’s disciplines across time.⁴ This integration is observed socially in the way subcultures or fringe social movements often with anti-mainstream, anti-establishment values – such as organic and biodynamic farming, punk/grunge music scenes or feminism – end up becoming part of the mainstream, losing their fringe or alternative status precisely because they have become so

popular and successful.⁹ What this serves to underline is the difference between ‘integration’ as an ongoing process of life, that part of the equation that is both inevitable and valuable and which allows human beings and communities to develop and evolve, and integrative medicine as a socio-political and economic entity that is embedded in a suspect system of values.

Dictionary definitions of the word ‘integrate’ include: ‘to bring together or incorporate (parts) into a whole’; ‘to give or cause to give equal opportunity and consideration to (a racial, religious, or ethnic group or a member of such a group)’.¹⁰ Integration suggests a coming together, a synthesis; within the context of medicine, it alludes to what is presented as an ideal, an interweaving of skills, practices and perception that meld the best of all that western allopathic (WAM) and complementary/alternative medicines (CAM) have to offer.

Edzard Ernst has spoken of two definitions of IM. Firstly he calls it 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’,¹¹ which, he goes on to say, ‘views patients as whole people with minds and spirits as well as bodies and includes these dimensions into diagnosis and treatment.’¹⁰ It should be recognised here that this definition of IM symbolises a new movement of ‘holism’, a capturing (and Ernst would say recapturing) of the body-mind-spirit trinity within established medical ranks. Secondly, he says, ‘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.¹⁰

On the face of it, these IM definitions, particularly the second, seem entirely reasonable. After all, ‘[n]o single therapy, specialty or discipline can provide everything needed for comprehensive (mind, body, spirit) care’,¹² and Ernst’s definitions give us a vision of a ‘two-eyed medicine’, the interweave of clinical practice that seems to hold out the ideal of a ‘team approach’ within primary healthcare arrangements, affirming the patient-centred model, where ‘cure’ and ‘care’ are no longer in opposition or competition with each other³ but rather form part of a *circle* of medical response and practice that wraps around each person. This team approach truly seems to offer an idealised vision. So where’s the problem?

It is not the act of union between CAM and the dominant culture of WAM that is of concern, although this is problematic for some,¹³ it is the nature of the union, the nuance of the relationship between paradigms that requires comment. The main problem lies in the exclusivity and the lack of equality within integrative medicine professional bodies.

Indeed, the mission statement of the Australasian Integrative Medicine Association (AIMA) states that it is 'the peak medical body representing the doctors who integrate complementary medicines/therapies into mainstream medical practice.'¹⁴ This definition seems reasonable, if a little one sided, but what is not immediately apparent is the exclusivity of AIMA. 'Our Full members consist of medical practitioners [GPs] who provide integrative and holistic health care for their patients. Associate members include allied health professionals including physiotherapists, nurses, dieticians, pharmacists, naturopaths and a wide range of other health professionals.'¹² Full membership to AIMA is open only to registered medical practitioners (GPs); other health practitioners can join but not on equal terms and thus without full voting rights, muting the agency of their agendas. This issue of equality and exclusivity sends a clear message that the value of the work done and the vision that CAM practitioners provide within the healthcare/wellness landscape isn't being acknowledged on equal terms. It is interesting to note here that naturopaths are being grouped with 'allied health professionals', rather than as complementary or alternative health professionals.

AIMA's mission statement certainly suggests that one person can be all things to either an individual or a community, but this 'ideal' in any other guise is abhorrent. Just as 'no single therapy, specialty or discipline can provide everything needed for comprehensive care',¹¹ so too no single person, no matter how bright, skilled or talented, can provide everything for every patient. It is an arrogant assumption that 'Someone can Practice All Medicine'¹¹ (SPAM) without compromising outcomes and providing poor patient care. The motivations for the experiences that people have and the reasons they seek different medical therapies and practitioners, are as varied as they are complex. Diversity of choice is important and may well be challenged in the longer term by IM.

The supposed ideal of one person providing and ministering to all needs of all people is a fallacy, finding ground perhaps by appealing to our very human and modern yearning for 'wholeness'. Perhaps it is desire for the illusion of control, inherent in obedience to the fascist logic buried in the nature of 'productivity'.⁹ Or perhaps this ideal finds favour in the human failing of emulating omnipotence (as holders of power in the practitioner/patient dynamic), that as practitioners of integrative medicine they can offer more as better.

Turning our vision more broadly though, it is no coincidence that with the substantial growth in support for and use of CAM within the last decade,¹⁵ interest in 'integration' for the mainstream medical establishment has become of such pressing concern. As Shuval and Mizrahi 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.'¹³ So effectively have patients as consumers sculpted the medical agenda with their dollars, IM should well be viewed as the mainstream medical fraternity's response to refocusing priorities to the socio-economic and political pressures that have rapidly gained momentum within the last decade in relation to CAM.

But that is not to say that the only rationale for working cooperatively is purely economic and status quo driven. Factors such as patient-centred care, best practice, efficacy, safety, quality,¹⁶ reliability and sustainability are also relevant and worthy rationales for working together. With the growth in CAM services the developing professionalisation of CAM therapists, the implicit if begrudging acceptance of it and its practitioners by the broader medical community¹⁷ has meant that working together is becoming an imperative, if these values and ideals are not to be idle if good intentions. But is integrative medicine representative of co-operative medical relationships, given its exclusivity? Exclusivity is the death knell of equitable relationships among diverse communities. If we accept that IM really means SPAM,¹¹ then it holds deceptively little for patients and CAM professionals alike. Integrated services that encourage a team, with the best outcomes for patients being paramount, can only be achieved by working together, while still maintaining the pluralism of our practices.⁴ Diversification, understanding, acceptance and respect for differences, commitment to the patient and the medicine, all these elements must be engendered within the relationships which lie at the heart of patient-centred medicine.²⁷ When there is a shared vision that enables inclusion rather than

Clinical Commentary

Language and the way we narrate ourselves is a formative and foundational force in our existence as subjective, objective, personal and professional selves. As people, clinicians and patients, we are being continually shaped, formed, informed, developed and caught by language and narrative. It is so profound, so essential to ourselves that, like the breath, we hardly notice it until we find it's become problematic. So the language that is used by us or by others, within the broader medical and social context, affects, however subtly, communal awareness and the accepted 'real'. As members of the health and medicine profession, it is critical that the integrity of our medical wisdom, our skills and professionalism are respected and appreciated within the broader medical communities, and that the challenges and development of the roles required of us are discerned within a broader socio-political and economic framework.

exclusion, plurality rather than uniformity, intention centred in the patient/human/care axis rather than within the money/status/power axis, then working for the benefit of the one is to the benefit of all.

Conclusion

The definitions of WAM and CAM highlight the degree of flexibility and arbitrariness of the 'orthodox' and 'other' dynamic inherent in these two medical paradigms. Given that integration as an organic process enables the absorption and utilisation of new material, each paradigm can show or can trace past degrees of such exchange, without it having ruptured the integrity of the medicine. But this is different to the co-option of particular therapies by an exclusive set of orthodox medical practitioners, marketed as a new medical paradigm, for the purpose of maintaining a position of primary healthcare provision. It may present itself as a new paradigm in medicine, but really, integrative medicine is an entity established for the hegemonic benefit of western allopathic medicine.

References

1. Leckridge B. The future of complementary and alternative medicine – models of integration. *J Altern Complement Med* 2004;10(2):413–16.
2. Shuval JT, Mizrachi, N. Changing boundaries: modes of coexistence of alternative and biomedicine. *Qual Health Res* 2004;14(5):675–90.
3. Kaptchuk TJ, Miller FG. What is the best and most ethical model for the relationship between mainstream and alternative medicine: opposition, integration, or pluralism? *Acad Med* 2005;80(3):286–90.
4. Scheid V. Lost in translation? On the (im)possibilities of integrating Chinese medicine into modern health care. Keynote address, Australasian Acupuncture and Chinese Medicine Annual Conference; 23–25 May 2008; Sydney, Australia.
5. MacPherson H, Vickers A, Scheid V. Acupuncture for hypertension: a tale of two trials. *Forsch Komplementmed* 2007;14:371–75.
6. Hammerly M. A conceptual template for CAM and integrative medicine [Online]. No date [cited 28 Aug 2008]. Available from: <http://www.healingpartner.com/articles/physicians/TJFP1.html>.
7. Siegel DJ. *The mindful brain: the neurobiology of well-being* [CD]. Louisville, CO: Sounds True; 2008.
8. Kaptchuk TJ. An audience with Ted Kaptchuk. *Nat Rev Drug Discov* 2008;7:554.
9. Bruce H. Periods/fertility, pregnancy and loving – the missing link [workshop]. Australasian Acupuncture and Chinese Medicine Annual Conference; 23–25 May 2008; Sydney, Australia.
10. 'Integrate'. Dictionary.com [Online]. c2006 [cited 28 Aug 2008]. Available from: http://dictionary.reference.com/browse/integrate#dict_header.
11. Ernst E. Commentary: disentangling integrative medicine. *Mayo Clin Proc* 2004;79:565–66.
12. Hammerly M. WAM, CAM, hold the SPAM (Why integration without collaboration can't succeed) [Online]. No date [cited 28 Aug 2008]. Available from: <http://www.healingpartner.com/articles/physicians/spam2.html>.
13. Holmes D, Murray SJ, Perron A, Rail G. Deconstructing the evidence-based discourse in health sciences: truth, power and fascism. *Int J Evid Based Healthc* 2006;4(3):180–86.
14. Australasian Integrative Medicine Association [Online]. Sydney: c2009 [cited 4 Jan 2010]. Available from: <https://www.aima.net.au/membership/services.html>.
15. Australian Bureau of Statistics. Australian Social Trends (Complementary Therapies) [Online]. c2008 [cited 1 Sept 2008]. Available from: <http://www.abs.gov.au>.
16. Fong HHS. Integration of herbal medicine into modern practices: issues and prospects. *Integr Cancer Ther* 2002;1(3):287–93.
17. Hess DJ. Medical modernization, scientific research fields and the epistemic politics of health social movements. *Social Health Illn* 2004;26(6):695–709.