
VII. C O M B I N I N G C O N V E N T I O N A L ,
C O M P L E M E N T A R Y, A N D
A L T E R N A T I V E H E A L T H C A R E:
A V I S I O N O F I N T E G R A T I O N

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I. INTRODUCTION

The explosion of interest in and use of complementary and alternative health care (often referred as complementary and alternative, unconventional, unproven, or unorthodox medicine/ therapy) world-wide is well documented, sometimes as an alternative, but most often as an adjunct to conventional medicine. Longitudinal data indicate that prevalence of complementary and alternative health care use is growing rapidly¹. Factors underlying the increased popularity of complementary and alternative health care include the rise in prevalence of chronic diseases, an increase in public access to world-wide health information, reduced tolerance for paternalism, an increased sense of entitlement to quality of life, declining faith that scientific breakthroughs will have relevance for the personal management of the disease, increased sense of personal responsibility for health and health care, concern about the side effects of ever more potent drugs, and an increased interest in wellness and personal spirituality.

Complementary and alternative medicine was defined at the Office of Alternative Medicine Research Methodology Conference (1995) as

...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 (p.50)².

Some complementary and alternative approaches are complete systems of assessment and treatment, while others are single modality interventions offered as alternatives or complements to conventional treatment. Some approaches have well-developed regulatory structures (e.g., massage therapy), others are fragmented professions with little interdisciplinary agreement about regulation (e.g., acupuncture),³ or are not likely to ever be regulated (e.g., folk remedies).

Conventional health care is broader than, and not limited to, conventional medicine, the latter being therapeutic action by or under the direct supervision of a conventionally trained physician⁴. Therefore, we use the term "health care" to refer to all services, products and activities used by individuals for promoting, maintaining, monitoring, or restoring health.

Conventional and unconventional health care have been described as two solitudes⁵. The boundary between them however is fuzzy and dynamic and changes over time. Conventional health care was at one time limited to the professions of medicine and nursing, but now includes services provided by other professions, such as physiotherapy, occupational therapy, and to a more limited extent, psychology, social work, and pastoral care. Even chiropractic, traditionally an alternative profession, is increasingly included in conventional health care.

Trends in population health, clinical practice and medical research demonstrate that the distinctions between complementary, alternative and conventional health care are becoming less pronounced. For example, family medicine and nursing are adopting styles of practice that are more holistic and patient-centred and emphasise exercise, nutrition, stress-management, and a balanced-lifestyle in achieving and maintaining health and wellness⁶. The philosophy behind these recommendations is intrinsic to many complementary and alternative health practices. Many complementary and alternative providers specialise in these services, and thus provide potential resources for conventional medicine. Accordingly, we suggest that integrated health care already exists, in rudimentary form at the consumer level, that the system is evolving, and that the integration of (presently) alternative health care professions into the different levels of health care will continue as a natural unfolding of the forces at play in the present system. This evolution can be facilitated by a systemic vision. Our vision sees conventional and complementary and alternative

practitioners functioning together within a systemically-co-ordinated, interdisciplinary, holistic, and client-centred model of care, in a health care system that delivers an expanded repertoire of empirically validated treatments that not only focuses on treating disease, but actively promotes the health and well-being of individuals and society.

In this paper we will:

- 1) Present a conceptual framework that illustrates the similarities and differences between the various complementary and alternative and conventional modalities and helps define concepts such as holistic and wellness oriented health care.
- 2) Discuss the changing demographics of Canadian society and the impact this is having on the health care system.
- 3) Show that within the conventional health care system, forces and themes are emerging that endorse health care principles inherent in complementary and alternative health care and vice versa:
 - a) Population health researchers are promoting the idea that a greater proportion of health care resources be directed at disease prevention and the non-biological determinants of health.
 - b) Patient-centred care places the client as a central decision-maker in his or her own health care.
 - c) Evidence-based health care provides a methodological and scientific standard for accepting or rejecting new health care practices.
- 4) Discuss the degree of integration at the different levels of the health care system, different models for integration, and ways and principles to facilitate integration at each level.

II. FRAMEWORK FOR CONCEPTUALISING HEALTH CARE PRACTICES

In this section we clarify the similarities and differences in the underlying assumptions about determinants of health, illness, diagnosis and treatment of conventional and complementary and alternative health care. In general, conventional medicine focuses on biological determinants of health, and diagnoses and treats disease.

Complementary and alternative health care focuses on a wider range of determinants, on evaluating imbalances (physical, emotional, structural, energetic, etc.) and on restoring these imbalances to improve health and well-being. However, we will show that within each of the conventional and complementary and alternative health care systems there is a wide range of philosophies and practices. Upon close examination, many complementary and

alternative health care practices are more similar to conventional health care practices than they are to each other, and vice versa. Complementary and alternative health care also highlights the tendency of conventional health care to neglect non-physical aspects of health and disease.

A. Paradigms of Health and Disease

Tataryn⁷ has proposed a framework that classifies both conventional and complementary and alternative health care practices according to basic assumptions regarding the nature of health and disease. In this framework, there are four basic paradigms – Body, Body-Mind, Body-Energy, and Body-Spirit (See Table 1).

Table 1: Tataryn's Four Paradigms of Medicine: Classifying Common Therapies

Body	Body-Mind	Body-Energy	Body-Spirit
Substances	Affirmations/Suggestion	Acupressure	Dervish Dancing
<i>Diets and Natural Supplements</i>	Counselling	Acupuncture	Exorcism
Aromatherapy	Dream Interpretation	Ayurvedic Medicine	Faith Healing
Gerson Diet	Expressive Therapy	Chinese Medicine	First Nations Traditions
Herbal Remedies	Hypnosis	Crystal Therapy	Laying-on-of-hands
Macrobiotic Diet	Imagery/Visualisation	Homeopathy	Magic/Occult practices
Shark Cartilage	Meditation	Magnetic Therapy	Prayer
<i>Extracts/ Concentrates</i>	Psychotherapy	Polarity Therapy	Psychic Diagnosis
Vitamin & Mineral Supplements	Stress Reduction	Qi Gong	Psychic Interventions
Antineoplastons	Support Groups	Reflexology	Ceremonies/Rituals
Live Cell Therapies	Music Therapy	Reiki	Sacraments/Rites
Laetrile	Relaxation Training	Therapeutic Touch	
Ozone Therapy		Tai Chi	
		Yoga	
<i>Synthetics</i>			
Chemotherapy			
714-X			
Chelation Therapy			
Physical Manipulation			
Exercise			
Massage			
Physiotherapy			
Chiropractic			
Hypo/Hyperthermic Therapy			
Radiotherapy			
Surgery			

- Therapies adhering to the Body paradigm, whether they are conventional or unconventional, are based on the assumption that biological mechanisms are the primary causative agents of health and disease.
- The Body-Mind paradigm extends the Body paradigm to include factors such as stress, psychological coping style, and social support as influencing the formation of health and disease.
- The Body-Energy paradigm assumes health and disease are functions of the flow and balance of life energies, and underlie such interventions as acupuncture and therapeutic touch.
- The Body-Spirit paradigm assumes one or more transcendental aspects or personalities existing outside the limitations of the material universe can influence health and disease, for example faith healing.
- Therapies classified in the non-body paradigms — Body-Mind, Body-Energy, and Body-Spirit — are more truly alternative than the first type of therapies, since they are founded on alternative assumptions of the determinants of health and disease.

Therapies based on body paradigm assumptions of health and disease can be further divided into two main categories : 1) Substances (i.e., diets and natural supplements, extracts and concentrates, and synthetic products), and 2) Physical Manipulation. The subcategories within Substances represent a continuum from "natural" to "synthetic", while practices within Physical Manipulation can be ordered from "natural" to "invasive".

B. Two Types of Alternative Health Care Practices

This framework illustrates that there are two different types of complementary and alternative therapies.

- The first type of therapies is based on the same underlying assumptions as conventional treatments regarding the importance of the biological determinism in the health of the body. These types of complementary and alternative therapies are simply an alternative modality for delivering a body-based treatment. As seen in Table 1, complementary and alternative practices within the "Substances" and "Physical Manipulation" therapies differ from conventional medicine largely by the physical mechanism through which the biological effect is achieved.

Complementary and alternative therapies that adhere to the body paradigm tend to be more "natural" than the conventional therapies in this paradigm. For most conventional practitioners crossing this "naturalness" or modality gap is much easier than the conceptual leaps needed to move "horizontally" across paradigms. The overlap in philosophy between conventional and complementary and alternative therapies and interventions in the first column in Table 1 accounts for why these are relatively easily accepted for investigation by conventionally funded institutes and researchers. On the other hand, many consumers and practitioners who believe in the superiority of natural interventions tend to view the use of chemical and synthetic interventions as "unnatural". Since "natural is good", some people infer that "unnatural is bad", and thus many therapies of the first type tend to be used as an alternative to conventional medicine. In contrast, the alternative assumption therapies acknowledge, but do not limit themselves to, biological determinants of health. Because there is no intrinsic philosophical disagreement, these therapies are often used in a complementary way, as an adjunct to a body-based treatment.

C. Similarities and Differences in Health Care Systems

One of the strengths of this framework is in clarifying both the commonalities and differences between and within conventional and unconventional therapies. Table 1 shows clearly that the different complementary and alternative modalities are as diverse from each other as they are from conventional medicine. For example, Western-trained herbalists, naturopaths, traditional Chinese medicine practitioners, expressive therapists (music, movement, art therapies, etc.), Reiki masters, and faith-healers adhere to philosophies across the entire range of paradigms, and thus differ considerably in their conceptualisation and management of disease.

There is a similar diversity within conventional health care. These differences mostly concern treatments included in the first column of Table 1. The biomedical specialities of surgery, oncology, and radiation therapy perceive health and illness to be solely a function of biological factors and treat disease through physical and chemical manipulation of the body. Orthomolecular medicine specialists (a small but growing branch of conventional medicine) subscribe to the "diets and supplements" sub-category of the Body paradigm, while chiropractors, physiotherapists, and occupational therapists work within the sub-category of "Physical Manipulation". The professions of nursing, psychology, and social work, in acknowledging the importance of psychological factors such as stress, balanced lifestyle, and socio-economic influences on health, adhere to the philosophical assumptions of the Body-Mind paradigm. These assumptions are supported by the

work of population health researchers. Within the Body-Energy paradigm, an increasing number of physicians are trained to treat disease and help control pain using acupuncture, just as nurses are being trained and sanctioned to use therapeutic touch in hospital wards. Finally, pastoral care works within the Body-Spirit paradigm (their emphasis, however, is largely on healing the spirit and not the body).

While the paradigms framework has some limitations, such as deciding exactly where each therapy is placed, dealing with sub-factions within a discipline (e.g., "mixers" and "straights" within the chiropractic profession), or classifying very rare or little understood therapies, these limitations are inherent in any classification system. At this time, we find the paradigm framework useful in guiding and clarifying our vision of an integrated health care system.

III. UNDERSTANDING HOLISTIC HEALTH , WELL -BEING , HEALING , AND CURING

Using therapies and practices from all four paradigms to treat illness is a functional definition of holistic health care. In the absence of disease, many of these practices can be used to promote well-being. The emphasis on holistic well-being and quality of life is a potent and prominent component of complementary and alternative health care: A massage feels good and affects quality of life regardless of its impact on the body, so do relaxation therapy, aromatherapy, therapeutic touch, and many spiritual interventions. For people with terminal or chronic diseases with little or no hope for a cure, mind, energy and spiritual practices target dimensions of well-being over which a person can have some sense of control. Also, according to the holism assumption, increased well-being can improve physical health and well-being.

These concepts are presented in Figure 1, which depicts the four components of integrated or holistic healing. When dysfunction or disease occurs in the mental (deep guilt, repressed anger, depression, etc.),

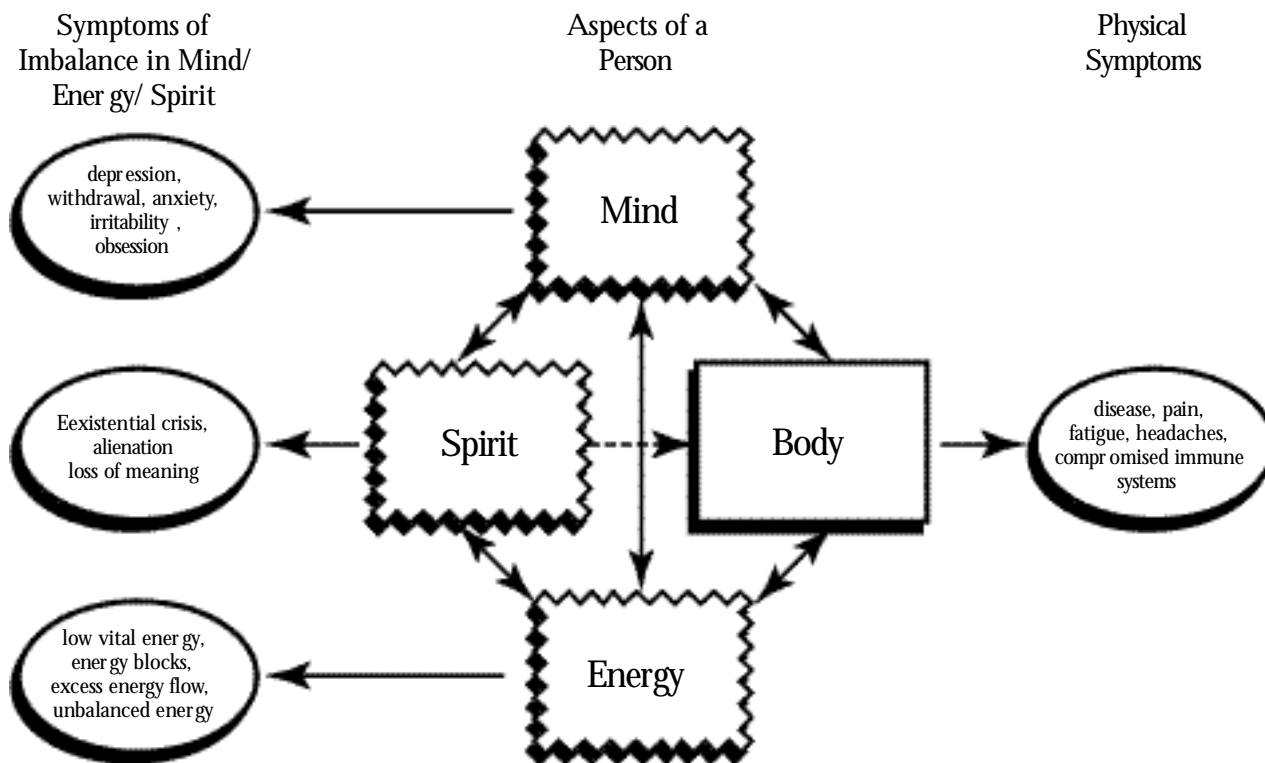
energetic (e.g., low vital energy, blocked energy meridian, etc.), and spiritual (relationship with a God or deeper self, finding meaning, etc.) aspects of well-being, this imbalance can affect the body. If the mental, energetic, or spiritual imbalance is severe enough, or maintained by the person long enough, it will interfere with the body's internal balance and eventually manifest as a physical disorder or illness⁸. Thus, from the holistic perspective of complementary and alternative health care, healing the dysfunction occurring at the level of the mind, energy, or spirit will remove a barrier to the natural healing power of the body (i.e., restore balance) and thus potentially facilitate the healing of the body. On the other hand, disease in the body (for example, chronic diseases) will affect mental, energy and spiritual well-being. In this case, healing of the mind, energy, or spiritual aspects of a person may contribute to increased well-being, despite the physical disease. While sometimes utilising a less multi-dimensional model, most body-oriented alternative and complementary health care

interventions are similar, with a focus on facilitating the natural healing processes of the body – in aiding the body rather than "curing" the disease.

In contrast to alternative and complementary health care, conventional medicine aims to cure the body and does relatively little to address the overall healing of the individual. The biomedical model taught in

medical schools tends to be reductionist and considers the symptoms of mind, energy, and spirit together as caused by the body. They do not exist independently from the body and/or brain and do not influence the body. Disease symptoms arise from chemical or biological disturbances and need appropriate chemical or biological intervention to correct them.

Figure 1: Integrated Model of Health, Wellness, Disease, and Healing



Health and well-being is a state of balance and communication between the different levels

IV. THE DEMOGRAPHICS AND MOTIVATION OF HEALTH CARE UTILISATION

While a holistic perspective on health and health care is a prominent and important factor in the growing use of complementary and alternative health care, there are many different motivations for its use. Just as there is diversity in the kinds of complementary and alternative providers, approaches and products, as well as in conventional health care, there are also many different consumer populations. Each group— the concerned well, individuals with stress-related conditions, mental illness, infectious disease, acute illness or injury, long-term disability or handicap, chronic disease, and the terminally ill— is unique in its needs and motivation for using complementary and alternative health care. Reasons range from health maintenance, improved quality of life and well-being, disease prevention, stress reduction, curative treatment, and palliation of symptoms.¹ Eisenberg et al¹ reported that 42% of complementary and alternative health care treatments were used to treat existing illness, and 58% were used, at least in part, to prevent future illness from occurring or to maintain health and vitality.

The Statistics Canada Population Health Survey conducted in 1996 indicates that 55% of Canadians suffer from one or more chronic health conditions⁹.

Changing population demographics show that the proportion of people over the age of 65 years will grow drastically in the years to come. This age group is at highest risk for developing a chronic disease and yet has rising expectations for remaining healthy and maintaining an active lifestyle as they age.

While conventional health care has not focused on, and has not been very successful in the promotion of healthy ageing, complementary and alternative health care have much to offer. This includes dietary, nutritional, and nutraceutical counselling, exercise training, stress management, promotion of structural (physical) integrity, environmental influences on health, counselling on purposeful living, and normalizing intercellular communication¹⁰.

Thus the growing cohort of soon-to-be over 65- year-old Canadians are doubly likely to become involved in the use of complementary and alternative health care, either for preventing disease and promoting wellness, or for treating their condition and improving quality of life should they develop a chronic condition.

V. TRENDS IN CONVENTIONAL HEALTH CARE

The changing demographics and motivations of health care consumers are not the only factor influencing the growth of complementary and alternative health care. In this section we discuss three themes currently emerging in conventional health care research and practice that support the basic precepts of complementary and alternative health care. Conventional health care, in more fully embracing the trends and research conducted by its own disciplines, more fully embraces and recognises the strengths and potencies of complementary and alternative health care.

A. Population Health/ Health Services Research

The publication of the Lalonde report in 1975¹¹ by the Canadian government is often considered pivotal in the recognition that the health of a given population is not a function of its health services alone. Research evidence being accumulated by population health researchers is slowly revealing that non-biological factors (e.g., sociodemographic factors such as socio-economic status, psychological factors such as stress, etc) are critical determinants of the health of the population. In combination, these factors appear to affect health directly through mechanisms that are generally not well understood, and indirectly via their influence on lifestyle factors (e.g., smoking, exercise, diet, etc.) and health services utilisation. Large-scale population health surveys, particularly when linked to medical databases have also revealed non-biological determinants of health. Studies have indicated that an individual's sense of control at their place of employment in combination with their degree of job responsibility accounts for more variation in the occurrence of coronary heart disease and related disease events than the biological and physiological markers traditionally used to predict the disease.¹² This type of research focuses attention on psychological, social and economic influences on health.

A second important factor emerging from population health research is the importance of

prevention in maintaining long term health. This research not only provides evidence of the strong positive impact of population screening programs (such as mammography) and immunization programs on individual health, but also indicates such programs achieve large economic savings. Population health researchers continue to call for the investment of more money and resources in areas of prevention, rather than continue with the fiscally inefficient¹³ status quo of treating people only after they become ill.

As already mentioned, consistent with this message is the fact that many of the most popular complementary and alternative health care approaches are used in a preventative manner, to maintain optimal levels of health and ward off disease processes before they begin¹³. The "diets and natural supplements" and exercise and massage in the "physical manipulation" category of the Body paradigm, stress reduction and relaxation techniques of Body-Mind, as well as many of the Body-Energy practices, are best used in a preventative manner, to promote health and avoid disease. While some of the health care practices in the other categories of the Body paradigm can be used for these reasons as well, they are generally used as active treatment, after disease has occurred.

In both complementary and alternative and conventional health care, the need to deal with population health issues is recognised; however, each addresses it in a limited manner. Conventional health care has not made it a priority area in terms of funding yet, and complementary and alternative health care, possibly partly due to their current marginal role in the health care system, mainly focuses on the same principles at an individual level. Given the limited fiscal sustainability of the current health care system, it is important that the insight, experience, and expertise of both complementary and alternative and conventional health care professionals be used to improve the health of the population and reduce the burden of disease.

B. Patient-centred Care

A patient-centred clinical model acknowledges the primacy of the patient in his or her own care and is increasingly becoming the standard in conventional health care, particularly in disciplines such as nursing and psychology, but also in family medicine. Much of the impetus for this model of care has come from patient, who have expressed the need for improved practitioner-patients communication, greater control and participation in decision-making, and increased attention to holistic patient care. Patients want physicians who are sensitive to mind-body interactions and are able to acknowledge them as more than physical bodies, but as mental, emotional, and spiritual beings, and members of a family and social communities.

The central role of the patient in his or her own diagnosis, which was originally central to medical practice and care, gradually shifted with the introduction of medical technology¹⁴. In this context, the patient no longer had primary insight into or responsibility to describe his or her own disease condition. The physician, with the aid of technology, such as blood tests, electrocardiogram and magnetic resonance imaging, could determine the objective state of the person's body with much greater precision and nuance than the patient.

It is not surprising that rejection of the implicit "technology-centred care" model has come from the medical discipline that has the least direct contact with technology. In Canada, family medicine has formally adopted patient-centred care as a model of practice, expressed in six guiding principles: 1) exploring both the disease and the illness experience; 2) understanding the whole person; 3) finding common ground regarding treatment/management, 4) incorporating prevention and health promotion; 5) enhancing the doctor-patient relationship; and 6) being realistic¹⁵. Patient request or preferences (in addition to lack of response to conventional treatment) is a common reason for physicians to become interested in complementary and alternative health care, to refer to complementary and alternative practitioners, or even to practise complementary and alternative approaches¹⁶. This shows that concern for the welfare of the patient is, at least for some physicians, transcending the boundary between

conventional and complementary and alternative health care. There have also been some initial reports that indicate that the need for a patient-centred approach is recognised by medical specialities .

Complementary and alternative health care is commonly characterised by a strong focus on wellness rather than disease. This approach encompasses more than maintaining health and prevention of disease, it is "a focus on engaging the inner sources of each individual as an active and conscious participant in the maintenance of his or her own health"¹⁸. The concepts of "holism" and "the mind-body connection" are central to many complementary and alternative modalities and consistent with the principles of the patient-centred care model being reintegrated into conventional health care. Chiropractic is one of the complementary professions that explicitly developed a "patient-centred paradigm" of care¹⁹.

Explicitly advocating a patient-centred approach to health care comes primarily from (conventional and complementary and alternative) specialities whose practices are founded on the principles of the Body paradigm. The other paradigms have less need to make such principles explicit, because patient-centred care is a central foundation of their practice. Clearly, across all paradigms and types of practices, patient-centred care is becoming increasingly recognised as an important foundation of health care.

C. Evidence-Based Practice

Evidence-based practice has gained rapid recognition over the past 10 years in the medical profession, both in North America and Europe. It is defined as the conscientious, explicit and judicious use of the current best evidence in making decisions about the care of individual patients²⁰. Evidence-based practice has often been used as a defining boundary between complementary and alternative and conventional health care, the latter generally considering itself to be evidence-based (as expressed in the use of and dependence on randomised controlled trials) and depicting complementary and alternative health care not to be so (e.g., based on anecdote and folklore). This division, however, is largely illusory, because there

are still many conventional treatments that lack an appropriate evidence base. Reviews suggest that less than about 30% of conventional medicine is actually based on randomised controlled trials²¹. Furthermore, at a practitioner level, the acceptance of evidence-based practice in conventional medicine may not be as common as often thought. For example, Astin's review of physician practice of complementary and alternative health care suggests that physicians' decisions on which complementary and alternative approaches are useful are not based on evidence of efficacy or effectiveness, but on regional economics and cultural norms¹⁶. Also, practising physicians often resist the adoption of empirically based practice guidelines and published policy research.

While some complementary and alternative professions ignore or oppose evidence-based practice, in general, the importance of evidence-based practice in complementary and alternative health care is increasing. A wide range of randomised controlled trials have been and continue to be conducted to assess complementary and alternative therapies, noticeably in chiropractic, homeopathy, herbal medicine, acupuncture, and massage therapy. However, complementary and alternative modalities are faced with major barriers to conducting high-quality research including lack of research capacity, training, funding, awareness of the importance of research, a supportive infrastructure³, and negative attitudes towards the relevance of evidence-based practice. Both complementary and conventional investigators recognize the intrinsic difficulties and limitations of traditional research methods to assess the efficacy and safety of many complementary and alternative approaches.

The lack of standardization and generalization in complementary and alternative health care due to individualised care, adds to the challenges of assessing the safety and efficacy of these approaches. A growing body of literature is developing methodological approaches to study the efficacy of complex treatments such as those mentioned

above^{22,23,24,25}. It is also important to recognize that several conventional interventions, such as surgery, psychotherapy, physiotherapy and nursing, share concerns and needs, related to methodology, with complementary and alternative health care. For example, in conducting randomised controlled trials to assess safety and efficacy, blinding, placebo control and standardised treatments are often not possible.

It is necessary to further clarify not only the benefits, but also the limitations of evidence-based practice as it is presently practised. Under the current understanding of evidence-based practice, the individuality of patients tends to be devaluated, the focus of clinical practice is subtly shifted away from the care of individuals to the care of populations, and the complex nature of sound clinical judgement is not fully appreciated²⁶. This issue reflects the tension between patient-centred care and evidence-based practice and illustrates why it is difficult to combine both. This same tension is reflected between conventional and complementary and alternative health care, as one – conventional medicine – has a much stronger emphasis on evidence-based practice and the other – complementary and alternative health care – on patient-centred care. However, in theory the practice of evidence-based medicine means integrating the best available evidence from systematic research with individual clinical expertise²⁰. This means that neither alone is enough, and that without clinical expertise, practice risks becoming tyrannised by evidence, prescribing treatments that may be inapplicable to or inappropriate for an individual patient. Conversely, without empirical evidence, clinicians run the risk of treating patients in ways that have become outmoded or with treatments that have been shown to be ineffective. Evidence-based practice has the potential to unify both conventional and complementary and alternative health care into one medicine: "There is no alternative medicine. There is only scientifically proven, evidence-based medicine supported by solid data." (p.1618)²⁷

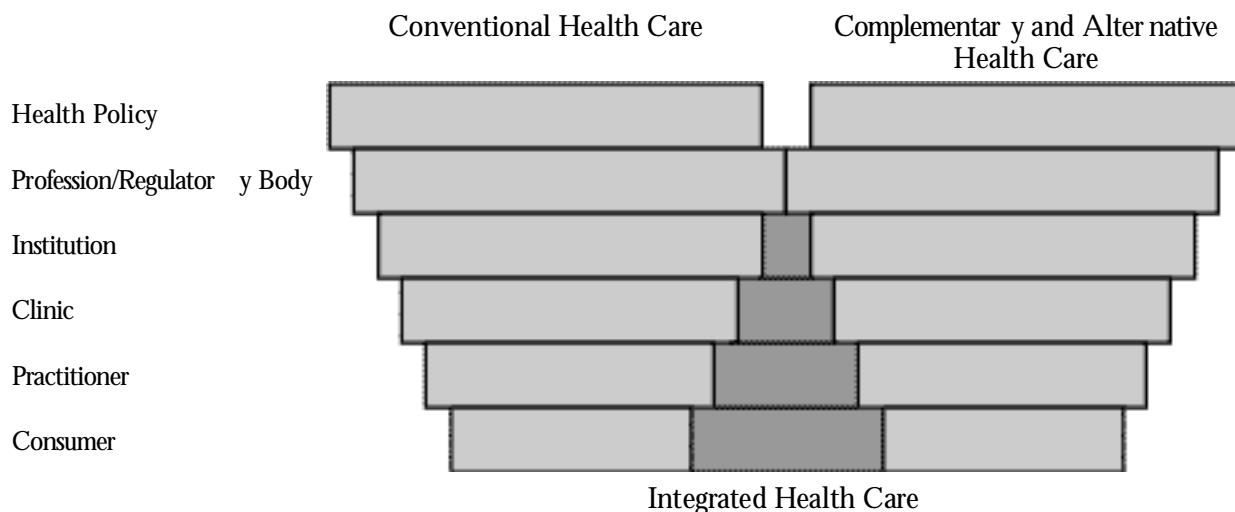
VI. PRESENT INTEGRATION AT THE DIFFERENT LEVELS OF HEALTH CARE

Integration has not been well-defined in the literature to date. The most common components of published descriptions of integration are the way health care is delivered, the range of health care services that is available, and the need for an evidence base. For example, "interdisciplinary teams to deliver an expanded repertoire of safe and effective treatments that include a focus on the whole person", and "providing novel insights and tools for human health, practised by health care providers skilled and knowledgeable in the multiple traditions and disciplines that contribute to the healing arts" (p.17)²⁸, or "having access to a wider range of effective and safe forms of treatment" (p.210)²⁹. The Advisory Group on Complementary and Alternative Health Care has described integration as "evidence-based care across therapeutic traditions"³⁰. In the literature, integration of conventional and complementary and alternative health care is most commonly described in terms of needs (for research, training, regulation, dissemination and information), but as yet there is

little attention to the specific integration needs and issues at the different levels of health care. At present, integration is mainly driven by the increased consumer utilisation and the demand of different consumer groups (e.g., breast cancer and HIV/AIDS advocacy groups). This trend is generally recognised as the most powerful facilitator for integrating of complementary and alternative health care with conventional health care³¹, and has a major impact on other levels of the health care system. Figure 2 shows the different levels of health care^{32,33}, that must be acknowledged and co-ordinated in an integrated health care system. This figure suggests that increasing consumer utilisation and demand has affected other levels of health care, in particular on practitioners, the combined group of which has affected clinical and institutional initiatives, etc. We refer to this as "upward pressure" for integration. In this section, we will describe the current state of integration at the six levels of health care identified in Figure 2 and identify some of the barriers to integration at each level.

Figure 2: "Integration Pyramid": Degree of Integration Between Conventional and Complementary and Alternative Health Care by Level of Health Care System

Level in Health Care System



A. Integration at Consumer Level

Health care consumers are most advanced in integrating complementary and alternative and conventional health care and select practitioners and products from all categories of health care services to create a health care package that meets their personal needs and beliefs. Integration at this level is limited by personal, financial and educational resources; knowledge about complementary and alternative health care; and biases with regards to the appropriateness of the different complementary and alternative modalities. Based on the factors underlying the increased popularity of complementary and alternative health care (see section 1), it is predicted that this trend for consumers to expand their repertoire of health services and practices will continue. The functional integration of the different approaches at this level has caused a strong bottom-up pressure for integration at other levels of health care. For example, the consumer demand for complementary services with empirical evidence for efficacy was instrumental in integrating physiotherapy, chiropractic and acupuncture (for chronic pain), and most recently, herbal remedies, into the conventional health care system.

B. Integration at Health Care Practitioner Level

The demand for complementary and alternative health care services has spurred some health care practitioners to make referrals to complementary and alternative practitioners, to provide some of these services, and to become educated regarding safety, efficacy, and underlying assumptions of different complementary and alternative approaches. The themes described previously suggest that conventional and complementary and alternative health care are converging towards common models of health and treatment. For example, the disciplines of family medicine and nursing share assumptions related to holistic health and patient-centred care with complementary and alternative modalities. The importance of disease prevention and health promotion is increasingly recognised by conventional health care, and vice versa, the importance of evidence-based practice is increasingly endorsed by complementary and alternative health care professions. These trends have the potential to ally conventional and

complementary and alternative practitioners³⁰. Integration at this level is limited by the personal resources of the patient to pay for many complementary and alternative health care services and products, lack of empirical evidence, issues of safety and accountability³. In addition, it is limited by both the restrictions of practice imposed by their regulatory bodies, and the less explicit but nonetheless powerful influences of colleagues' attitudes and biases.

C. Integration at Clinical Level

Partly based on consumer and practitioner involvement in integrated care, there is an increasing number of new initiatives in Canada as well as in the United States, seeking to provide integrated health care using new and innovative delivery models. An example is the Tzu Chi Institute of Complementary and Alternative Medicine in Vancouver, which aims to develop and provide integrated health care that supports people in making positive health changes, and to advance knowledge about health care and healing through research and evaluation, education and the provision of information resources. Many challenges need to be addressed in establishing such models, including working within multiple and sometimes conflicting paradigms of care, and the comprehensive and timely evaluation of programs that are in a continual state of evolution. Difficulty in securing funding, lack of "conventional" evidence for complementary and alternative health care practices, and biases from the side of the conventional health care system are the most prevalent barriers.

D. Integration at Institutional Level

Explicit integration in teaching and health care institutions is rare. Some of the more progressive health care institutions now have formal recommendations, practice guidelines, and have courses covering complementary and alternative health care^{35,36}, but little in the way of actively integrating complementary and alternative modalities into its health care package. Factors unique to this level of integration have to do with philosophy of care and training – just what is the mandate of the organization? – as well as institutional inertia to maintain the status quo. The Seven Oaks Wellness Centre, associated with a

general hospital in Winnipeg, Manitoba, is the first large-scale wellness-oriented institution of its kind in Canada. Its mission statement is to "provide the community with services that promote health, prevent illness and disability, and restore wellness of the body, mind, and spirit". Like the Tzu Chi integrated care program in British Columbia, this centre is also being empirically evaluated. The likelihood of this model being implemented elsewhere will depend on demonstrating the impact on critical health dimensions such as reduction in disease morbidity or mortality, decreased utilization of conventional services, or increased quality of life, functionality, longevity, etc. Barriers at this level include the contemporary conditions of the health care system, a time of fiscal restraint and often over-burdened employees. There is a sense of having inadequate human and financial resources to comprehensively and responsibly address the responsibilities of conventional care, let alone consider the possibility of having to add additional services or training.

E. Integration at Professional Regulatory Level

Integration at the level of professional regulatory organisations has been actively addressed by complementary and alternative professions that have regulatory bodies, but is a very recent and evolving development for conventional health care regulatory bodies. For example, while referrals to physiotherapy, massage, and psychology have been approved for a number of years now, only recently, and only after the outcome of a lengthy legal battle from chiropractors³⁷ has the Canadian Medical Association allowed referral and professional interaction between its members and the profession of chiropractic. The level of interest and integration by reputable physicians and the demand for such services by consumers has resulted in complementary and alternative health care becoming a topic of many continuing education workshops and conferences. While some of the barriers at this level are equivalent to those faced by the individual practitioner, additional barriers include lack of regulation of many complementary and alternative modalities, concerns over loss of professional identity, and the potential fiscal and

professional impact of sharing the consumer health care market with other professions.

F. Integration at the Health Policy and System Level

Integration at this level is almost entirely non-existent. However, very recently, driven by the economics and perceptions of its consumer base, private third party insurance companies have been both progressive and instrumental in increasing access to and integrating many complementary and alternative practices with conventional health care³⁸. For example, Blue Cross began a pilot program covering naturopathy, homeopathy, and other complementary and alternative approaches in the West Coast region in the mid-1990s. The governments of Canada and the United States are presently studying the complementary and alternative health care movement. Health Canada's Health Systems Division has a mandate to examine the impact of complementary and alternative health care on the health system and to consider the implications of this impact on health system renewal. Three of the newly formed Canadian Institutes of Health Research include complementary and alternative health care as an important crosscutting theme for research. While not formally funded at this time, academics and clinicians from across Canada have formed an Integrative Health and Medicine Network to address systemic issues in the empirical evaluation and study of complementary and alternative health care.

One of the major barriers at this level is the fear of increased service options translating into escalating reimbursement and operating costs. Other barriers include lack of knowledge, training, regulation, standards, evidence, and funding. Political influences, resistance to change, bias and prejudices, ethical, and legal issues are among many other factors that need to be overcome. As analyses of this level suggests, the higher the level of health care (see Figure 2), the more barriers and obstacles there are to integration. Overcoming these barriers is a daunting task. In the next section, we will present our vision of integration and identify ways in which integration can be facilitated at each level.

VII. VISION OF INTEGRATIVE HEALTH CARE

The health care system of tomorrow is evidence-based, wellness based, customer focused, integrated, accessible, affordable and appropriate. (M. Spence, February 2001)³⁹

Integration of conventional and complementary and alternative health care will allow "bringing together the strengths and to balance the weaknesses inherent in different systems of health care, representing a coming together of the heart, head and hand" (p.156)⁴⁰. The creation of a functioning integrative health care system is a profound (but it appears, necessary) undertaking. Such a system would have positive outcomes for users of health services, practitioners/service providers and policy makers and would be founded on the core values and principles identified in the Canada Health Act, and supplemented by values such as choice, wellness and mutual respect³⁰. It entails selection and co-ordination of a great number of presently practising health care groups that know little of each other's training and knowledge bases, and that have fundamentally different assumptions of the nature of health and illness. Supporting integrative health care at all levels of the health care system would contribute to developing seamless and transparent health care delivery and greatly reducing the fragmentation and haphazardness of the present system. Collaboration and building partnerships between conventional and complementary and alternative health care practitioners would be of major importance. Efforts to engage in such collaboration with the intent to further develop an integrated health care system should be supported — financially as well as in-kind — by the government and by professional and consumer organizations.

In this section, we will first discuss the need for criteria to select complementary and alternative approaches suitable for integration followed by possible models of integration. The section will conclude with a discussion, at each of the six levels of health care, of factors that have the potential to facilitate integration. An overriding factor that

applies to each level is the need for research assessing the safety, efficacy and cost-effectiveness of complementary and alternative modalities.

A. Criteria for Inclusion of Complementary and Alternative Approaches

The fact that the state of integration is more progressive on the individual level than on professional, institutional and systemic levels is understandable. Consumers can respond and react quickly and even haphazardly, with little concern of the impact of their decisions beyond themselves. The criteria by which such decisions are made are idiosyncratic, with some consumers doing extensive research before adopting a new complementary or alternative health care practice, while others might adopt the same practice simply because a friend suggested it, or because it agrees with their philosophy of health, without reference to efficacy. However, at systemic, professional, institutional, clinic, and practitioner levels, criteria for including complementary and alternative approaches should be carefully developed and based on thorough investigation of the practices. Three important criteria are: 1) evidence of safety and efficacy of treatment modality; 2) evidence for improving quality of life; and 3) evidence of the potential to prevent disease and illness.

First, the criterion of evidence, as opposed to philosophy, popular, political, or grassroots pressure, is probably the most defensible and cost-effective criterion in the long run. Any complementary and alternative health practice or intervention that meets the criteria of efficacy in a double-blind randomised clinical trials should become part of an integrative health care system. Other proven methodologies for assessing evidence can be considered as well and include properly conducted and scrutinised observational studies. For example, many alternative medical traditions have accumulated a vast wealth of knowledge on the medical uses of plants and other practices that have withstood the test of time. Second, the growth of

complementary and alternative health care appears to be at least partially motivated by the desire to enhance well-being and fits with the need for holistic patient-centred care. With the ageing of the population and the growing proportion of people living with chronic diseases, quality of life issues are becoming more salient at all levels of health care. Therefore, health care practices that have proven benefits for quality of life (and ideally, have the potential to extend life as well), are viable candidates for integrated health care. An example is psychosocial interventions for degenerative disorders such as heart disease and cancer. Randomised controlled trials have shown that participation in psychotherapy groups greatly improves the quality of life of participants decreasing depression, anxiety, fatigue, and physical symptoms⁴¹. Evidence also indicates that such interventions can improve survival, either directly via Body-Mind interactions^{42,43}, or indirectly, by improving compliance with conventional treatment protocols. Another example is the potential use of acupuncture and nutraceuticals to mitigate the side effects of chemotherapy, which also increases compliance with treatment protocols.

Third, health care practices and interventions that have been empirically proven, in a similar way as above, to prevent disease and illness should become part of integrative medicine as well. The need for prevention has been accepted by both conventional and complementary and alternative health care professions, but the range of interventions in complementary and alternative health care is much wider than in conventional health care. The principle of restoring balance at the body, mind and spiritual levels is a foundation of many complementary and alternative health care interventions. Complementary and alternative practitioners to be integrated should have regulatory organizations and national standards of education and practice. Other factors to consider include extent of present use and demand for complementary and alternative practices, cost and ease of integration, and risk/benefit ratios.

B. Models of Integration

There are ethical, moral, conceptual and pragmatic issues that need to be addressed when considering system wide integration of complementary and

alternative healthcare modalities. The method of integration is a major factor that needs to be considered.

a. Co-optation

The present default, generally after empirical evidence for the intervention has been secured, is co-optation, where complementary and alternative health care practices are simply delivered by a conventional health care practitioner. For example, physicians are reimbursed to provide acupuncture for pain control, but traditional Chinese medicine practitioners, who evolved the techniques and philosophy of acupuncture, are not. Physiotherapists are covered for massage, while massage therapists are not. Physicians are often, with little or no training in psychotherapy, stress management, or marital counselling, etc, reimbursed to provide services developed in psychology, but at the same time, psychology is not reimbursed by the present health care system.

While co-optation may be the default and easiest route, it is morally and ethically hard to defend. Conceptually and pragmatically it may also be dangerous, because each system brings with it a diverse and often elaborate knowledge and philosophy of health and illness that sets the technique or product of the intervention in a very different context. For example an aboriginal sweat lodge ceremony is more than sitting in a sauna, just as a homeopathic preparation can not be prescribed by using a simple symptom look-up table. The multiple dimensions of the interventions, including the spiritual, social, emotional, and psychological aspects, all have empirically demonstrable, albeit little understood, impact on both quality and quantity of life. Co-optation of an approach or intervention without its natural context may dramatically reduce its impact. Co-optation could also stifle the evolution and knowledge acquisition of an alternative health care system that may eventually prove more robust and effective than the present conventional medical system, which limits itself to the philosophy of biological reductionism.

b. Co-existence

When co-optation has not been possible, in particular in the case of complete systems of regulated complementary professions, such as naturopathy or chiropractic, uneasy co-existence

has been the next default option. Under this option, the distinction between conventional and complementary and alternative health care is maintained and the focus is on whether and how conventional and complementary and alternative practitioners communicate and collaborate with each other (e.g., referral, inter-professional communication, etc.). The inter-professional isolation and mistrust, stifled knowledge flow, and tension it places between the practitioner and consumers who uses both systems, make this a less preferable method of integration as well.

c. Systemic Integration

Systemic integration refers to the system-wide perspective on integration. Systemic integration recognises the different levels of the health care system, from consumer to health policy makers, and is proactive in facilitating integration both within

and across those levels according to explicit and rational processes. It is a co-ordinated and visionary top-down response to the upward pressures exerted within the health care system. Systemic integration synthesises empirical evidence with clinical understanding and academic knowledge to provide an integrated health care system that balances the needs of consumers and practitioners with the longer-term responsibility to society at large. It recognises the fiscal efficiencies and humanitarian benefit of health promotion and disease prevention, and expands the health care domain; from caring for the ailing body to promoting and maintaining wellness, and healing disease in the body, mind, heart, and soul. Systemic integration recognises the inter-dependence of the health care system and the unique role and contribution each level has to make to integrating health care, both above and below itself.

VIII. FACILITATING SYSTEMIC INTEGRATION

Clearly there is a need for systemic integration of the health care system, as opposed to co-optation or co-existence. It is based on rationality and vision rather than on the somewhat haphazard evolution that is presently occurring. In this section, we provide some suggestions to guide integration at each of the different levels of health care. It is beyond the scope of this or any single paper to be inclusive in this section; we simply offer suggestions and a beginning orientation.

A. Facilitating Integration of Consumer Health Care

The lack of knowledge, lack of education about complementary and alternative health care, and societal biases all highlight the need for better information about complementary and alternative health care. Currently an overwhelming amount of information from many different sources is available. In spite of this, evidence of efficacy and safety is limited and the available information is often conflicting, patchy and disorganised. In

addition to providing better quality information for consumers, it is important that initiatives to provide information are co-ordinated and that information is easily accessible. Increased practitioner education will also benefit patients. Conventional as well as complementary and alternative practitioners should be open and willing to discuss the use the entire range of treatment modalities with their patients so that patients feel free to discuss their needs and preferences. Such open discussion will increase patient satisfaction and minimise the risk of potentially harmful pharmaceutical-natural substance interactions. Financial barriers to accessing complementary and alternative health care are still substantial. The provincial and territorial health care plans should reimburse patients for approved complementary and alternative health care services and natural health products (as they become regulated and standardised). This would be important step towards systemic integration and addresses several of the five principles of the Canada Health Act.

B. Facilitating Integration of Health Care Practitioners

Regulation of complementary and alternative health care professions will contribute to legitimising complementary and alternative health care and to greater transparency of these approaches. Regulation of practitioners, an area of provincial/territorial jurisdiction, differs in each province and territory. To date, several of the complementary and alternative health care professions are regulated or, in some jurisdictions, are in the process of being fully regulated (chiropractic, naturopathy, massage therapy), while others (herbalists, homeopaths, Reiki practitioners) are not regulated by government in any manner. Inter-provincial standards would contribute to the development of an integrated health care system.

Both conventional and complementary and alternative practitioners need to be aware and informed of each other's scope of practice. Conventional and complementary and alternative practitioners who keep an open mind about the other professions' ability to help patients and who allow their own patients to feel comfortable utilising different health care options are instrumental in realising an integrated health care system. Creating more of these types of professionals requires a different approach to training and educating practitioners than is currently the case. So far, nursing, psychology, and medicine mostly on their own when it comes to becoming familiar with complementary and alternative professions and products. Education should include formal study and exposure to the philosophies and practises of alternative and complementary health care. Weil has suggested that it is not enough to give physicians new tools, such as herbs in addition to or instead of pharmaceutical drugs. Rather there should be "a shift in some of the basic orientations of medicine: toward healing rather than symptomatic treatment, toward a closer relationship with nature, toward a strengthened doctor patient relationship and an emphasis on mind and spirit in addition to body" (p.142)⁴⁴. Conversely, many complementary and alternative health care training programs could benefit from more exposure to the scientific paradigm and the need to thoroughly evaluate their treatment regimens. Currently, initiatives are

underway to promote complementary and alternative health care in medical education, through Health Canada and the Association of Canadian Medical Colleges. Greater provincial/territorial regulation of complementary and alternative health care professions, along with the upcoming federal regulatory framework for natural health products would facilitate such initiatives, particularly with respect to adopting evidence-based practice in educational programs.

Both conventional and complementary and alternative health care practitioners provide primary care (e.g., family practice and naturopathy). Presently, referral to specialists is essentially limited to the 'techo-specialists' of the conventional medicine (e.g., surgeons, radiation technologists, etc). Other specialists to which primary health care providers should be able to refer, include certified practitioners within the Body paradigm (e.g., herbology, "straight" chiropractic, etc), the Body-Mind paradigm (e.g., psychologists, relaxation therapists, etc.), the Body-Energy paradigm (e.g., acupuncture, therapeutic touch, etc.), and the Body-Spirit paradigm (e.g., pastoral care, aboriginal traditions, faith healers, etc.).

C. Facilitating Integration at Health Care Clinics

Funded demonstration or pilot projects are a valuable means to obtain information on the effectiveness of integration. Initiatives such as integrated health care delivery clinics (including community health clinics) should be evaluated and the results disseminated among all stakeholders. Research collaboration and co-ordination of integrated health care initiatives is an important part of this development. This could potentially involve collecting similar data in a shared database, which would allow comparison of patient populations, treatment modalities and outcomes (including cost-benefit assessments), and thus further assessment of the models and their success factors. Ideally, outcomes should be compared with those patients not seeking integrative care. This is currently being done at the Manitoba Seven Oaks Hospital, which, in conjunction with researchers from the Manitoba Centre on Ageing, is evaluating its recent addition of a holistic wellness centre. As different models of care and intervention are evaluated, those that demonstrate efficacy, with

high consumer and practitioner satisfaction and ideally, low delivery costs, should be marked for further expansion. Such expansion would only be successful if provincial insurance plans support these initiatives.

There is an increasing prevalence of chronic health conditions and individuals given "garbage can" diagnostic categories such as fibromyalgia, chronic fatigue syndrome, and auto-immune disorders. A diagnostic clinic could be piloted in several provinces, where patients with uncommon or hard-to-diagnose and treat conditions, could be assessed by diagnostic specialists, trained and knowledgeable of the four paradigmatic views on illness. This type of single centre has the potential to greatly reduce human suffering by appropriate diagnosis and referral (e.g., acupuncturists and energy balance specialists for pain control). It might also reduce health care costs by eliminating the present "diagnosis journey" of the patient and inappropriate cross-level health care use (e.g., treatment of psychological, energetic, or spiritual imbalance by biomedical means). There is considerable research on the "offset" phenomena, indicating the addition of appropriate services to medical insurance coverage (e.g., chiropractic⁴⁵, psychotherapy^{46,47}, etc.) could pay for itself in reduced use of conventional biomedical services.

D. Facilitating Integration of Health Care Institutions

Health care institutions such as community and teaching hospitals co-ordinate the activities of a great number of health care professionals. Many of the specialised programs and services offered, such as surgery, long-term care, maternity, emergency medicine, and palliative care, have a potentially large impact on both physical and non-physical aspects of the quality of life. Accordingly appropriate "in-house" complementary and alternative health care services might form useful additions to conventional health care services, depending on institutional specialisation, local needs, and available resources. Services might include crisis counsellors in emergency wards, counselling and spiritual care in long-term and palliative care wards, herbal and nutraceutical counselling for chemotherapy patients wishing to maximize their natural healing resources,

nutritional programs for expectant mothers, and symptom control-oriented interventions such as acupuncture, therapeutic touch, massage, and relaxation training.

Because opinions and knowledge of complementary and alternative health care services vary considerably from one person and one profession to another, institutional policies and procedures regarding complementary and alternative services should be developed, providing clear and consistent messages from the practitioner to the consumer. Such policies tend to facilitate open and easy communication between consumers and professionals, and encourage the patient to discuss their use of complementary and alternative health care services. These discussions are particularly important given their potential for affecting conventional treatment regimes. Explicitly recognizing the existence of the alternative paradigms and methods for health and healing, not only acknowledges the impact of disease on the other aspects of existence (e.g., psychological, emotional, and spiritual), it also provides a safe, more holistic, and more client-centred healing environment. In this environment, it is important to provide easily accessible, valid and clear educational resources for both patients and health care practitioners, including access to the Internet, peer-reviewed complementary and alternative health care journals, and lists of local reputable complementary and alternative health care practitioners whose services are not yet available at the institution.

E. Facilitating Integration of Professional Health Care Organisations

Professional regulatory bodies set the general philosophical milieu and explicit standards of conduct under which its members practise. Allowing their members to make referrals to, and formally communicate with, other professionals contributes greatly to integrating the two health care domains and easing patient-practitioner interactions for those using both therapeutic modalities (e.g., the CMA allowing physicians to make referrals to chiropractors). Formal discussion and by-laws regarding referral to other types of health care practitioners needs to occur. These decisions should be guided by both empirical

evidence and by health care policy decisions makers who have the resources and mandate to determine national standards of care.

Inter-professional communications via research collaborations or educational programs and workshops would also be beneficial in removing misconceptions and enhancing practitioners' knowledge bases. Other more novel programs, such as inter-profession residencies and fellowships, would allow new graduates or long time practitioners to receive first hand training and expertise in the other health care systems. They would then be able to serve as ambassadors between the respective worlds. This is similar to previous initiatives in which physicians could become certified in traditional Chinese medicine, or nurses who became graduates and advocates for therapeutic touch. This model has also been used successfully in several provinces in the education of physicians on population health research and epidemiology (i.e., Manitoba Centre for Health Policy and Evaluation fellowship program for physicians).

F. Facilitating Integration at Health Policy and System Levels

To date, integration of the health care system has been driven by consumer demand and preference. What is required to further develop systemic integrative medicine is federal support and infrastructure. The federal government has a role in guiding and facilitating the various health care organization and professions in moving towards integrative care⁴⁸. Part of this responsibility is to provide an overall vision of how an integrative health care system might look, as well as clarify the logistical and fiscal responsibilities of the new system. While provinces and territories can have considerable latitude in developing their systems of health care, ultimately integrative care must follow

the five principles of the Canada Health Act: public administration, accessibility, comprehensiveness, universality, and portability. As discussed before, experimentation with different models of integration and evaluation of these initiatives are useful and necessary steps. The co-ordination of federal, provincial and territorial responsibilities for health care will continue to be challenged by the integration of alternative and complementary practices and products. For example, while provincial and territorial governments are responsible for delivery of health care payments and reimbursements for health care, and the regulation of practitioners, the federal government is responsible for the standards and governance of health products (e.g., herbs, natural health products and nutraceuticals).

The pharmaceutical industry is another major influence on all levels of the health care system that must be addressed, monitored, and possibly regulated at the health care policy and systems level. With a deeply vested interest in the biological model of health and health care, pharmaceutical companies are both a blessing and a curse to conventional health care. These private, for-profit companies are responsible for developing and distributing our health care system's most powerful and effective biological agents. However, consumers are being educated and prompted into the biological model and its treatment options, leaving little attention and space for complementary and alternative health care options and products, many of which have been shown to be more cost-effective and have greater long-term effectiveness⁴³. This creates conflict of interest and ethical dilemmas that need to be addressed by health policy makers in an integrative health care system, particularly in light of the growing expansion of the pharmaceutical industry to include the natural health products.

IX. CONCLUDING STATEMENT

Society has benefited immensely from the biomedical model of health care and its biological and technological advances in diagnosis and treatment. In the past decades, conventional health care has also incorporated the skills and philosophies of other professions, expanding our health care options to include physiotherapy and occupational therapy, psychological services and counselling, and most recently, chiropractic. At the same time, complementary and alternative health care approaches have developed rapidly and made a great impact on the current health care system. This has created many new, more holistic treatment opportunities, but also resulted in tensions between conventional and complementary and alternative health care professions that need to be addressed and resolved.

Integration of health care by consumers (and to a lesser extent, practitioners) is creating an upward pressure for systemic integration of services across the other levels of the health care system. It is

expected that this trend will continue. This process of integration is facilitated by current trends in conventional health care, including an increased focus on patient-centred care, increased attention to the evidence base of treatment, greater recognition of the importance of health promotion and disease prevention, and wider appreciation of psychological and social determinants of health. The further expansion of conventional health care to include complementary and alternative health care, with its different beliefs and expertise on the non-biological determinants of health and well-being, simply continues and augments this trend of integration.

Conventional health care is on the verge of becoming what it has always aspired to be—a truly effective and explicitly compassionate, integrated health care system, which, in the larger context of family and society, cares for the body, mind, heart, and soul of people, both before and after they become ill.

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