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**The politics of integrative medicine: The case of CAM**

 There are debates amongst both academics and practitioners alike about the meaning of integrative medicine, which is a contested concept [1]. One such interpretation is as an evidence-based approach focusing on the whole person drawing on all appropriate therapies, professions and disciplines to promote health and healing [2]. However, here it is looked at in terms of its more common Western interpretation based on its links to complementary and alternative medicine (CAM) [3]. In these terms CAM has been a highly political phenomenon as will be illustrated in this editorial in its development in relation to orthodox medicine in Britain. In fact as a fundamental mooring point it is noted that the very definition of CAM can be seen as the inverse of that of medical orthodoxy. This is because it includes all the practices – from acupuncture and aromatherapy to homeopathy and naturopathy – that are not currently underwritten by the state and can therefore be seen as politically marginal. This largely contrasts with biomedical orthodoxy which has a range of exclusive self-regulatory powers and protection of title underwritten by law – albeit with the recognition that the unorthodoxy of one period can become the orthodoxy of another, and vice versa [4].

 This recognition is very apposite in early modern Britain where medicine established itself for the first time as the dominant force in healthcare endorsed by the state in the mid-nineteenth century with the 1858 Medical Act. This enabled medicine politically to supplant the previous pluralist field in which a wide span of therapists and therapies flourished in a competitive marketplace at the beginning of the industrial era – with little difference between practitioners in terms of their underpinning theories, training and repute [5]. With the rise of a medical profession as a result of medical lobbying and a subsequent medical-Ministry Alliance at a time when it was difficult to justify such a monopoly in terms of clinical outcomes, the consequences for the newly created realm of CAM were severe. Although its practitioners were still generally allowed to operate under the Common Law, amongst other things, they had very limited state legitimacy and financial support; there were increasing legal restrictions on the conditions they could claim to treat; and they were heavily attacked by the developing medical elite through the columns of the medical journals and other mechanisms [6].

 This process of marginalisation was to some degree reversed in Britain and elsewhere by the rise of the counter culture in the late 1960s and early 1970s which increased awareness of the limits to medicine and other established professional practices and was associated with a growing public desire for empowerment through the exploration of alternatives [7]. As a result of this general cultural shift, interest in using CAM in healthcare increased, with rising numbers of practitioners and escalating over the counter sales of CAM therapies for self-help [8]. With important lobbies from key figures like Prince Charles and Members of Parliament, there was an increasing move by CAM therapists to form voluntary registers of practitioners based on enhanced and more systematised programmes of training and education – and indeed both osteopathy and chiropractic gained statutory regulation through professionalization in the 1990s [9]. This was paralleled by the expansion of CAM practice by doctors and allied health practitioners in a more sympathetic political climate, symbolised by the pioneering House of Lords Select Committee on CAM in 2000 which adopted a more supportive stance on research into, and the application of, selected forms of CAM therapies [10].

 However, this was very much the political high water mark for CAM in Britain. Since the early years of the new millennium CAM has come under serious attack from several quarters, including lobbies from orthodox scientists, criticisms by the leaders of the medical profession, resistance from big pharmaceutical companies and reducing support from the government itself [11]. In the latter case this was initially indicated by the drying up of the stream of ring fenced funding instituted to support CAM research and subsequently the reining back on spending in the National Health Service on the provision of CAM services. Another more recent indicator that the tide has turned was the backtracking by government in 2015 on its pledge to allow herbalists to form their own statutory professional body in the interests of public protection. This shift in positioning has had knock on effects on access to CAM, including that by minority social groups – not only because of the less favourable political environment that was in consequence created for potential users, but also as its subsequent marginality drove CAM ever more into the private sector, thereby exacerbating geographical and class inequalities [12].

 This political background helps to explain the changing terminology surrounding the CAM field in Britain. The term ‘fringe medicine’ was used to delineate its situation in the 1950s and early 1960s when it was truly at the margins [13]. It then became ‘alternative medicine’ in the wake of the counter culture. The therapies clustered under this category were attacked in the 1980s by the British Medical Association which labelled alternative medicine as unscientific and associated its constituent therapies with witchcraft and cultism, in contrast to the march of scientific medical progress [14]. However, shortly thereafter this body shifted its position in face of the upsurge of popular support for CAM to re-designate it as ‘complementary medicine’ – giving selected CAM therapies a small foothold in the medical curriculum, with the proviso that they were more fully subordinated to the authority of doctors [15]. However, in face of attacks from various quarters over the past decade or more CAM has reinvented itself as ‘integrative medicine’, not least to gain greater political legitimacy as part of a rebranding exercise [16]. This is perhaps best illustrated by the recent deconstruction of the Royal London Homeopathic Hospital and its repositioning as the Royal London Hospital for Integrated Medicine, synergistically bringing together conventional and complementary medicine.

 The positioning of CAM is not of course the only politicised dimension of integrative medicine. There are others such as those related, for example, to the level of integration within CAM in terms of the development of referral networks between therapies in the interests of users, who have not always been well served despite the holistic ideologies so often held by CAM practitioners [17]. In addition, the relationship between exponents of CAM and medical and allied health professionals in practice has also long been a political issue – not least because of the gender-based marginality of most CAM practitioners [18]. Nor are such issues regarding the politics of CAM by any means restricted to Britain. They have frequently emerged in many countries internationally [19]. In Europe this even includes in Russia where the medical profession itself is by no means as well developed as in Britain because of its deconstruction under the Bolsheviks in Soviet times – when it was seen by the socialist state as a bourgeois class enemy [20]. Intriguingly too politics pervades the very assessment of CAM as an integrative medicine – not least through the methodology employed in evidence based medicine in Britain and elsewhere.

 Here the randomised controlled trial (RCT) has become the gold standard of the evidence base of orthodox medicine in many ways reinforcing the hegemonic position of biomedicine. In part this is because the costs for large scale trials are prohibitive and successful bids to medical research bodies to sustain them are typically beyond CAM practitioners – who also do not usually enjoy the sponsorship of large multinational pharmaceutical companies. This overwhelming methodological dependence on RCTs, though, can be queried. First, it is unclear whether medicine in practice lives up to its own standards – given that there are ethical and practical reasons why many aspects of healthcare orthodoxy, from surgery through to physiotherapy, cannot be subjected to thoroughgoing RCT assessment [21]. Moreover, without wishing to throw the baby out with the bathwater, there are significant debates as to the value of RCTs in evaluating holistic CAM therapies focused on the individual client as opposed to standardised conditions. In a related way, for many CAM therapists, the placebo effect is not seen as something to be eliminated from consideration by control and experimental groups matched on selective assumptions, but as a force to be employed in the healing relationship between practitioner and client [22]. The CAM field therefore can be seen to be further politicised, with a need in evaluating all medicines for a more level playing field including qualitative as well as quantitative methods – encompassing the subjectivity of the client voice and as well as objective clinical indicators based on biomedical reference points [23].

 Pleasingly, this issue of the journal includes papers employing a range of methods in the assessment of CAM therapies, from more theoretical analyses of approaches and user centred methods of evaluation to systematic reviews of randomised controlled trials themselves. Despite the political base underpinning their ascendancy, it is very important that CAM addresses the RCT agenda as pragmatically it remains the touchstone against which much modern medicine is judged and undoubtedly has its value alongside a basket of other methodological currencies, even if this has been overly inflated. Encouragingly too, the contents of this issue cover a wide span of CAM therapies from acupuncture and herbalism to meditation and osteopathy, as well as addressing a broad range of significant maladies afflicting humankind. The main point of this editorial, though, has been to sensitise the reader to some of the political issues surrounding integrative medicine – particularly in respect of CAM – as a wraparound context. In so doing, it is hoped that readers will be more appreciative of the politics of integrative medicine in reflecting on their work in this area and better equipped to engage in the further dialogues that inevitably lie ahead.

In this last issue of EuJIM for 2016, our Cochrane review summarises the evidence for Yoga and Epilepsy (p - ). Yoga is used as a method to induce progressive relaxation through breathing, exercise and meditation, this in turn can reduce levels of arousal and reduce stress. Evidence suggests that both epilepsy and IBS worsen under stressful circumstances and so research to explore the use of yoga as a self-help technique is valuable. The recent Cochrane summary gives some promising indications regarding the effectiveness of yoga for people with epilepsy, though there were some, there was some concern about their low quality, and issues around blinding and design (p - ). Two original articles in this issue (p- , p -) on Yoga for Irritable bowel syndrome (IBS) report on aspects of the same randomised controlled trial which employed a cross overdesign, in which the wait-list group, received yoga after the end of a 12 week intervention ( p - , p - ) . Improvements in the severity of IBS symptoms, improvements in quality of life, and lowered anxiety, depression, and autonomic symptom scores were observed in the groups practising yoga. Significant improvements were also observed in physical flexibility (p). Over a subsequent 12 week supported follow up period the yoga groups continued to maintain/further improve and the wait-list group also demonstrated improvements after they received the Yoga intervention (p- ) . Yoga also helped in relieving other health issues.

Two other studies focus on mind-body techniques (p-, p-) .

Anapanasati meditation is a specific form of meditation in which the focus of attention is entirely on the incoming and outgoing breath. It is a technique belonging to a particular school of Buddhism. In this study its effect was assessed by using Electrophotonic Imaging (EPI) and compared 2 groups of meditators (long-term practising for at least 12 months) and naïve( first time learners) [ p- ]. Health related advantages were shown at the physiological and psychological level. Unfortunately as there was no control group, the study has its limitations. Interestingly, after only 7 days of regular meditation practice, naive meditators showed a trends towards improvement as seen with the long-term group. In a quasi-experimental study, the use of meditative qigong among breast cancer patients receiving treatment demonstrated lower symptom severity and interference scores at 12 weeks for those practising qigong when compared with the non-qigong control group [p- ]. It may be that cancer patients may even benefit further if they learnt qigong prior to cancer treatment. Many cancer patients also have problems sleeping which can last for several years after their cancer treatment. A small 3 arm feasibility study of auricular therapy, self-administered acupressure or no treatments, for insomnia following cancer treatment showed clinically significant improvements in global PSQI scores [ p- ]. As non invasive interventions, both auricular therapy and self-acupressure may provide potentially effective treatments for cancer patients with insomnia, though a definitive study is needed.

The inhalation and external use of essential oils is also known to have various beneficial effects, such as promoting sleep and relaxation. The Editor’s choice for this issue explores the science of aroma and the effect of its constituents on brain activity [p-] . These essential oils, volatile mono- and sesquiterpenes are responsible for flavor and fragrances and exhibit different states of brain function affecting different regions of brain. This EEG activity of isomers on the human brain appears to be highly related to the structural arrangement of individual compounds. In this study on (+)-limonene and terpinolene, women appeared to respond well to both compounds but terpinolene exhibited a more positive effect in reducing tension and increasing relaxation my measuring brain function. These isomers action on brain function was directly related to the fragrance and structural arrangement of the compound and did not depend on the molecular formula.

Two of the systematic reviews in this issue focus on aspects of respiratory disease, namely non small cell lung cancer (NSCLC) and chronic obstructive airways disease [ p – p -]

The low survival rate for patients with NSCLC is problematic and in Asian countries traditional herbal medicine is often used for the treatment of cancer. This is one of the first systematic reviews and meta analysis to assess the efficacy of herbal medicine as an adjuvant therapy. English, Chinese, Japanese, and Korean language databases identified 27 RCTs (2382 patients). Quality of Life for patients with NSCLC taking concomitant traditional herbal medicine treatment significantly improved as assessed by 4 different outcome measures. A definitive conclusion regarding the efficacy of the adjuvant treatments is limited due to and low quality of the included trials but identifies its potential and the need for more rigorous clinical trials.

Pharmaceutical treatment for chronic obstructive pulmonary disease **(**COPD) is also problematic as it is usually accompanied by side effects and is why people may explore the use of complementary approaches to address symptoms. Acupuncture point injection therapy involves the injection of a substance together with western or Chinese medicines, vitamins, sterile water or saline solution. The benefit of this technique is believed to be the result of the dual action of the substance being injected, and the stimulation of acupuncture points during injection. The review of English and Chinese databases in this issue [p-] evaluates the efficacy and safety of acupuncture point injection therapy plus pharmacotherapy for COPD using a range of clinical outcomes. It yields some evidence demonstrating that acupuncture point injection therapy may improve lung function and effectiveness rate in people with COPD but evidence is insufficient to support the use of acupuncture point injection therapy for COPD due to clinical and statistical heterogeneity.

The last systematic review in this issue focuses on English and Chinese databases to explore the evidence for acupoint stimulation for chronic urticaria [ p -] . Western treatment for chronic urticaria is often unsatisfactory and usually requires treatment by antihistamines. The addition of acupuncture into the treatment regimen suggests there is superiority though there are issues about the quality and blinding in the trials.

Korea with its dual healthcare system of western medicine and traditional Korean medicine plays an important role in public health. A Health Promotion Programs Using Traditional Korean Medicine (HaPP-TKM) incorporated into health centre programmes paves the way toward an integrative preventive health system [p -] This paper charts the history and current status of implementing such programmes and suggests how this model could be used in other countries.

Safe clinical practice should include the communication of potential risks to patients. Recording of adverse events (AEs) is also key. In response to this the UK osteopathic profession has explored the feasibility of using an online questionnaire to capture prospective (AEs) [p- ]. Minor AEs are fairly commonly reported which resolve within 1 week of treatment. The study identified that smoking may be a potential predictor of AEs and suggest this is further explored.

A systematic analysis of the evolution and modernisation of traditional Chinese medicine (TCM) ‘herbal pieces’ (Zhong Yao Yin Pian), and the issues with quality control is described on [p -]. Historical literature is important in determining how treatments are developed and used. The key reference text in Iranian traditional medicine is the Canon of Avicenna (980-1037AD). Focussing on the treatment of ascites, regardless of the underlying cause the paper by Mahdavi et al [p-] explores how this text could be used to explore the underlying causes of ascites, potential treatments to reduce ascites fluid and possible life style modifications and dietary interventions. Exploring differences and knowledge from clinical practitioners can provide useful sources of important knowledge. Interviews with traditional healers in northwest Iran identified 16 medicinal herbs which were used as natural medicines for urinary stones. [p --] . Five of these plants were mentioned by more than 70% by traditional healers as treatment for urinary calculi and may be new potential herbal candidates for the treatment of urinary stones. They contain natural compounds, such as saponins and flavonoids, and could be potential sources remedies against kidney stones. Similarly a study from Thailand suggests that there are promising results from selected Clerodendrum plants, traditionally used for inflammatory related diseases [p- ]. Phytochemical analysis revealed the presence of antioxidant and anti-inflammatory molecules.

In Mosavat et al’s paper [p - ] biochemical markers (cytokines, hormones and neurotransmitters ) from serum and skin lesional tissue fluid in patients with vitiligo is used to identify specific syndromes. The significant associations confirm the traditional method of differential diagnosis in Uighur medicine. As Uighur traditional herbal medicines have already shown positive effects in animal models, the authors suggest that further work is needed to develop quantitative diagnostic tests based on which could be useful as a tool for deciding on an appropriate treatment.

A randomised trial explores the use of leek (Allium iranicum) extract, used as a traditional remedy in Iran for the management of haemorrhoids. The intervention group experienced less bleeding severity and generally reported subjective improvement compared to the standard anti-hemorrhoid and placebo groups. No differences were observed between the groups in relief of pain, defecation discomfort and itching.

Safety is paramount in patient care and it is important to explore how side effects can be reduced. Western medicine anti-cancer treatment is particularly problematic particularly in terms of inducing liver dysfunction. Mohaghegh et al [p- ] report promising results in their trial on the use of silymarin (Milk Thistle) for reducing the hepatic side effects of taxane, used in chemotherapy for invasive breast cancer as assessed by liver function tests. More research is needed to confirm the efficacy of this herbal based drug in pre-treatment and for concomitant treatment in cancer chemotherapy.

In this issue, please look at the two sets of abstracts, the UK CAMSTRAND PhD conference [p- ] held at London South Bank University (in June this year and the RCCM’s conference ([www.rccm.org.uk](http://www.rccm.org.uk)) entitled **‘Demonstrating the value of integrative medicine’** which was held at Middlesex University in September [p - ]. The first issue in 2016 will be a Special issue on Complementary medicine in Sexual and Reproductive Health, and will soon be followed by a Special issue on Integrative paediatrics. Calls for papers for 2016 for the new Special issues will soon be announced on the website.

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