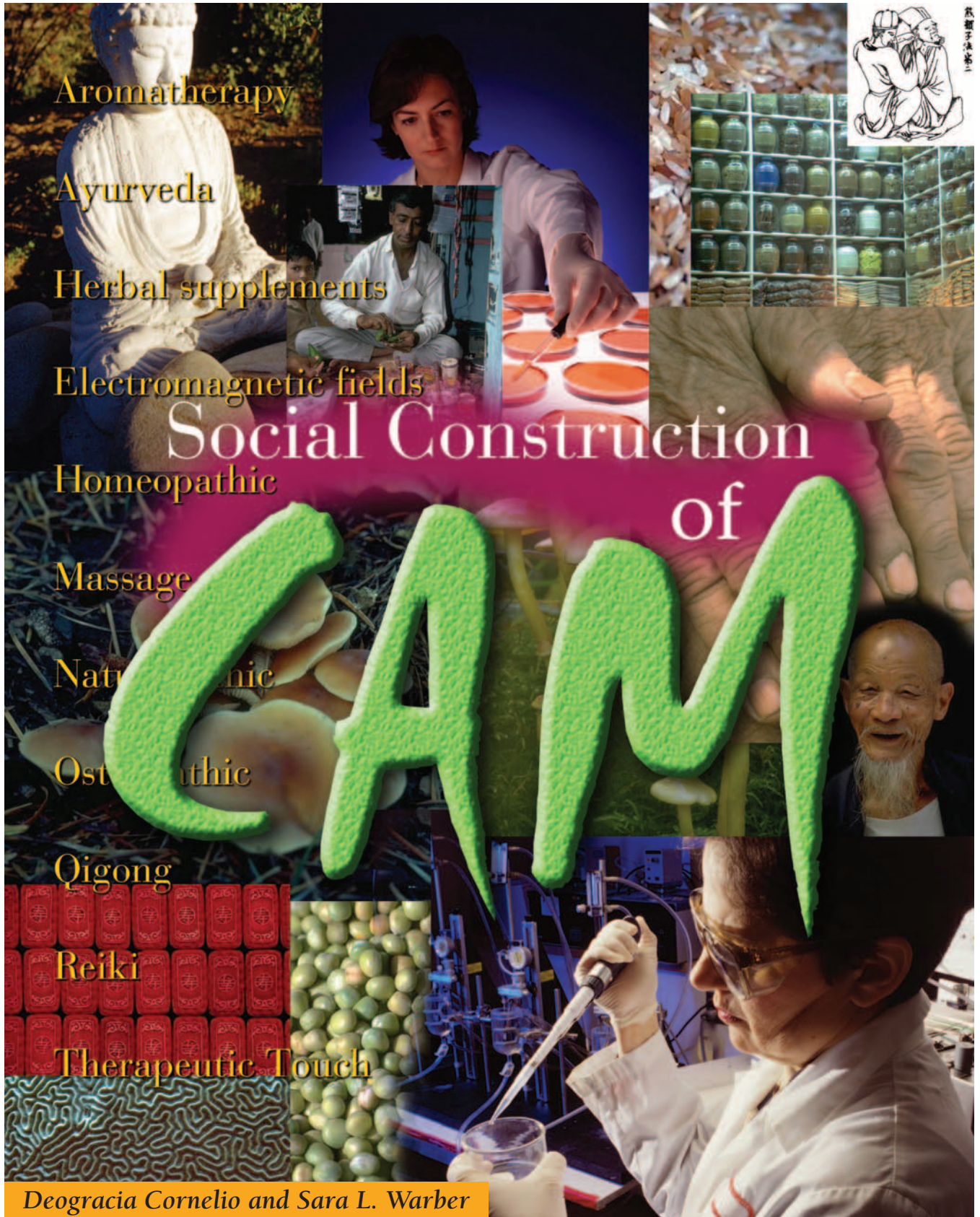


Reflections

Science in the cultural context



Deogracia Cornelio and Sara L. Warber

Here, we review official language published by three important institutions and their attempts to define CAM (i.e., contemporary and alternative medicine): The National Center for CAM (NCCAM) Five-Year Strategy 2001-2005 (1); the White House Commission on CAM Policy (WHCCAMP) Final Report, released in March 2002 (2); and the World Health Organization (WHO) Strategy on Traditional Medicine (3), made public in 2002. Their stated mandates provide and/or capture the discourse, the framework, and the investment for the institutionalized engagement with CAM.

Knowledge is often the product of the subjugation of objects, or perhaps it can be seen as the process through which subjects can be constituted as subjugated.

—Sara Mills, *Discourse*

Introduction

As part of the more generalized process of scientific validation and social legitimation, research mandates have been funded to evaluate the “safety and efficacy” of complementary and alternative medicine (CAM). Accomplished at an interface of social and institutional biomedical spheres, CAM research represents itself as appraising cultural phenomena according to the standards of reliable knowledge. The whole social enterprise, however, can be depicted as one of defining alternative medicines and practices strictly in relation to the dominant biomedical establishment. Indeed, “CAM” decreasingly refers to health and healthcare borne in the context of specific cultural systems and social structures, and increasingly corresponds to practices developed in close relation to the production of orthodox medical knowledge

We are interested in addressing how statements that constitute a discourse about CAM are situated within conceptual relations, institutional histories, and broader relations of power. These relational settings establish the conditions of emergence of “truth statements” concerning CAM. To acknowledge this process of discursive re-articulation, which is our focus, we will refer to unorthodox, non-Western healthcare traditions in the Western context as “alternative medicines and practices.” “Scientific medicine,” or “biomedicine,” will refer to conventional Western medicine.

Constituting “CAM”

“Complementary and alternative medicine” is an official designation of the National Center for CAM (NCCAM) and the White House Commission on CAM Policy (WHCCAMP). The World Health Organization (WHO), given its global action and influence, has had to account for the social and linguistic realities of cultures beyond “First-World” countries. Thus, the WHO document uses the terms “traditional medicine” (TM) and “CAM” interchangeably: CAM initially becomes “TM/CAM.” A

footnote clarifies that differences in terminology indicate the way in which health systems are referred to in different geographical locations. Nevertheless, the prevailing form of healthcare in any given society consistently fails to be regarded by the document as a “dominant” medical system; regardless of the sociocultural context, biomedicine never becomes “CAM.” Following the WHO scheme, medical practices that do not originate from the Western biomedical establishment are *complementary* and *alternative*, even in those locations where they are the dominant form. Thus, “healthcare systems” are a priori defined as a particular set of formal institutions. Biomedicine remains equitable to *the* national healthcare system because it is supported by standards of healthcare production and delivery that are presumed a priori to be the more desirable.

The goals and the language of the WHO Strategy subordinate unorthodox medicines to scientific medicine. Apparently, even in undertaking an investigation of non-Western practices, the globalized context of biomedicine demands increasingly normative and homogeneous structures. Pursuing its mission of “facilitating the integration of TM/CAM into national health care systems,” the WHO manages to represent older, widespread systems of medical knowledge and healthcare as susceptible of fitting into *national healthcare systems*.

...‘Traditional Medicine’ is a comprehensive term used to refer to...traditional Chinese medicine, Indian ayurveda and Arabic unani medicine, and to various forms of indigenous medicine. TM therapies include medication therapies—if they involve use of herbal medicines, animal parts and/or minerals—and non-medication therapies if they are carried out primarily without the use of medications as in the case of acupuncture, manual therapies and spiritual therapies.

Even the use of *traditional medicine* in quotation marks tends to place TM beyond the limits of normality and solidity, and we are led to assume that what is essential about any medical system is how it fits within Western classifications. The criteria for grouping Chinese, Indian, Arabic, and indigenous medicine together are not explained in scientific terms; the alignment, rather, is naturalized by the usage of the term “alternative” simply to mean non-Western and pre-modern. (In fact, the recourse of unifying diverse medical systems is a pervasive discursive practice within the literature from NCCAM and WHCCAMP, as well as within that from the WHO.)

According to the WHO, TM is practiced in poor countries owing to its “availability” and compatibility within “belief systems.” Yet, the objectives of the WHO’s involvement with TM/CAM regulation and the challenges in developing the potential of TM/CAM are “access,” and “expansion of its

Reflections

knowledge” accompanied by “policy, safety, efficacy and quality,” and “rational use.” From *availability to access*, from *belief systems to knowledge* (in singular), the rhetoric is consistently unifying. The language of the WHO document thus conforms to biomedical standards despite explicit aspirations to explore “alternative” medicine.

A Selective Engagement with “Alternatives”

With conventional medicine itself valorizing evidence-based standards, both CAM supporters and skeptics are limited to questions of proof and observable outcomes. The truthfulness ascribed to scientific knowledge claims is squarely based on a specific scientific notion of evidence. Thus, the NCCAM Five Year Strategy’s basic characterizations of CAM are not in any way about substantive contrasts between different systems of medical knowledge; they refer to the scientific plausibility and the status thereby conceded to these practices:

Complementary and Alternative Medicine **practices** are best described as those not presently considered an integral part of conventional medicine. Implicit in this definition is the acknowledgement that as **CAM practices** are proven **safe and effective**, they may become adopted into **mainstream healthcare practice**. *(Emphasis added)*

In this passage, CAM practices are defined by their place (and movement) within an existing institutional structure. The definition clearly corresponds to the selection, evaluation, and validation of practices, and excludes substantive engagement with the conceptual system from which they derive. Allusions to the temporary status of CAM imply that, through the application of scientific criteria, some of these practices can be imparted the value that would qualify them to be properly mainstreamed and integrated. There is an implicit process by which practices (plural) are relieved of their exclusionary label, “alternative,” in favor of a renewed medical system (singular).

Paradoxically, meaning is assigned to CAM practices only as their application and usage are interpreted according to biomedical mechanisms. The WHCCAMP Final Report is explicitly sensitive to this act of interpretation:

While “complementary and alternative medicine” is the term used in this report, the Commission recognizes that the term **does not fully capture all the diversity with which these systems, practices, and products are being used by consumers, CAM practitioners and mainstream health care institutions**. The Commission recognizes that most CAM modalities have not yet been **scientifically** studied and found to be

safe and effective. The fact that many Americans are using CAM modalities should not be confused with the fact that most of these modalities remain **unproven by high-quality clinical studies**. The Commission believes that conventional and CAM systems of health should be held to **the same rigorous standards of good science**. *(Emphasis added)*

Notice that the recognition of the shortcomings of the term CAM does not refer to any substantive claim, but rather to the suitability of CAM as a commodity. The Commission’s Final Report strongly advocates research as essential to the task of regulating and incorporating CAM into the mainstream healthcare system. Having held town-hall meetings where CAM advocates provide multiple testimonies, the Commission’s documents are more inclusive of CAM terminology. However, this sensitivity is outbalanced by the Commission’s focus on public policy, access, dissemination, agencies and infrastructures (institutional), accountability and standards, coverage and reimbursement, products and consumers, maximizing benefits and stimulating private sector investment, and spending and regulation, all of which are reminiscent of the current medical landscape. The principles on which the Commission’s recommendations are based include:

A wholeness orientation in healthcare delivery; evidence of safety and efficacy; the healing capacity of the person; respect for individuality; the right to choose treatment; an emphasis on health promotion and healthcare; partnerships as essential to integrated health care; education as a fundamental healthcare service; dissemination of comprehensive and timely information; and integral public involvement.

The use of the word *wholeness* in place of *holistic* is telling. Holistic, arguably a better grammatical choice, is discursively associated with approaches to health more readily identifiable with CAM. At the same time, it is the delivery of healthcare that will have a *wholeness orientation*, not the conceptualization of health. Furthermore, how would the *safety and efficacy* of the *healing capacity of the person* be bridged? Does the stress on individual usage undermine the power of *public involvement* and of *health promotion*? CAM advocates might argue that important concepts in their practices have been removed from their cultural or sub-cultural contexts. The Report’s focus on policy promises an enriched healthcare inventory for a consumer who is a perfect match, isolated and endowed with formal rights, for a health system that is increasingly shaped by market forces and models. The WHCCAMP recommendations encompass an amalgamation of jargon belonging to several interest groups but manage nonetheless to reinforce a single, dominant framework. Recommendation number four, for example, calls for support of

“core questions posed by frontier areas of scientific study associated with CAM that might expand our understanding of health and disease.” This recommendation indeed points to questions that may be “outside the current research paradigm.” It is the only recommendation where we find allusions to the concepts of health and disease, to CAM’s potential for transforming these basic concepts, and to other cultures. These “core questions,” however, do not belong to CAM quite, but rather to “the scientific study” associated with it. Furthermore, CAM is not represented as a paradigm—not even an “alternative” paradigm—in its own right; rather, it is located on the frontier of scientific knowledge. The word paradigm is reserved for the implicitly overarching practice of Western biomedicine.

Interestingly, there was public debate following the publication of the WHCCAMP Final Report. Critics found its strong support for research on CAM and the push for an integrated health system as representing an assault on scientific medicine. One example accused the Report of

...overthrowing medicine’s century-old commitment to science... Not fully disclosed by this is that the “CAM fundamentals and principles” which will be taught are the very same ones that were overthrown by the Flexner Report in 1910 when medicine was steered onto its present scientific course (4).

In fact, the reporting institutions seem willing to engage CAM’s *fundamentals and principles* only if they can be operationalized, or translated, according to biomedical practices. It is thus problematic that the institutional language of the reports clings on one hand to entrenched standards, and yet professes to explore “fundamentals and principles [that] may expand the horizons of the current research paradigm.” The use of the word disease, instead of illness, may signal intentions to stay well within that paradigm. Arthur Kleinman (5) has developed a differentiation between the concepts of disease and illness, where the latter incorporates cultural and psychological connotations and corresponds to the patients’ mediated perception of their experience, in contrast to the biomedical concept of disease, which manifests as such in all individuals and is the focus of attention for the biomedical practitioner.

Interestingly, in a letter (6) added to the final report as an appendix, two dissenting members criticize the Commission for the rhetorical gesturing toward “recommendations for research on ‘frontier areas of science,’” as well as for considering “spending precious health care research dollars on areas that are unlikely to yield any beneficial data.” The dissenters’ own language recapitulates the classical dichotomy where the precepts of science are set for purposes of exclusion: “Where medical care is concerned, the common good calls for

ideology and advocacy to yield to scientifically sound evidence of safety and efficacy.”

Conclusion

The redefinition, reproduction, and distribution of medical knowledge are at the center of the “First World’s” selective engagement with alternative and complementary practices. In CAM research, the focus is limited to the legitimacy and efficacy of these practices. However, alternative medicines and practices can be reconceptualized in terms of their accessibility to those without technical resources or academic credentials, their oral transmission of knowledge, and in terms of local social hierarchies. Although CAM is generally constructed as far-removed from cultural, geographical, or socioeconomic boundaries, the tensions between north and south, or east and west, are in fact central to its practice, significance, and efficacy as measured within the biomedical arena.

We have argued that there is a reification of medical scientific standards that precludes consideration of the social and political issues that not only accompany CAM and its fragmented incorporation by biomedical institutions, but also that inform medical practice in general and its relation to different social groups. Paradigmatic transformations that expand our understanding of health and illness may evolve from alternative systems of medical knowledge and from a recognition of complex social and environmental realities. We would argue that thoughtful innovation can and should be brought to bear against the ingrained stronghold of discursive frameworks intrinsic to institutional and systemic preservation. 🌍

REFERENCES

1. Expanding Horizons of Healthcare: Five-Year Strategic Plan 2001-2005. National Center for Complementary and Alternative Medicine
2. Final Report of the White House Commission on Complementary and Alternative Medicine. White House Commission on Complementary and Alternative Medicine Policy
3. WHO Traditional Medicine Strategy 2002-2005. World Health Organization
4. Opposing the White House Commission on Complementary and Alternative Medicine Policy.
5. Kleinman A. 1980. *Patients and healers in the context of culture: an exploration of the borderland between anthropology, medicine and psychiatry*, University of California Press, Berkeley/Los Angeles/London
6. Fins J, Dog TL. 2002. White House Commission on CAM Policy Final Report, Appendix G.—Statement from Commissioners. Letter from Joseph Fins, M.D. and Tieraona Low Dog, M.D.

Deogracia Cornelio is a research associate at the University of Michigan Complementary and Alternative Medicine Research Center (UM-CAMRC). **Sara Warber, MD**, is a University of Michigan Assistant Professor and the Co-Director of the Complementary and Alternative Medicine Research Center.