

2. Background: Alternative Medicine in the United States

The current interest in AM in the US stems from the growing use of these practices by Americans.¹⁻⁵ In the US, private insurance companies largely cover healthcare costs, and subscribers' medical expenses are reimbursed in varying degree by health insurance, depending on their plans' policies. Reimbursement usually covers the accepted standard of care. Therefore, AM is, by definition, not covered by these plans, and must be paid out of the pocket. Non-reimbursed costs associated with use of AM in the US seem to have increased considerably, from US\$14 billion in 1990 to US\$21 billion in 1998,^{1,2} a figure considerably higher than that of all non-reimbursed conventional healthcare expenses. This confirms a trend of increasing use of AM that was already suspected as early as the 1980s. Reflecting this interest of the American public in alternative medical care, the American Congress, in October 1991, instructed the National Institutes of Health (NIH), the premier medical research institution in the nation, to create an office to "investigate and validate unconventional medical practices." In 1993, that office was renamed "Office of Alternative Medicine (OAM)", and in October 1998, it was elevated to the rank of an NIH Center, the National Center for Complementary and Alternative Medicine (NCCAM).

3. Current Definition of Alternative Medicine

Despite the worldwide increasing use of and attention paid to AM,⁶⁻⁸ no accepted definition of this term has been established thus far. The importance of definitions has been underestimated in that they define the scope of AM for the lay and professional public, and bias the mindset for approaching this varied and complex field. I also contend here that the "*why AM*" is essential to defining "*what is AM*". *Why* is there a field of AM in our ever-shrinking world, when the once-distant cultures that gave birth to most AM are now familiar to most? *Why* also, is there AM if science is dispassionate

as it claims to be in theory, and open to examining any worthwhile phenomena, instead of dismissing them at the outset? Shouldn't one expect that the best possible therapies would be available to patients regardless of what these therapies are or where they come from? Why have entire age-old systems of health been ignored by biomedical science?

Existing definitions of AM are unsatisfactory, in part because they fail to address the fundamental issue of *why* they are "alternative", and because they fail to take into account diverse fundamental characteristics of AM, which should be part of any definition. For example, many healthcare practices are labeled "alternative" because it is felt that there is a lack of relevant, good quality scientific research to substantiate claims of efficacy.^{9,10} However, issues beyond the scientific appear to be involved, if one considers that it required congressional intervention for the US National Institutes of Health (NIH) to earmark 0.02% (US\$2 million) of its US\$10.7 billion 1992 budget to evaluate practices used by more than 35% of the American population.^{11,12}

Some of the current definitions are pragmatic, and consist of ad hoc lists of disparate practices deemed alternative: entire complex traditional healthcare systems (e.g. Chinese (TCM), East Indian (Ayurveda) and Native American^{5,13}); their components practiced as distinct complementary entities (e.g. herbal medicine, acupuncture, dietary principles and spiritual practices); and also a wide variety of difficult-to-categorize discrete modalities and products. Furthermore, among the proponents of practices such as hypnosis, osteopathy and chiropractic (taught in the US by degree-granting institutions for more than a century), there is little consensus as to whether these modalities are alternative or mainstream.

The few attempts at conceptual definitions identify AM as what is not conventional, e.g. what is not covered by insurance, or is not taught in medical schools.¹ These definitions also have drawbacks, as reference criteria are changing rapidly and are not consistent worldwide (nor even across the US). Health insurance coverage for alternative practices varies widely among countries, and regionally

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within many countries. For example, homeopathic medicines have been reimbursed by the French national healthcare insurance for decades, while in other countries they are not. In Germany, medical doctors can prescribe herbal medicines like pharmaceutical drugs, while in France botanical medicine is not covered. In the US, great regional variation exists in the pattern of reimbursement for alternative forms of care, and most are not yet covered. In some countries (e.g. France), only physicians can legally practice any kind of medicine (including osteopathy, acupuncture and homeopathy), while in other countries (e.g. Great Britain and Germany) these same disciplines can be practiced by individuals who are not conventional physicians. Within the US, some 75 or so medical schools offer courses in AM. Most of these courses are elective, a few are now compulsory, and their curriculum varies widely.^{14,15}

4. Proposed Definition of Alternative Medicine

To provide a rational definition of AM, it is clearly necessary to identify common traits of these very disparate practices. Most of what falls under the scope of AM has its origins in traditional systems of health. It is apparent that some kind of spirituality, often directly related to the dominant religion or philosophical system of the originating culture, is an integral part of most traditional systems of health.^{5,13,16-19} In contrast, for biomedicine, spiritual aspects are often deemed peripheral to health promotion. This tacitly understood position of biomedicine is congruent with the observation that spirituality or holistic philosophies are among the major reasons for the growth of AM in the West.³

Based on a number of observations, we have proposed that AM may well be defined as a broad set of healthcare practices (i.e. already available to the public) that are not readily integrated into the dominant healthcare model because they pose challenges to diverse societal beliefs and practices (cultural, economic, scientific, medical and educational).¹⁹