Keynote Speech for Nottingham Conference June 29/05

THE STATUS OF CAM: WHERE ARE WE NOW?

HOW I BECAME INTERESTED IN CAM and HOW IT CHANGED MY LIFE

When I look back at my academic career, I ask myself--How did I get hooked on the subject of CAM? I was a medical sociologist, teaching and doing research in the medical faculty at the University of Toronto. Our mandate was to bring some psychological and social perspective to the training of physicians. Sometime in the late 60's, I began to feel uneasy at the narrow scope and somewhat arrogant stance of the students I was wanting to influence. I thought they might benefit from knowing about another type of healing and I contacted the chiropractic college, which was located in Toronto. The president agreed to come and talk to the students about how chiropractors help people, and I thought that would make a great teaching session.

The lecture proved to be a disaster. The students were angry and threw paper aeroplanes and booed the speaker. We regrouped, and tried again the next year and eventually seemed to get through to them. In the process, I got to know some of the chiropractic leaders, and they approached our department to do some research on chiropractic in Canada. We told them that we were not clinicians and couldn't make any conclusions about the effectiveness of their therapies, but we could study their training and the characteristics of their patients, as well as their level of satisfaction. They seemed happy with that, even though we warned that our findings might not be flattering. They said that their reputation was already so bad; they weren't worried about negative findings--it couldn't get any worse. So we began a major cross-Canada study, funded by the federal Dept of Health, and over the next three years, I spent a great deal of time with the chiropractors. We sat in on classes, we observed them with patients in their offices and we attended their conferences and meetings.

I had the opportunity to see first hand just how these alternative healers treated their patients, and thought about health and illness. Over time it became clear that they were operating in a different manner than conventional medicine---today we would call it working from a different healing paradigm. They had a much more personal relationship with their patients, inquiring about their diets, their exercise habits, their working conditions, their posture when walking and sitting and their general mode of living. I saw practitioners who went out in their car to pick up elderly patients when the weather was bad, and I saw genuine involvement in the life events of their patients of all ages. I came to understand and value the emphasis on the natural healing power of the body and the balance between body, mind and spirit. Gradually, I started to change my own way of life to include regular exercise, more careful eating habits and a consciousness of the way that I stood, sat and walked. My experiences had a significant impact on my life and my thinking.

When the study came out as a book in 1980 (Chiropractors: Do They Help?), it documented a picture of an occupation that was striving to upgrade the qualifications of its practitioners and was giving personal, holistic care to its patients. I was just coming up for tenure at the time and to the credit of the university and the medical school, they

didn't hold me back because I had the temerity to study a non-medical healing occupation. The dean at the time read the study and said to me: "I understand---it is about caring, not curing."

Some years later, one of my graduate students did a master's thesis, which compared patients with back problems who were seeing physicians, chiropractors or Alexander teachers. That student was Beverly Wellman, who later became my research associate and colleague, and we have worked together since 1993, employing a social science framework to study CAM. At that time, there were only a few of us who shared this interest and there was not much research being done on questions such as who used CAM, why they used it, and the pathways they took to find their CAM practitioners.

Our first study dealt with patients (300 of them in the Toronto area). We chose four types of CAM practitioners: chiropractors, naturopaths, homeopaths and Reiki healers. We randomly chose five from each group and then asked each of them to recruit 15 of the patients they saw on a given day or two days if necessary, for us to interview. We conducted personal interviews with all these patients,. On the basis of this data, we were able to draw a reliable profile of CAM users (typically female, under 65, well educated, affluent, and spiritual). We were also able to ascertain why and how they were consulting CAM practitioners. One of the most important findings from this first study was that almost all the patients we interviewed were also using conventional medical care. It was not a matter of either /or. They consulted family physicians for checkups and monitoring of medications and they saw medical specialists when it seemed necessary for acute or life-threatening problems. They turned to CAM practitioners for chronic conditions and to help them maintain their health. These patients acted as 'smart consumers', selecting the kind of health care they thought most appropriate for their particular problems.

Because we felt intellectually lonely at our university, we sought out other scholars who shared our interests and we held the first international social science symposium on CAM, in 1998. We were delighted to connect with people like Ursula Sharma, Mike Saks, Adrian Furnham, Edzard Ernst and others. Our papers for the symposium became a book in 2000 (CAM: Challenge and Change). Since that time, we have been joined by other colleagues at our university (Heather Boon and Sandy Welsh), and have concentrated our research on the professionalizing process that has characterized many CAM groups during the last decade. It is the findings from these later research efforts that underlie my observations today about the current status of CAM.

TODAY--A PLATEAU?

The dramatic growth of CAM in the Western world over the past few decades has perhaps peaked. According to a recent survey by Tindle et al, the use of CAM therapies in the United States remained stable from 1997 to 2002. (About one in three Americans had used at least one CAM therapy during 2002; the most commonly used modalities in 2002 were herbal therapy, relaxation techniques and chiropractic). In Canada the increase in use between 1995 and 1999 has been extremely modest (2%). Clearly, CAM is not for everyone and patients of CAM practitioners have found that treatments are time-consuming and expensive. There is no magic bullet or quick fix with CAM. These therapies take time and persistence and require steady cooperation between practitioners and patients. In a society that is geared to instant results, some people give up on CAM

and seek faster relief from physicians even though it may be accompanied by unpleasant side effects.

People also find that CAM products are expensive and take weeks and even months time to have an effect. Lately we have been hearing that sales of these products have flattened out in the US. and Canada. Consumers are concerned about the potential for negative interactions between conventional medicines and CAM products. While many people are convinced that since they are ‘natural’, CAM medications can do no harm, others are not so confident about their properties. In Canada, the government has formed the Natural Health Products Directorate to bring some order and reliability to the scene. Under its regulations, all natural health products making claims must undergo a pre-market review. They must provide sufficient evidence to prove the safety, quality and efficacy of the products in order to receive market authorization. This process has only recently begun and there are a great many research projects underway, but as yet, many CAM products have not been thoroughly tested. In other countries, there is no such authority to offer assurances to consumers. All these factors combine to make at least some people sceptical about the value of CAM.

In Ontario at the present time, the government is seriously considering the granting of statutory self-regulation to several CAM groups. This move, if it is successful, would confer considerable legitimacy on CAM practitioners. While this does not mean their services will be covered by the provincial insurance plan, it is possible that such a move will encourage more consumers to try CAM services.

Today I want to talk with you about what I regard as the three main issues in CAM. My remarks stem from my background as a medical sociologist, my long term research on CAM and my own personal experience in using these therapies.

1) EVALUATION

Evidence of efficacy and safety for CAM is crucial to acceptance as a legitimate part of the established health care system. Policy-makers recognize that the scientific evidence for CAM is still sparse, and they are concerned with what this means for the accountability of CAM practitioners and the regulation of both products and providers. Physicians and other established health care practitioners want evidence so that they can decide if, and when, to refer their patients for CAM therapies..

While everyone understands the importance of evaluation, there is little agreement about the best way to do it. Deciding how to establish the efficacy and safety of CAM modalities is proving to be a challenging enterprise. At the present time, the randomized clinical trial (RCT) is still considered the gold standard for testing clinical interventions. The dominance of the RCT has meant that many CAM therapies have been ignored or dismissed by the medical establishment because their efficacy has not been demonstrated by this particular research strategy. We explored this issue during our recent interviews with the leaders of four CAM groups (chiropractors, naturopaths, homeopaths and TCM/acupuncturists). They were aware that the RCT is generally accepted as the gold standard, but most of the leaders were opposed to using RCTs exclusively to evaluate CAM. They did not believe that this form of testing could be true to the underlying philosophy of CAM interventions, nor to what actually happens in their practices.

Their main objections will be familiar to most of you: 1) RCTs give no information about individual patients, and CAM therapies are tailored to each individual case, 2) They allow no room for patient preferences, a particularly important aspect of treatment,3) Randomization of patients poses a problem since patients tend to have strong beliefs about CAM and are likely to find being randomized to one of two or more treatment options unacceptable. 4) There is no simple endpoint for many CAM treatments. CAM practitioners treat the whole person and thus a wider range of outcomes is needed. 5) CAM often involves a long series of treatments while RCTs focus on one or two points in time. 6) For some forms of CAM, no adequate placebo exists, and furthermore, many CAM practitioners place a high value on the placebo effect and would be unwilling to rule it out of a test of effectiveness, 7) RCTs require that conventional diagnostic criteria are used but they are incompatible with many forms of CAM. Finally, there are still a few CAM leaders who tell us that a thousand years of success provide enough validation of their therapies and nothing else is needed.

Scholars like Edzard Ernst and his colleagues at Exeter, contend that all these objections to evaluating CAM with RCTs are unfounded. Ernst claims that these arguments can be overcome by adapting the standard RCT design so that it better fits the research question. In his view, the RCT is still the best method available for testing CAM interventions.

Another approach to evaluating CAM has been proposed by some Canadian scholars, led by MarjaVerhoef (Ritenbaugh C, Verhoef MJ, Fleishman S, Boon H, Leis L. Whole systems research: A discipline for studying complementary and alternative medicine. Alternative Ther Health Med 2003;9:32-36). They call it whole systems research. This system uses individualized, non-reductionist approaches to diagnosis and treatment and stresses the important role of the practitioner-patient relationship. Whole systems research encompasses investigation of the processes of treatment, the structure of the relationship as well as the treatment outcomes. It combines qualitative and quantitative methods to establish both whether the intervention works and why or how it works. It seems clear that we need to adapt evaluation techniques so that they are appropriate for CAM and fit with its underlying premises of the importance of the practitioner-patient relationship, the natural healing powers of the body and the necessity for individualized treatment. New imaginative methods for evaluating CAM will undoubtedly continue to be developed. But it is also clear that all forms of evaluation must be rigorously pursued and subject to scrupulous peer review and the scrutiny of their harshest critics.

The leaders we interviewed were quick to point out that their groups are small compared to the medical profession and that this gravely limits their capacity to do the kind of research required for credible evaluation. The lack of funds to do research as well as the scarceness of experienced researchers among their members pose continuing problems for CAM groups. As one leader told us: “To have the luxury of doing research, you need leisure time and the ‘know how’. Most of us are just making ends meet and there is not a lot of government or private money around to support us.” There remains an urgent need to develop research capacity and infrastructure among CAM practitioners, so that they can carry out their own research in a scientifically sound manner suited to their particular perspective. One way that some CAM researchers have developed to deal with this problem is to seek out collaboration with scientists in the academic and research

communities. This attempt to reach out to other disciplines for research expertise and collaboration is a promising new development that has the potential to strengthen the legitimacy and acceptance of CAM.

It is important to recognize that what constitutes credible evidence for one person will not necessarily work for another. Different groups in society ask different types of questions and require different types of data for evaluation. For example, people in severe pain may be satisfied with anecdotal evidence of relief provided by a CAM intervention, while their physicians may insist on evidence produced by an RCT. Governments are accountable to their citizens and need to base their health care policies on reliable data about safety and cost-effectiveness. Consumers, on the other hand, are more focused on health maintenance and prevention of illness and look for evidence of good health from the histories of close friends and family. So in the end, evaluation is essentially a subjective matter.

2) INTEGRATION

As the demand for CAM has grown, and established health care providers have taken an interest in some CAM therapies and products, the prospect of integrating conventional medicine with these practices is receiving serious consideration. The process of integration is a massive challenge. The concept is still evolving and is being interpreted in a whole variety of ways.

Education

In the field of education, there has been a move toward introducing the teaching of CAM in allopathic medical schools. According to surveys conducted on this topic, there has been a sharp rise in the number of medical schools in the US and in Canada that offer courses in CAM. I feel certain that the same patterns are emerging here in the UK. The amount of time devoted to this topic, however, varies widely. The typical CAM course is sponsored by a clinical department as an elective and is most likely to be taught in the first or fourth year of medical school. The average contact hours are about 20 hours of instruction and CAM practitioners or prescribers of CAM therapies teach most of the courses. For the most part, the instruction appears to be descriptive and while there is an assumption that CAM therapies are effective, little scientific evidence is offered. The fact that a different paradigm is being used for CAM than students are accustomed to, means that they are likely to regard it less seriously. Nevertheless, it has been the impetus of the students that has driven the current move to integrate CAM into the curriculum. They recognize that their patients will be asking them about these therapies and products and they want to have a basis of knowledge with which to advise them. It is a very different scene today than when we first tried to introduce medical students to the idea of alternative modes of healing!

Research

When it comes to integrated research on CAM, there is also encouraging news. CAM practitioners who are interested in research have begun to establish linkages with experienced medical and academic scientists. In our recent interviews with leaders of CAM groups in Ontario, for example, we were told that several such research teams had recently been formed. While the CAM researchers get the benefit of excellent facilities and the talents of the established scientists, they also bring with them a deep understanding of CAM modalities. Exciting new research possibilities are opening up.

For example, new brain imaging technology will allow researchers to physically explore how things like herbs, acupuncture and prayer can help people feel better. One of the foremost engines for integrated research is the National Center for Complementary and Alternative Medicine sponsored by The National Institutes of Health in the US. They are currently carrying out a whole range of different kinds of CAM research with medical health care centres and the science departments of a number of universities (NIH website).

Practice

It is in the provision of health care services that integration has really been flourishing. But we should recognize that until recently, it has been patients themselves who have done most of the integrating, albeit in an ad hoc, unsystematic manner. They have been the ones who determine when to choose CAM and when to utilize conventional medicine.

Today, however, there is an increasing interest among health care providers in integrating at least some CAM therapies with conventional care. While there is little consensus on what an integrated health care system would look like, or how best to operationlize it, the basic principle is the use of non-hierarchical multidisciplinary teams, that combine the best of both conventional medicine and CAM. It implies a partnership in healing; a partnership, which includes a wide, range of providers as well as the patient, and involves new organizational roles, structures and processes. In the United States and Canada, integrative medicine is being developed in an invidualistic manner; there is an increasing body of literature on individual experiments in creating integrated centers. In Britain, development has been facilitated by the initiative of the Prince of Wales Foundation, which brought together a steering committee and working groups to examine and facilitate integrated care. There are now numerous examples of CAM and conventional medicine being provided side by side across this country, as primary care trusts (PCT's) provide opportunities for physicians to include CAM practitioners in their practice settings.

There are several different versions of integrated care. the version favoured by many physicians is that of *co-optation*. This consists of incorporating techniques of CAM into the conventional medical system, leaving control in the hands of the physicians. Such a process allows medicine to dominate and protect its strategic interests, while at the same time, accommodating patients' interest in trying CAM therapies. Furthermore, incorporating CAM therapies ignores the fact that CAM is more than just a set of techniques. CAM interventions are based on a distinct philosophy of health and health care, which have a significant influence on the effectiveness of the interventions. For example, in CAM, both the individuality of the patient and the relationship with the practitioner are believed to be key elements in the healing process. Co-optation involves stripping CAM therapies of the paradigm within which they are delivered.

Another version can be called *gate keeping*. What this involves is that physicians make the original diagnosis and then decide whether or not to refer the patient to a CAM practitioner to treat the condition. They justify this position by arguing that it is for the benefit of the patient's overall health and well-being if a physician makes the diagnosis, since the patient can then be assured that his/her condition does not urgently require conventional medical care. Once again, this approach leaves control in the hands of the physicians, who decide, on the basis of little real understanding of CAM, who should treat which kinds of conditions. In both versions the medical profession is attempting to

use its esoteric knowledge to erect exclusionary barriers and to demarcate physicians as the legitimate caregivers.

Beyond these two versions, there are now an increasing number of *integrated health care settings*, some in freestanding clinics and some in hospitals. This kind of arrangement seems much closer to the ideal of multidisciplinary and interprofessional collaboration. Integrated centres are supposed to offer comprehensive access to a full range of health care services, based on patient need. Judging from the various published reports on these centers, however, it is clear that there are still significant problems of authority, jurisdiction and competition as well as differences over healing paradigms to be worked out. The challenge is to unify the two distinct paradigms, biomedicine and CAM, without doing violence to either.

There are many variations of integrated health care settings in existence today, with different types and numbers of modalities, practitioners, treatment styles and patterns of professional interaction. In Canada, there was a pioneer centre in Vancouver called the Tzu Chi Institute (Mulkins et al, Verhoef and Eng. An assessment of the TZU Chi Insitit, for CAM as an optimal healing environmnet. Evidence-Based Integrative Medicine 2004 1 (3), 195-202). It provided an excellent model of integration but sadly; it was not profitable and was forced to close due to lack of funds.

It seems that a number of integrated centres in North America are having financial troubles (Benda 2005). Some of the issues have to do with lengthy patient encounters, a paucity of third-party payment for CAM services, and discrepancies in the philosophical approaches of the various providers. It takes a foundation of trust and credibility and slow steps to create a successful integrated centre.

But the one I want to tell you about today is a unique centre that is very dear to my heart. It is called The Artists' Health Centre and is located in a major teaching hospital in Toronto. The impetus behind the centre was the expressed need of professional artists for integrated health care particularly suited to their problems, and that they could afford. Artists tend to have multiple conditions arising from their work, such as strained tendons for dancers and musicians and breathing problems from paint fumes for visual artists. To help them cope with their distinctive problems, which can seriously affect their ability to work, they need a range of treatments that include, but go beyond conventional medical care. The problem is that while medical care is covered by public health insurance in Canada, few artists earn the kind of living that will pay for additional services. Over a period of about ten years, a group of artists and supporters worked to design a centre which would be uniquely suited to their needs.

Finally, the centre has opened and is in operation within a special section of the hospital. It is averaging more that 170 visits per month. Artists can avail themselves of conventional medical care without cost, but subsidies are available to those who need additional kinds of care and do not have the means to pay for them. The development of truly integrated care is, however, still far off. The hospital hesitates to accept any CAM practitioners who are not regulated,so there are difficulties in enlisting practitioners who are known to the artists as being very helpful, such as Reiki healers or TCM doctors, but do not meet the hospital's requirements.

At present, the staff consists of mental health counsellors, a physiotherapist, a naturopath and a nurse practitioner, as well as a family physician. The plan is to hire, an osteopath and a chiropractor in the fall, if the hospital approves. None of these will be full

time yet. What is missing so far is any sense of team collaboration among the various practitioners. Each discipline seems to work on its own. Those of us who serve on the board have a vision of truly integrated care, but it is taking much longer than we hoped to achieve it. Fortunately, there is also a research component attached to the centre and we plan to study the patterns of interaction among the various providers to understand how to facilitate professional collaboration and respect. We are hopeful that this will develop over time, with prodding (or coaxing) from the board.

3) PROFESSIONALIZATION

For the last six years, our research team has been engaged in studying the process of professionalization pursued by CAM practitioners. As I mentioned ealier, we have been following four CAM groups in depth: chiropractors, naturopaths, TCM/acupuncturists and homeopaths. Before I report on our research, I first want to make some comments about professionalization in general. The push to achieve professional status is certainly not restricted to CAM practitioners. There are many other groups with the same goal, from beauticians to plumbers to barbers. It seems that a lot of occupations are working to legitimate their position and to gain the rewards of increased status and power, as well as more financial security, that characterize a profession.

It is really interesting that this move to professionalization is taking place at a time when many people in our society are becoming increasingly more skeptical of professionals. There appears to be a widespread feeling that professionals are arrogant, out-of-touch with the average person, and not to be trusted. Yet, at the same time, we are more demanding than ever that the people we deal with be legitimated by certification and accreditation. These conflicting trends are reflected in the case of CAM groups, where there exists a real tension between the formally educated expert who has been legitimated by the state, and the apprentice-trained practitioner who seeks to work in an equal partnership with the patient. It is against this background that we have studied the different paths that CAM groups have followed in their quest to professionalize.

Studying the Professions

The process by which an occupation changes to become a profession can be studied in a number of ways. In our work, we have chosen to analyze the professional project using key insights from three main sociological perspectives

1) The interactionist framework of Hughes (1958), Larson (1977) and Friedson (1986), that regards a profession as a socially negotiated status and focuses on the actions people take to become and remain professional.

2) The neo-Weberian concept of social closure, used by scholars such as Collins, 1999, Witz 1992 and Saks 2000, that points to the political aspects and power struggles involved in the process of professionalizing.

3) The system of professions, used by Abbott (1988) that conceptualizes professions as organized into an interacting system in which they compete for power.

Each of these approaches has been useful in our attempt to understand the process by which selected CAM occupations are seeking to gain legitimacy and professional status. They provide an overall framework within which we have sought to answer questions such as: How far has professionalization proceeded among these groups and what strategies have they used to promote their goals? What kinds of resources do they

need to move ahead? And what is the influence of the larger social and political forces on their efforts?

Strategies for Professionalizing

Each of the four groups we have studied is at a different place in the professionalization process. While they operate outside of the formal system, they are struggling to find their way in. To accomplish their goals, the leadership of the groups ---each in its own way---is attempting to pursue four main strategies:

1) Improving the quality of their educational programs

The leaders were keenly aware of the importance of continuing to upgrade the training they are providing to future practitioners. They understood that other stakeholders in the system would critically assess their entrance requirements and training programmes. Students today are required to be familiar with all the basic elements of the biomedical model, even though they are operating from a different health paradigm. How they reconcile the two approaches is not clear.

2) Elevating their standards and ethics of practice

The leaders understand that high ethical and practice standards are crucial if they are to make a claim for professional status. They believe that their clinical standards must be based on a sound knowledge of biomedicine, both to ensure safe and effective care and also to create legitimacy. The challenge for the leaders is not only to raise clinical standards but also to ensure that they are uniformly followed and enforced. I sometimes think that CAM is judged more harshly and held to a higher standard than conventional medicine. This is something all the leaders are currently grappling with.

3) Developing peer-reviewed research

There are significant differences between the groups in the amount and quality of research they have been able to mount. They lack adequate funds and they have only modest research capabilities. Governments ask for proof of efficacy but are not yet providing enough money to pursue the necessary studies.

4) Increasing cohesion among members

Abbott (1989) argues that in order to effectively fight for a territory, an occupation's members need to agree on the parameters of what they do and how they should do it. Increasing group cohesion is a major way to strengthen a group's ability to negotiate with others and move ahead. To utilize any of the strategies for professionalization outlined, an occupation must have a cohesive organizational structure and be able to act in concert. As a consequence, the leaders focussed on the need to increase cohesion and ensure uniform standards among their members.

Resources for professionalizing

In order to implement and maintain their strategies, these leaders have to be able to summon up a range of resources with which to combat the countervailing forces in their environment. Without these resources, the CAM groups cannot successfully compete for power with other interest groups in the system, and cannot define jurisdictional boundaries or achieve the social closure required for their professional project.
Our research indicates that the main resources our respondents had available to them were:

1) Public support--The strength of public demand has fuelled the current re-emergence of CAM in Western societies. If it were not for the support of the public, these

occupations would never have received serious consideration as components of the health care system.

2) Political allies-- It is also important for these groups to gain the backing of other stakeholders in the system. In particular, government approval, either formal or informal, can go a long way to legitimize CAM occupations.

3) A critical mass--Numbers count. A critical mass of practitioners is necessary when CAM groups try to negotiate for influence and position with other interest groups such as the established health care professions, government, and other CAM occupations. None of the groups we studied have yet managed to attract sufficient members to provide them with this fundamental resource.

The socio-political context

The ability of an occupation to pursue strategies for professionalizing is heavily influenced by the socio-political context in which these efforts are occurring. The medical profession remains the dominant structural interest group and has the power to impress its paradigm of health care on government, other health care providers, hospital administrators and large segments of the public (Coburn 1993, Kelner et al 2004). In order to maintain its superior position, organized medicine and its allied practitioners want to constrain change in the system. To this end, they lobby to persuade government that health care is really only medical care. They argue that medicine requires most of the funds designated for health care and that it would dilute the quality of care if funds were diverted to other kinds of treatments. If they can continue to convince government and the public of this argument, the CAM occupations will be denied adequate financial resources to pursue their key strategies.

The efforts of CAM groups to carve out a professional niche are directly related to the policies pursued by the state. In Canada as in other Western societies today, a paramount consideration of the state is reducing the costs of health care. Unless CAM occupations can convincingly demonstrate that their services will ultimately save money by reducing the load on conventional medical care, the state is unlikely to grant them full professional status. Concerns that recognition of CAM groups will add further to the financial burden keep the state from actively supporting them.

On the other hand, governments are increasingly interested in modifying their health care systems to include more preventive measures and less curative care. In this respect, the state may see the CAM groups as allies, since their philosophies and therapies place a good deal of emphasis on health promotion and maintenance. Also of interest to governments trying to improve their health care systems and reduce costs, are increased public health measures and changes in the organization of primary care. Once again, the CAM groups can play a useful role in helping government to achieve these goals.

THE FUTURE ?

Sociologists are known to be notoriously bad at predicting the future, so I suggest these thoughts with considerable humility.

The place of CAM groups in the health care system

There seems to be no doubt that CAM is here to stay and will become part of routine care. This does not mean that people will discontinue the use of conventional medical care. Patients will use a variety of modalities depending on the way they

perceive their needs over time. In the future, the hope is that multidisciplinary teams will decide on the most appropriate care for each patient; care that meets the standards of efficacy, safety and cost-effectiveness.

CAM groups expect that statutory self-regulation will be a huge step in providing them with the power to effect social closure around their particular specialties But it is important to recognize that state recognition is not the end point of the professional project. As illustrated by the case of the chiropractors in Canada, the struggle for legitimacy continues even after professional attributes like regulation have been attained. New challenges seem to keep arising to make full acceptance out of reach.

The political struggle

Because integration and professionalization for health care providers in Western society seems to require the imprimatur of scientifically validated findings as understood by conventional medicine, CAM groups may be tempted to modify their distinctive philosophies and approaches in order to fit the biomedical model. I believe that such a move would render them mere shadows of allopathic practitioners and would deter the development of alternative paradigms for healing. It would represent a severe loss to the unique potential of CAM therapies for healing and preventing illness and society would be much the poorer for it.

In order to move from the margins to the mainstream, the CAM groups will need to engage in ongoing dialogue and negotiations with the government and other stakeholders in the system that are reluctant to let them in. They will also need to reach agreement among themselves and to work with the other CAM groups. They will need to address issues such as cost-effectiveness, evidence-based care and the overall shape of health care in the future. They need to show how their different models of health care fit in with the overall system and speak to the new goals of wellness and prevention in an era of primary care reform. Ultimately, it will be a political contest between the countervailing powers of the professions, the public and the different levels of the state that will decide the fate of CAM.