

INTEGRATIVE HEALTH CARE UNDER REVIEW: AN EMERGING FIELD

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ABSTRACT

Objective: The purpose of this study was to review the research literature for the emerging field of Integrative Medicine/Integrative Health Care (IM) using the methods of systematic review.

Methods: We conducted an electronic literature search using PubMed, Allied and Complementary Medicine, BIOSIS Previews, EMBASE, the entire Cochrane Library, MANTIS, Social SciSearch, SciSearch Cited Ref Sci, PsychInfo, CINAHL, and NCCAM grantee publications listings from database inception to May 2009, as well as searches of the gray literature. Available studies published in English language were included. Three independent reviewers rated each article and assessed the methodological quality of studies using the Scottish Intercollegiate Guidelines Network.

Results: Our initial search yielded 11 591 citations. Of these, only 660 were judged to be relevant to the purpose of our search. Most articles deal with implementing and implemented programs. They focus on practice models, strategies for integrative health, the business case, and descriptive studies. This is followed in terms of numbers by conceptual/philosophical writings. These in turn are followed by research articles including randomized controlled trials, program evaluations, and cost-effectiveness studies. The literature reflects an emerging field in that it is focused more on how to create IM than on researching outcomes. However, the lack of definition and clarity about the term *integrative medicine* (also known as *integrative health care*) and the absence of taxonomy for models of IM make it very difficult to efficiently conduct systematic reviews of this field at the moment.

Conclusion: Our review revealed that most articles focused on describing practice models and conceptual/philosophical models, whereas there are fewer randomized controlled trials and observation studies. The lack of consensus on a clear definition and taxonomy for integrative health care represents a major methodological barrier on conducting systematic literature reviews and meta-analysis in this emerging field. (*J Manipulative Physiol Ther* 2010;33:690-710)

Key Indexing Terms: *Integrative Medicine; Complementary Therapies; Review; Systematic; Chiropractic*

Reviewing the literature on Integrative Medicine (Integrative Health Care or Integrated Medicine) (IM) poses several major problems. Johnson (2009)¹ identifies models of integrative care that have been discussed in the literature. As she notes, currently, we do not know if any given model is superior to another.

The first is defining what constitutes IM. In the United States, the recently held Institute of Medicine (IOM)

conference on IM was generally heralded as a milestone for the field. It brought together more than 600 individuals to Washington, DC, to explore the science and practice of IM. This is the first such conference held by the prestigious IOM on this field. But even the IOM conference² showed some confusion about defining IM. In one part, they referred to *integrative medicine*; in another, to *integrated medicine*. In their press release, they begin by stating that

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Paper submitted August 24, 2009; in revised form July 19, 2010; accepted July 21, 2010.

0161-4754/\$36.00

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integrative medicine is an approach to health care that places the patient at the center of care; focuses on prevention and wellness; and attends to the physical, mental, and spiritual needs of the person. But their press release ends with the statement that the Summit's leadership believes that the integrated approach to health care could provide the basis for our nation's health reform.³ But in the United States, *integrative medicine* and *integrated medicine* are not the same thing. Then there is the issue of whether the term is *integrative medicine* or *integrative health care*. As noted above, it can refer to institutional-/organizational-based delivery of care, provider-centered care, or patient-centric integrative care.

Integrative Medicine represents a rather recent but emerging field. Its arrival as a serious academic and practice paradigm perhaps was evidenced by the recent meeting held by the IOM on IM. A recent report^{2(p3)} prepared for the IOM conference on IM notes that both clinical effectiveness and cost-effectiveness are required "to formulate evidence-based policy." But whereas there is an increasing body of literature on the clinical effectiveness of Complementary and Alternative Medicine (CAM) and a much smaller literature on cost-effectiveness, there is a much smaller evidence base at the moment for IM. Two things however were very noticeable about the IOM conference: the first is that no clear definition emerged about what constitutes IM, and the second is that no taxonomy of IM practices has yet emerged that can guide a research agenda.

For the first, the definitions run the gamut from those who see it as simply the integration of CAM in some form of relationship with biomedicine (usually institutional and sometimes referred to as *adjunctive therapy* or *complementary/composition medicine*)⁴ to those who propose that it is a new form of medicine as "medicine that reemphasizes the relationship between patient and physician, and integrates the best of complementary and alternative medicine with the best of conventional medicine."⁵

Institutional integrative health care in the United States is being developed in a highly distinctive manner, and there is an increasing body of literature documenting attempts to establish integrative programs/centers.^{6,7} This include chiropractic, naturopathic, acupuncture and massage therapists, or holistic nurse practitioners; and increasingly, spiritual healers and touch therapy have all been brought into such settings, but the degree of integration may vary considerably.⁸

The definitions and diversity of terminology of integrative health care vary widely. Among researchers, the definition of *integrative health care* is under "debate, revision, and evolution."⁹ A study on the working definition for *integrative health care* by Boon et al⁹ defines it as the combination of the following: "1) an interdisciplinary, non-hierarchical blending of both CAM and conventional medicine that provides a seamless continuum

of decision-making and patient-centered care and support; 2) employs a collaborative team approach guided by consensus building, mutual respect, and a shared vision of health care that permits each practitioner and the patient to contribute their particular knowledge and skills within the context of a shared, synergistically charged plan of care; 3) seeks, through a partnership of patient and practitioners to treat the whole person, to assist the innate healing properties of each person, and to promote health and wellness as well as the prevention of disease; and 4) results in more effective and cost-effective care by synergistically combining therapies and services in a manner that exceeds the collective effect of the individual practice."^{9(p49)} Bell et al¹⁰ define *integrative health care* as "a transformative system represented by a higher-order system of systems of care that emphasizes wellness and healing of the entire person (bio-psycho-socio-spiritual dimensions) as primary goals, drawing on best both conventional and CAM approaches in the context of a supportive and effective physician-patient relationship." Whatever the definition, health care practitioners and policy makers have increasingly recognized that patients are using integrative health care to improve their wellness and treat illness.¹¹

Therefore, the definition of *IM* ranges from simply incorporating CAM into conventional medicine to the notion that integrative health care constitutes a new form of medical practice involving shared management of the patient, shared patient care, shared practice guidelines, and shared common values and goals (ie, to treat the person in a "whole-person approach" and not just the disease). What is noteworthy, however, is the lack of empirical evidence about how often this new form of medicine is found in actual practices. Others have found that professionals working in multiprofessional health care teams can differentiate between collaboration from integration. However, whole integration requires collaborations; but collaboration does not necessarily involve integration.¹²

For the second (a taxonomy of practices), there is a growing body of institutionally based attempts to create IM. But there is the problem that, as an emerging field, this type of practice is not clearly defined organizationally. There are almost as many organizational exemplars of IM as there are actual clinics. They vary in whether they are primarily medically based, nursing based, or based on CAM providers. They differ on what business model they embrace and the economic basis of the clinic (eg, fee-for-service vs insurance-based care). They also diverge in their locations from hospital based vs free-standing community clinics. Even where they are hospital-based IM institutions, they differ in whether it is a teaching hospital affiliated with a university, a not-for-profit nonteaching hospital, or a profit-driven hospital. In addition, they differ considerably in what kind of care is provided, from primary care to adjunctive therapy. Within the hospital setting, they may be in a primary

service role where they perform distinct therapeutic but limited services (eg, acupuncture for cancer patients with nausea); or they might be a distinctive form of patient management (eg, management of patients not responsive to biomedical care).

These IM clinics also range considerably by the amount of education that occurs within them, ranging from ones with formal residency programs to those with no educational component. Similarly, they vary with regard to whether they are involved in clinical research. Lastly, they differ in the principles that are used to determine both what professions are included and what practices are permitted. This ranges from those who only include evidenced-based practices to those who include either practices that “have stood the test of time” or those practices in most demand by the public. With regard to the professions, it can range from only those who have licensure to practice independently in the state to those who may not and must be under medical supervision.

Complementary and Alternative Medicine and biomedicine can be integrated at both the provider and patient levels. Provider-centric integration includes (a) incorporating CAM directly into hospital-based medical programs¹³ or by primary care practices¹⁴ or (b) allowing a limited number of CAM providers, particularly chiropractors, naturopaths, acupuncturists, and massage therapists;¹⁵ or holistic nurse practitioners including spiritual healers and touch therapists into conventional health centers. Kailin¹⁶ has noted that such attempts to bring such groups into these settings involve a “tangled web of tacit and explicit power relations.” At least one manual has been published to date on how to incorporate CAM into institutional settings.¹⁷

However, “patient-centric” integration may also be active in integrating the different paradigms. Increasing evidence about the use of CAM services¹⁸ suggests that patients develop their own personal strategies for obtaining IM¹⁹ outside of institutional integration. In one sense, CAM providers and biomedical physicians have always been connected in an informal network through their patients, even if this connection was unacknowledged. Few patients exclusively use CAM providers for their health care; and most CAM patients see a biomedical provider before or concurrent with seeking CAM care, with only a small minority seeking a CAM provider first.²⁰⁻²⁴ For example, more than 80% of chiropractic patients retained the services of a biomedical physician.²⁵ However, importantly, the majority of CAM patients do not disclose their use of CAM to biomedical providers,^{26,27} potentially increasing their risks for adverse effects such as adverse herbs-drugs interactions. The reasons patients fail to disclose CAM treatments are not fully understood. Furthermore, little is known about the consequences of such behaviors, that is, how such nondisclosure affects conventional treatment compliance. Whether use of multiple providers is in fact integrative

has yet to be established; but at some fundamental level, patients using CAM and biomedicine must use some form of integration to determine when to use either, whether to use them as supplements or complements or integratively, and for what type of health problems and health episodes they will use either or both. So at the patient level, integrating CAM with biomedicine occurs on a daily basis by the public. The majority of CAM use is consumer driven, with patients as the possible locus of health care integration.²⁸

The purpose of this article is to review the research literature for the emerging field of IM using the methods of systematic review.

METHODS

We conducted a systematic literature review using a Web-based, secure, systematic review management program called TrialStat SRS 4.0 (Copyright 2003-2009, Mobius Analytics Inc, Ottawa, Ontario, Canada). TrialStat automates article progression and management, eliminates data transcription, and reduces data collation work at the end of a review. We searched the following databases from 1965 to September 2007: PubMed, Medline, Allied and Complementary Medicine, BIOSIS Previews, EMBASE, Cochrane Library, MANTIS, SciSearch Cited Ref Sci, Social SciSearch, PsychInfo, CINAHL, and NCCAM grantee publications listings. For the initial search, gray literature was searched using ProQuest Dissertations and Theses and Google Scholar. In addition, hand searches and reference tracking were also performed; and the citation list was assessed for comprehensiveness by content experts.

An update secondary search was conducted on trials in May 2009 during manuscript development to ensure that all articles meeting the inclusion/exclusion criteria using the original search terms were included. In this article, however, we report only on the state of the field as revealed by the literature by the full review of all the categories of publication until September 2007. Although the more recent review covered the trials, it did not include the full field and so does not provide comparative data on the fields beyond September 2007.

Inclusion and Exclusion Criteria

In this systematic review, a guiding principle to the definition of integrative health care research is the study of the incorporation of CAM with biomedicine as collaborative and integral part of the health care system, that is, the integration of conventional (allopathic) medicine and CAM, involving shared management of the patient, shared patient care, shared practice guidelines, and shared common values and goals to address the whole person.

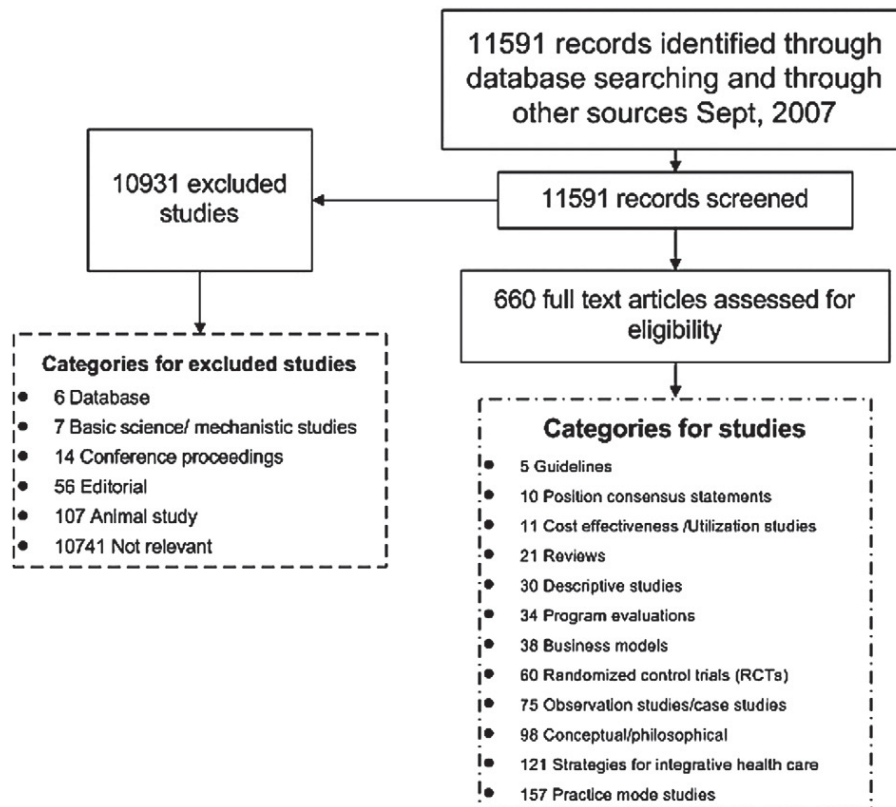


Fig 1. Flowchart for identified studies.

Our initial search terms were *Integrat* and Medicine; Integrat* and Health** (for health care); *multidisciplinary care; complementary or alternative and conventional medicine or health care; and delivery of health care and integrat**.

Articles were excluded if they (1) did not present original data or an analysis of original data (ie commentaries, editorials, or expert opinion pieces); (2) were published in other media or in incomplete formats (ie, abstracts, conference proceedings, posters, or Web postings); (3) were studies not focused on humans; (4) were herbal database and herb-drugs interactions; (5) were basic science/mechanistic studies and editorials; and (6) were studies that tested herbs and supplements. In addition, articles on integrated care pathways, integrated review, integrated managed health system (ie, electronic patient records, integrated delivery systems/networks, or health care delivery), clinical integration, integrated case management, integrated analysis, exclusively CAM without conventional medicine integration, exclusively conventional medicine without CAM integration, scholarship of integration, integration into a curriculum for education, integrating theory of conventional medicine, integrated approach to concepts, or integrating a single conventional medicine therapy to another were excluded as “not

relevant”; that is, we classified all these as irrelevant to our study (Fig 1).

We were interested in surveying the field of integrative medicine/health care that would be applicable in Western health care settings. We also excluded adjunctive therapy where CAM is used simply to supplement biomedicine as in the case of acupuncture of patients being treated with chemotherapy. We have accepted with Maizes et al²⁹ and Boon et al⁹ that combination therapy, adjunctive therapy, and complementary therapy are not IM.

RESULTS

We report here on the nature of the field as reflected in the literature. Our initial search yielded 11 591 citations (Fig 1). These were examined by 2 content experts in IM. Our objective was to identify studies that were on some form of IM. Excluded studies amounted to 10 931 articles.

We classified the articles in the following way: clinical trials, n = 60; cost-effectiveness and health care utilization, n = 11; descriptive studies, n = 30; observation studies/case studies, n = 75; conceptual/philosophical articles, n = 98; position/consensus statements, n = 10; practice models, n =

157; reviews, $n = 21$; program evaluation, $n = 34$; guidelines, $n = 5$; articles on business or practice model, $n = 38$; and articles on strategies for integration of integrative health care, $n = 121$. Figure 1 shows the distribution of the studies ranked by their frequency. The data in Figure 1 reflect that, at up until September 2007, the writings on implementing and implemented programs along with conceptual/philosophical writings dominate at the moment. These were followed by research articles. Since 2007, there has been growth in the research articles so that the number of randomized controlled trials (RCTs) by 2009 was 126. Because we have not conducted a full search of the other categories of literature from 2007 to 2009, we cannot give comparative data; so we cannot say if this has altered the rank ordering in Figure 1. Appendix A offers some article citations from our systematic review not including the 33 gray literature citations recovered during our online review process. These 33 citations are available upon request from the authors.

DISCUSSION

In many ways, the distribution of the studies reflects what one might expect of an emerging field. An emerging field has at least 3 elements that may be thought of as 3 legs of a stool. It usually begins in 2 ways: one practical and one intellectual. On the intellectual side, individuals attempt to conceptualize the field, to define it, and to lay out its philosophical foundations or principles.

On the practical side (the second element or leg), individuals go out and try to create programs. These are the builders. Here the literature tends to be more descriptive and normative and focuses on types of practice models (exemplars), strategies for integrative health care, and the business case. It is clear from Figure 1 that the practical and the conceptual/philosophical dominate the field at the moment.

The third element or leg of an emerging field is research. There is an emerging field of research in IM as evidenced by the RCTs and the program evaluations and cost-effectiveness studies. Although less developed than the other categories, 60 RCTs is a significant number for a new field. Not all of these are relevant to Western health care systems. These will be analyzed in a forthcoming publication.

In some fields, the research might precede the other 2 in that specific research projects or programs give rise to a practice paradigm and an intellectual metaphysical and theoretical paradigm. The concept of paradigms provides a useful conceptual tool for understanding how this occurs. Masterman's³⁰ account of Kuhnian paradigms identifies at least 3 types of paradigms (or meanings that Kuhn uses for paradigms): a construct paradigm, a metaphysical paradigm, and a sociological paradigm. Coulter³¹ notes that a construct paradigm may be a technical

achievement (a trick) such as a telescope or the methods for DNA analysis out of which develop all the metaphysics, philosophies, theories techniques, research, and organization that will make up the field. Palmer's account of his treatment of a deaf patient with manipulation might be considered a technical "trick" in this light. A metaphysical paradigm lays out the a priori assumptions, the conceptual field, and the philosophical underpinnings of the field. The sociological paradigm occurs when a group of scientists, scholars, and practitioners comes to identify themselves with the paradigm and construct social organizations around it such as professional societies, research conferences, etc. Several of such organizations now exist for IM, and international conferences are now being held regularly. In the case of Integrative Health Care, all of these "paradigms types" are occurring simultaneously.

In their article on the challenges of systematic reviews of CAM, Shekelle et al³² make several recommendations to improve systematic reviews of CAM. They see challenges related to the actual search of the literature including the nonuse of databases specializing in CAM, not using extensive key words, and no hand searching and mining of references. To this, we can add that the lack of clarity about the definition of IM—the fact that, in Europe, it is often referred to as *Integrated Medicine*, whereas in North America, *Integrated Medicine* has a totally different usage and can mean integration of simply medical services with no CAM involvement—and the lack of a taxonomy make searching this field very difficult. This particular study reviewed more than 11 000 references to get a yield of 660 articles. Given that all the articles were doubly reviewed, this is a very inefficient way of obtaining the references. So we have a dilemma here. If we use an extensive key word search strategy and databases specializing in CAM (ie, follow the Shekelle et al recommendation), we end up with a huge amount of wastage. If we use too narrow a word search strategy, we run the risk of missing important articles.

Limitations

This lack of clarity in terminology or definition for IM made it difficult to generate search terms for the systematic review. The search terms by necessity had to be very broad. The downside of this strategy was that the search generated 11 891 total citations. Much additional work was required, therefore, to ensure that the studies were truly focused on IM. This has resulted in a level of review that is not usual when reviewing citations for inclusion. Further limitations included the following: (1) only studies in the English language were reviewed, and (2) both peer-reviewed and non-peer-reviewed studies were reviewed. Non-peer-reviewed journals are generally considered of being lower quality.

CONCLUSIONS

Our systematic literature review on the state of Integrative Health Care has revealed that most articles focused on describing practice models and conceptual/philosophical models, whereas there are fewer RCTs and observation studies. The lack of consensus on a clear definition and taxonomy for integrative health care represents a major methodological barrier on conducting systematic literature reviews and meta-analysis in this emerging field.

Practical Applications

- The literature focuses on how to create integrative health care practices rather than on researching outcomes.
- The lack of a clear definition and taxonomy on how to operationalize integrative health care makes it very challenging to efficiently conduct systematic reviews.
- Much of the current literature deals with the conceptualization of the field and philosophical issues.
- There is an extensive body of literature that deals with practice models of IM and strategies for integration.
- At the moment, the literature reflects the fact this is an emerging field.

FUNDING SOURCES AND POTENTIAL CONFLICTS OF INTEREST

No conflict of interest was reported by the authors of this study. This work is supported by the US Army Medical Research and Materiel Command under Award No. W81XWH-07-2-0076 through the Samueli Institute. The views, opinions, and/or findings contained in this report are those of the authors and should not be construed as an official Department of the Army position, policy, or decision unless so designated by other documentation.

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APPENDIX A. INTEGRATIVE HEALTH CARE ARTICLES FOUND UP TO MAY 2009. THIS LIST INCLUDES ARTICLES FROM BOTH PEER-REVIEWED AND NON-PEER-REVIEWED SOURCES.

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