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Original article

Integrative medical practitioners and the use of evidence

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Abstract

Introduction: Increasing numbers of general medical practitioners in Australia define themselves as integrative practitioners, incorporating both allopathic and complementary and alternative medicine (CAM) in an environment where evidence-based medicine is the hallmark of best practice in medicine.
Methodology and approach: We conducted semi-structured qualitative interviews with 23 self-identified integrative medical practitioners in two states of Australia. Participants were recruited from publicly available lists of self-identified integrative medical practitioners – the local telephone listing and the website of their professional organisation. Interviews explored how doctors define and use evidence in their practice. We undertook a thematic analysis of the interview transcripts with particular exploration of the key ideas that emerged about their use of evidence.
Results: These practitioners are sceptical about the dominance of the evidence-based medicine movement, and push to reclaim their autonomy based on the indeterminancy of individual cases. They acknowledge that an understanding of clinical benefit may not be scientifically evidenced and utilise discourses of experience and safety in discussing their clinical practice.
Conclusions: Our findings provide further insights into how medical practitioners work within their own profession, their relationships with other care providers (specifically CAM practitioners), their views about their non-integrative medical peers and their resistance to prescribed ways of clinical practice.

Keywords: Integrative medicine; Complementary and alternative medicine (CAM); Sociology; Public health; Evidence; Professions

Introduction

General practice in medicine is an area of professional work that is fraught with ambiguity. Lacking the prestige of medical specialisation, dealing with the day-to-day health crises of patients, and subject to increased scrutiny by regulatory agencies, general practitioners (GPs) are often represented as working at the 'coalface' of medicine. The contemporary expectation of work at the coalface is the application of scientific knowledge to the healing of illness or the curing of disease. That the everyday reality of general practice does not accord with a scientific model of health and healing is encapsulated by May et al. [1] when they identify that a reductionist, scientific model of healing has 'poor utility' in three areas of general practice: the management of chronic illness; the diffuse symptoms that arise from the social and psychological character of the patient's world; and in preventative health care, with its focus on identifying and managing risk prior to the development of illness. As May and colleagues argue: 'A problem for medicine as a general field is what to do with the patient's subjective experience of illness, and how to connect it with medical knowledge and practice' [1].

Evidence based medicine (EBM) has arguably changed the way that scientific medicine is conceptualised. EBM provides a guide to assessment and use of evidence, with the strongest evidence found at Level 1, comprising systematic reviews and randomised controlled trials (RCTs), then cohort and case control studies at Levels 2 and 3 respectively, and lowest forms of evidence, Levels 4 and 5 obtained from case series and expert opinion [2]. While the focus on EBM suggests a unified body of knowledge, rather than a plurality of practices and contexts contributing to the construction of medical knowledge [3], the growth of evidence-based practice has not resolved differences

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between scientific evidence, subjective experience or the tacit knowledge that is seen as vital to practising the 'art of medicine' [4].

One area that has caused extensive debate about evidence is Complementary and Alternative Medicines (CAM). CAM can be defined as systems and practices, which are outside the domain of conventional medicine, used to prevent or treat illness, and/or promote health and wellbeing [5], and includes a broad spectrum of natural and complementary therapies, treatments, and modalities. While CAM has, in the past, been considered outside the conventional medical system, increasing numbers of Australian doctors believe that some CAMs are effective, some are even considered 'mainstream' [6] and as such are incorporated into clinical practice [7–9]. However, among Australian medical practitioners, the use of CAM is contested. While some argue that it is ethical to prescribe CAM if it is done so in the context of the healing relationship and where there may be an 'accumulation of knowledge' [10], others argue that the trend towards incorporating CAM into medical practice is a 'form of medicine that would be rejected by most of their peers' [11].

Thus the rise of the 'Integrative Medical' practitioner is one that deserves further attention. There are definitional debates about integrative medicine and definitions are contested [12]. The Australian Integrated Medicine Association (AIMA) [13] defines integrative medical practice as:

> medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, health care professionals and disciplines to achieve optimal health and healing.

Others [14] identify integrative medicine as incorporating a holistic approach that may include a range of practices such as diet and lifestyle advice as well as CAM modalities. This suggests that not all doctors who identify as practicing integrative medicine necessarily utilise CAM modalities [15]. Coulter et al. [16] point to the lack of empirical evidence for integrative medicine as a new form of practice. One Australian study of integrative practices pointed to the 'accessory' role that co-located CAM practitioners played alongside their medical counterparts, suggesting that within integrative medical practice the hierarchy of knowledge still favours biomedicine [17] although this may vary according to the training and experience of the medical practitioner [18].

The trend towards acceptance and/or use of CAM by medical practitioners can partially be explained by consumer pressures. In 2004, there were an estimated 1.9 million consultations with naturopaths and western herbal medicine practitioners, at a cost of AUD 85 million excluding the costs of medicines [6]. In 2010, it was claimed that two in three Australians have used CAM over the last 12 months, spending over AUD 3.5 million each year [19]. As elsewhere, Australians are increasingly using CAM as a health care option for a variety of chronic conditions, with women the primary users [20–22]. Medical practitioners have responded to these trends by adapting the services that they provide.

Sociologists have argued that incorporation of CAM into medical practice may also be a strategy to maintain occupational territory and authority over health and healing [23]. This perspective draws on traditional understandings of medicine as the dominant profession in health, and the 'medical dominance' thesis [24], thus, integrative medicine is a way of 'co-opting' CAM practices [25]. Medical practitioners are at an advantage relative to their non-medical CAM counterparts, as their consultations (even if not all the therapies they provide) are subsidised by Australian national medical insurer, Medicare. Theorists from this perspective argue that while professionalising is a constant process, with many more players seeking a stake in health care, medicine is not so much in decline as 'adaptive' to contemporary conditions [24,26]. Saks [27] argues the medical response to occupational challenges by CAM practitioners may take two forms – either incorporation of specific practices within their own repertoires of practice or maintaining dominance through delegated authority to CAM practitioners in subordinated or limited roles. Similarly, Easthope [28] argues that integration of specific practices will continue and is an adaptive strategy by medical practitioners in the face of consumer and global industry pressures.

Other writers suggest that integrative medical practice may be about boundary work within medicine. Easthope et al. [29] suggest that there is a hierarchy of accepted medical practices ranging from being deemed as 'normal practice', to formal recognition by the state, and finally, inclusion in medical curriculum. Further, they argue 'lower status practitioners are more likely than higher status practitioners to accept an 'alternative' therapy as normal practice' [29]. For GPs, identification as an 'integrative medical practitioner' may also be about the re-assertion of clinical authority [30,31], especially in the current environment where autonomy is perceived as under threat, due to a combination of government intervention and consumer demands. Adams [32] points to integrative practitioners' use of CAM as a response to the perceived constraints of evidence-based medicine. He locates his finding as one of many intra-professional debates about the work of general practice, which is viewed as both an 'art' and a science' with a reliance on the importance of intuitive decision making.

Thus the challenge is to understand what the move to 'integrative medical practice' really means – whether it is about a new way of practice or a co-option of CAM. Baer and Coulter [23] argue that the term integrative medicine requires scrutiny, as 'it has been developed largely by those to claim who practise it'. While the definition is important in terms of development of a sociological approach to this topic, it is also interesting to examine why medical practitioners choose to label themselves as 'integrative'. There has been less exploration about what it means in terms of the intraprofessional boundary work to self-define as an integrative medical practitioner in a context where the dominant mode of practice is focused on EBM.

Method

The research on which this paper is based, sought to explore the reasons why medical practitioners identify their clinical