

# OF ROGUES AND REGULATION: A REVIEW OF *THE ROLE OF COMPLEMENTARY AND ALTERNATIVE MEDICINE: ACCOMMODATING PLURALISM*

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## INTRODUCTION

Daniel Callahan, a distinguished philosopher, bioethicist, and founder of The Hastings Institute, is to be commended for his courage in editing a volume of essays entitled, *The Role of Complementary and Alternative Medicine: Accommodating Pluralism*.<sup>1</sup> The task is not easy. In putting together a book of scholarly essays about the controversial arena of complementary and alternative medical (CAM) therapies—with particular emphasis on the notion of “accommodating pluralism” in health care—the editor risks offending both adherents and objectors.

The book has received at least one critical review in the mainstream medical literature—namely, in the *Journal of the American Medical Association (JAMA)*.<sup>2</sup> As discussed below, the review arguably adheres to presuppositions and fallacies that undergird much of the perspective within parts of the conventional medical world—a perspective that, as Callahan suggests, comes prepackaged as hostile to CAM.<sup>3</sup> The review also hints that Callahan and fellow authors are advocates of CAM therapies, and therefore fatally biased.<sup>4</sup>

This essay is thus a review of a review, as well as a review of the original book. It is not, however, the author’s intent to trash a review that trashed a book, and thereby support the book, in the sense of the old adage, “my enemy’s enemy is my friend.” That kind of banter merely perpetuates the old duality, the kind of polarization that Callahan acknowledges in the first paragraph of *Accommodating Pluralism* and that he is trying to overcome.<sup>5</sup>

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1. *THE ROLE OF COMPLEMENTARY AND ALTERNATIVE MEDICINE: ACCOMMODATING PLURALISM* (Daniel Callahan ed., 2002) [hereinafter *ACCOMMODATING PLURALISM*].

2. James M. Humber, Book Review, 288 *JAMA* 1655 (2002).

3. *ACCOMMODATING PLURALISM*, *supra* note 1, at vii.

4. See *infra* Part II (discussing and critiquing Humber’s review).

5. Callahan draws attention to the “almost inexplicable” tenor of professional debate on the subject—to “the fact that a large and prestigious group of clinicians and biomedical researchers seems so utterly hostile to CAM while a large portion of the . . . educated public . . . seems so attracted to it.” *ACCOMMODATING PLURALISM*, *supra* note 1, at vii.

Rather, this essay seeks to shed some new perspectives on an emerging clash in worldviews, thus helping to break a deadlock stuck largely in epithets; the charge of "advocacy" perhaps being softer than "quackery," but, at least in the academic sphere, no less politically deadly. It is the author's hope that in the process, the reader will learn something about CAM therapies; about the debate around clinical recommendations involving these therapies; about the conflux of social, cultural, political, ideological, legal, and medical forces shaping this debate; and about some possibilities for transformations of our world perspective concerning health, illness, and healing.<sup>6</sup>

Part I of this review briefly describes the content of Callahan's book. Part II analyzes the *JAMA* critique and points out some flaws and potential distortions in that critique. Part III offers some emerging possibilities for regulatory contemplation.

### I. CALLAHAN'S CONTENT

CAM therapies refer to modalities such as acupuncture and traditional oriental medicine, herbal and nutritional care, chiropractic, massage therapy, body-oriented psychotherapy, and homeopathy, and include spirituality and prayer directed towards healing. Once defined as therapies not commonly used in U.S. hospitals or taught in U.S. medical schools,<sup>7</sup> the notion of CAM therapies has grown to describe modalities that are used as both adjuncts and complements to biomedical therapies.<sup>8</sup> A useful definition of CAM in *Accommodating Pluralism* is: "a broad domain of healing resources that encompasses all health care systems, modalities, and practices and their accompanying theories and beliefs other than those intrinsic to the politically dominant health care of a particular society or

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6. Academic discussions around the integration of CAM therapies are open to an array of hermeneutics and need not necessarily preclude advocacy of critical thinking and self-inquiry; of being as well as doing; of taking responsibility for one's actions; of doing no harm but taking professional and interpersonal risks; of friendship and of solitude; and of integrating head, heart, and soul. See generally MICHAEL H. COHEN, *BEYOND COMPLEMENTARY MEDICINE: LEGAL AND ETHICAL PERSPECTIVES ON HEALTH CARE AND HUMAN EVOLUTION* (2000); MICHAEL H. COHEN, *COMPLEMENTARY AND ALTERNATIVE MEDICINE: LEGAL BOUNDARIES AND REGULATORY PERSPECTIVES* (1998) [hereinafter *CAM: LEGAL BOUNDARIES*]; MICHAEL H. COHEN, *FUTURE MEDICINE: ETHICAL DILEMMAS, REGULATORY CHALLENGES, AND THERAPEUTIC PATHWAYS TO HEALTH CARE AND HEALING IN HUMAN TRANSFORMATION* (2003) [hereinafter *FUTURE MEDICINE*].

7. David M. Eisenberg et al., *Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use*, 328 *NEW ENG. J. MED.* 246, 246 (1993).

8. For example, in-hospital massage for stress reduction and relief from depression, or acupuncture to help relieve nausea following chemotherapy.

culture in a given historic period."<sup>9</sup> A number of CAM therapies have been shown safe and effective, whereas others have been questioned or discredited.<sup>10</sup>

In the introduction, Callahan articulates his vision for the book as "putting together a research group . . . with good critical faculties, aware of the arguments about, and objections to, CAM, but able to make their own judgments . . . take it seriously, and yet [be] quite willing to subject it to criticism."<sup>11</sup> According to Callahan, the book attempts to address four basic problems:

- [1] Is there only one acceptable method of scientific evaluation?
- [2] How tolerant should medicine be of different methodologies and standards of evaluation?
- [3] What does it mean to say that a therapy 'works' or does not 'work'?
- [4] What is a suitable research agenda for alternative and complementary medicine?<sup>12</sup>

In a sense, these are not legal, regulatory, or ethical questions but rather questions directed to the current rubric for measuring acceptance of CAM therapies. The questions challenge biomedical orthodoxy, moving beyond the notion of 'shifting paradigms' to an exploration as to whether the tools and conventions of biomedicine are sufficient to explore CAM therapies with appropriate rigor, while maintaining openness. Callahan suggests that examining the meaning of public interest in CAM therapies is "no less important" than examining efficacy; in fact, he argues, such examination transcends the current focus of the research agenda established for CAM therapies by the National Institutes of Health.<sup>13</sup>

In addition to Callahan's introduction, the book contains eleven chapters from different authors on a broad range of topics, including: methodological pluralism;<sup>14</sup> CAM and cultural diversity;<sup>15</sup> the role of

9. Loretta M. Kopelman, *The Role of Science in Assessing Conventional, Complementary, and Alternative Medicines*, in ACCOMMODATING PLURALISM, *supra* note 1, at 36, 38 (citing Bonnie O'Connor et al., *Defining and Describing Complementary and Alternative Medicine*, 3 ALTERNATIVE THERAPIES HEALTH & MED. 49, 50 (1997)).

10. See, e.g., Michael H. Cohen & David M. Eisenberg, *Potential Physician Malpractice Liability Associated with Complementary and Integrative Medical Therapies*, 136 ANNALS INTERNAL MED. 596, 597-98 (2002) (citing examples and correlating clinical scenarios with potential liability).

11. ACCOMMODATING PLURALISM, *supra* note 1, at ix.

12. *Id.* at viii.

13. *Id.* at vii-viii.

14. Kenneth F. Schaffner, *Assessments of Efficacy in Biomedicine: The Turn Toward Methodological Pluralism*, in ACCOMMODATING PLURALISM, *supra* note 1, at 1-14.

15. David J. Hufford, *CAM and Cultural Diversity: Ethics and Epistemology Converge*, in ACCOMMODATING PLURALISM, *supra* note 1, at 15-35.

science in assessing CAM therapies;<sup>16</sup> epistemological issues;<sup>17</sup> implications of the placebo effect for study and practice of CAM therapies;<sup>18</sup> the role of spirituality in clinical care;<sup>19</sup> the interpretation of results of trials;<sup>20</sup> the evaluation of global medicine;<sup>21</sup> the nature of evidence;<sup>22</sup> medical culture and CAM therapies;<sup>23</sup> and the quest for holism in medicine.<sup>24</sup>

Of these, the first chapter is one of the most striking and represents the attempt by Callahan and his colleagues to accommodate pluralism with intellectual honesty. In his material on assessments of efficacy, Kenneth Schaffner questions the "unity of method for science practitioners," and argues that there is "no common method."<sup>25</sup> Rather, according to Schaffner, developments in the philosophy of science by Thomas Kuhn and Paul Feyerabend, among others, have "lent support to what have been termed variously relativist, instrumentalist, or constructivist analyses of scientific theories."<sup>26</sup> Schaffner explains, "[r]elativists view scientific evidence as relative to an accepted paradigm. Instrumentalists view theories and hypotheses as tools, and not as purportedly true descriptions of the world. Constructivists . . . conceive of many biomedical entities . . . as being 'constructed' rather than 'discovered.'"<sup>27</sup>

Schaffner comments that while such positions are "attractive and even exciting to some," they are "distressing and outrageous to others."<sup>28</sup> Further, these positions ultimately suggest a methodological pluralism in

16. Kopelman, *supra* note 9, at 36-53.

17. Bonnie B. O'Connor, *Personal Experience, Popular Epistemology, and Complementary and Alternative Medicine Research*, in ACCOMMODATING PLURALISM, *supra* note 1, at 54-73.

18. Howard Brody, *The Placebo Effect: Implications for the Study and Practice of Complementary and Alternative Medicine*, in ACCOMMODATING PLURALISM, *supra* note 1, at 74-83.

19. David B. Larson & Susan S. Larson, *Spirituality in Clinical Care: A Brief Review of Patient Desire, Physician Response, and Research Opportunities*, in ACCOMMODATING PLURALISM, *supra* note 1, at 84-106.

20. Asbjørn Hróbjartsson & Stig Brorson, *Interpreting Results from Randomized Clinical Trials of Complementary/Alternative Interventions: The Role of Trial Quality and Pre-trial Beliefs*, in ACCOMMODATING PLURALISM, *supra* note 1, at 107-21.

21. Wayne B. Jonas, *Evidence, Ethics, and the Evaluation of Global Medicine*, in ACCOMMODATING PLURALISM, *supra* note 1, at 122-47.

22. Thomas Whitmarsh, *The Nature of Evidence in Complementary and Alternative Medicine: Ideas from Trials of Homeopathy in Chronic Headache*, in ACCOMMODATING PLURALISM, *supra* note 1, at 148-62.

23. Paul Root Wolpe, *Medical Culture and CAM Culture: Science and Ritual in the Academic Medical Center*, in ACCOMMODATING PLURALISM, *supra* note 1, at 163-71.

24. Alfred I. Tauber, *The Quest for Holism in Medicine*, in ACCOMMODATING PLURALISM, *supra* note 1, at 172-89.

25. Schaffner, *supra* note 14, at 1.

26. *Id.* at 1-2.

27. *Id.* at 2.

28. *Id.*

which science is seen as progressing by a disunity of methodologies.<sup>29</sup> On this point, Schaffner concludes:

These disunity views open up the possibility that all methodologies may be local, and that complementary and alternative medicine may be pointing toward methods that diverge legitimately from traditional science. But appeals for a common unified (at least at a general level) methodology have their strong defenders in contemporary medicine.<sup>30</sup>

After suggesting a disunity of scientific methodology and discovery, the essay goes on to discuss the various kinds of study designs typically used to answer different clinical questions. These questions include the differences between efficacy,<sup>31</sup> effectiveness,<sup>32</sup> and efficiency,<sup>33</sup> and the different types of validation questions dependent on the type of scientific evidence.<sup>34</sup> After laying this groundwork, Schaffner provocatively questions whether evidence is "*paradigm dependent*," in the sense that "standard notions of diagnostic categories, permissible measurable outcomes, and experimental design criteria represent an imperialistic 'Western' mode of thinking that obscures important health results only *evident* from a non-Western perspective."<sup>35</sup> Schaffner admits that this may be an "overly strident"<sup>36</sup> way of putting things, but goes on to suggest that "just as . . . the notion of 'evidence' become[s] more complex on analysis, the notion of [what therapy] 'works' also has some subtle nuances."<sup>37</sup>

While Schaffner proceeds to spin out different variations of understanding "what works,"<sup>38</sup> he ultimately subverts the argument for methodological pluralism and disunity by suggesting that although CAM may (and may not) have "different evidentiary standards," the "tried and

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29. *Id.*

30. *Id.* at 3.

31. Efficacy is defined as "an intervention that has been shown to be superior to placebo in randomized controlled trials." *Id.* at 4.

32. Effectiveness means "that the treatment still works when used by the average clinician with the average patient." *Id.*

33. Efficiency is defined as "the level of resources required to produce benefit." *Id.*

34. *Id.* at 3. Schaffner distinguishes several different types of evidence, which he calls: experimental, clinical practice, safety, comparative, summary, rational, demand, satisfaction, cost, and meaning. *Id.* at 5 (citing John W. Spencer, *Essential Issues in Complementary/Alternative Medicine, in COMPLEMENTARY/ALTERNATIVE MEDICINE: AN EVIDENCE-BASED APPROACH* 20 (John W. Spencer & Joseph J. Jacobs eds., 1999)).

35. Schaffner, *supra* note 14, at 5-6.

36. *Id.* at 5.

37. *Id.* at 8.

38. *Id.*

true methodologies" and the "need to have agreed-upon measures of abnormal physiology" indeed may be the best way to gather medical evidence.<sup>39</sup> Yet, despite this twist, Schaffner asserts in closing that "something *has* changed. CAM can help make us realize both that the influence of belief systems may have powerful effects on health and disease and that discerning these effects may require a relaxation of the most Procrustean standards."<sup>40</sup> The dialogue, he claims, has "only begun."<sup>41</sup>

Regardless of whether Schaffner succeeds in unseating the use of medical orthodoxy as a unified arbiter of scientific discovery and thereby the sole determinant of validity for CAM therapies,<sup>42</sup> he raises enough provocative questions to stimulate the reader's thinking about pluralism in health care. Further, he does so in a way that respects contemporary evidence-based medical standards as an important, though not exclusive, method for determining what works. Such a weaning of the reader—from certainty to questioning, from absolutism to relativism, and from the despotism of declaration to the freedom of openness—creates a corresponding increase in ambiguity around the validity and meaning of CAM therapies. It also accords with Callahan's stated purpose, and, when dispatched with sensitivity and judgment, is emblematic of much of the book.

## II. THE *JAMA* CRITIQUE

The *JAMA* review of *Accommodating Pluralism* critiques the book on the ground that the "vast majority" of chapters are nothing more than "defenses of CAM," and that each of these defenses is fallacious.<sup>43</sup> According to the review, the three-pronged defenses of CAM are: "they attempt to discredit critics of CAM, offer support for the view that CAM has worth and should be used to rectify some of mainstream medicine's shortcomings, and construct a very general, nonmedical justification for the study and/or practice of CAM."<sup>44</sup>

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39. *Id.* at 12.

40. *Id.*

41. *Id.*

42. See, e.g., Marcia Angell & Jerome P. Kassirer, *Alternative Medicine: The Risks of Untested and Unregulated Remedies*, 339 *NEW ENG. J. MED.* 839, 839-40 (1998).

Alternative medicine also distinguishes itself by an ideology that largely ignores biologic mechanisms, often disparages modern science, and relies on what are purported to be ancient practices and natural remedies. . . . [W]ith the increased interest in alternative medicine, we see a reversion to irrational approaches to medical practice . . . .

*Id.*

43. Humber, *supra* note 2, at 1655.

44. *Id.*

There are multiple flaws in the argument. First, this critique, while pointed, is not necessarily a valid characterization of the book. As Callahan notes in his introduction, the book's major aim is to move beyond the rhetoric of hostility and find contributors that are sympathetic, yet have sufficient intellectual distance to offer perspectives that go beyond rhetoric. Using Schaffner's chapter as an example, the objective is not to discredit critics, but to welcome them, yet question methodological orthodoxy by asserting the plausibility of methodological pluralism. As another example, in the chapter on "Evidence, Ethics, and the Evaluation of Global Medicine," Wayne Jonas "outline[s] a model for research strategies that attempts to be true to the core scientific advances of the past century and yet allows for a more balanced role for research methods often considered secondary to experimental approaches."<sup>45</sup> In similar fashion, Loretta Kopelman, in her chapter, "The Role of Science in Assessing Conventional, Complementary, and Alternative Medicines," argues that "[e]ven if we agree that science should play an essential role in testing conventional medicine and CAM, its role is limited."<sup>46</sup> Yet, "[d]espite such limitations, science has an essential role to play in all frames of reference that make causal claims about how to promote health or avoid illnesses."<sup>47</sup>

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45. Jonas, *supra* note 21, at 123. Jonas argues that while biomedicine "succeeds dramatically in many areas, such as the control of acute and infectious disease, it also fails in others, such as the management of chronic conditions with complex etiologies." *Id.* at 122. He notes that randomized controlled trials are more likely to succeed "when a disease occurs over a short period of time and involves single domains so that multiple confounding factors have little time to influence the outcome." *Id.* at 126. He calls, however, for a "more explicit 'balance' in research and evaluation strategies between the criteria of internal validity (focused on identifying causal links) and external validity (focused on clarifying impact and utility)." *Id.* at 127. Jonas argues for less reliance on causal models that "look for specific treatments (the magic bullet)," and greater reliance on probabilistic models (that "look for wide and general medical effects") and acausal models (that "look for methods of altering these associations—often by creating new meanings (causal links) that are not dependent on classical time and space relationships"). *Id.* at 131. Core research methods in his model would include a balance of: (1) qualitative research; (2) laboratory and basic science approaches; (3) observational studies; (4) randomized controlled trials; (5) methods for assessing the accuracy of the above methods, such as meta-analyses and systematic reviews; and (6) health services research. *Id.* at 135–36.

46. Kopelman, *supra* note 9, at 47. Kopelman goes on to state that within such frames, "scientific assessments of CAM may even be regarded as incomplete, biased, or irrelevant." *Id.* As an example, she cites "[h]ealing rituals within certain religious or spiritual frameworks," which do not rely on the kind of causal explanations used in scientific inquiry. *Id.*

47. *Id.* at 48. She concludes:

Although limited, science has a genuine and important role in assessing . . . CAM by the same or best available methods. Scientific explanations may have a different force in some framework when their goals, values, and presuppositions differ, yet science will at least have an important role in evaluating certain claims, such as in settling disputes over the value of some interventions to fulfill certain goals of health or avoidance of disease.

*Id.* at 49.

Second, it is questionable to dismiss the inclusion of, and insights from, disciplines such as philosophy, anthropology/ethnography, behavioral science and psychiatry, and sociology as "a very general, nonmedical justification for the study and/or practice of CAM."<sup>48</sup> Indeed, the subtitle of the book—*Accommodating Pluralism*—suggests that the phenomenon of CAM therapies is to be viewed through multiple lenses, not simply through the lens of biomedical or other orthodoxy.

Interestingly, the second sentence of the review observes that "[e]ight contributors hold the MD degree, six do not."<sup>49</sup> One may wonder why this observation should deserve such prominence.<sup>50</sup> Although certain practices within the medical community hostile to CAM providers have faded into history—for example, labeling CAM providers as cult practitioners;<sup>51</sup> using the ethical code of physicians to forbid consultations with such providers;<sup>52</sup> and anticompetitive practices such as those exposed in *Wilk v. American Medical Association*<sup>53</sup>—this contemporary review still takes pain to distinguish how many chapters about CAM therapies have been written by providers *other than* medical doctors. It is precisely because of the reduction of broad, cultural notions of healing to biomedical diagnosis and treatment, and the regulatory hegemony of medical authority in the late-nineteenth and twentieth centuries over social definitions of illness and health, that multiple scholarly lenses are both useful and necessary.<sup>54</sup>

Third, although the review is critical of the book's interpretations and analyses of controlled clinical trials, the reviewer steps into dubious interpretation and analysis, offering that consumers use CAM "because it holds out promise of easy cure or because of advertising."<sup>55</sup> The reviewer, dispensing with methodological rigor to prove a point, cites as evidence for this hypothesis his own convenience sample of advertising "in a single day on cable TV and a radio station that targeted a 'mature' audience."<sup>56</sup> In so

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48. Humber, *supra* note 2, at 1655.

49. *Id.*

50. Interestingly, the reviewer is listed as holding a PhD., but not an M.D. degree. *Id.* at 1656.

51. See generally CAM: LEGAL BOUNDARIES, *supra* note 6, at 20-21 (citing the American Medical Association's past characterizations of CAM practitioners as cultists).

52. See *id.* (citing the American Medical Association's early admonishment that "[a]ll voluntarily associated activities with cultists are unethical").

53. *Wilk v. Am. Med. Ass'n*, 895 F.2d 352, 364 (7th Cir. 1990) (finding that "the AMA participated in a nationwide boycott and conspiracy designed to contain and eliminate a profession that was licensed in all fifty states," namely, chiropractic).

54. See generally CAM: LEGAL BOUNDARIES, *supra* note 6, at 21, 133-34 n.34 (discussing the benefits and burdens of medical innovation (citing Eric J. Cassell, *The Sorcerer's Broom: Medicine's Rampant Technology*, 23 HASTINGS CENTER REP. 33 (Nov. 1993)).

55. Humber, *supra* note 2, at 1655.

56. *Id.*

lending personal testimony to this hypothesis, the reviewer overlooks or perhaps neglects law relevant to deception and fraudulent claims<sup>57</sup> and law relevant to false claims in advertising.<sup>58</sup> The reviewer also violates the scientific maxim that the plural of anecdote is not evidence; or, at least, sets up a double standard—Why are consumers' experiences over many events to be disbelieved and discounted, but the reviewer's experiences in a single day to be counted and trusted?

Fourth, the reviewer simply concludes that the book's justifications for CAM therapies such as "cultural diversity, pluralism, folk beliefs and psychology, spiritual values, and the instability of communal standards for objectivity"<sup>59</sup> are "all logically and causally irrelevant to establishing the efficacy of any medical treatment."<sup>60</sup> But, neither Callahan nor his contributors push any of these notions as ways to establish medical efficacy. Rather, the editor and authors amplify policy discussions with considerations *other than* conventional notions of medical efficacy. In other words, the book both questions monolithic notions of efficacy, effectiveness, and efficiency, and also addresses other policy considerations that might bear on patient access to a variety of therapies.

For example, the chapter written by Jonas suggests using research strategies that also respect the information preferences of audiences other than scientists and clinical researchers, including preferences of patients, practitioners, and policymakers.<sup>61</sup> Jonas calls these new research strategies a "balanced pluralism."<sup>62</sup> He does not repudiate existing strategies or the need to find accurate ways to measure medical efficacy. The point is simply that other values, perspectives, and considerations might bear on the debate as to the appropriateness of including CAM therapies in health care.

Finally, the reviewer argues that "it would be a waste of resources to spend . . . research funds on study of CAM therapies," since "my reading of the text under review convinces me that advocates of CAM would simply" dismiss negative study results by claiming that conventional study methods "cannot properly be used to test CAM."<sup>63</sup> Again, the reviewer's empirical methods lend themselves to question; objectivity is negated by concluding,

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57. See, e.g., CAM: LEGAL BOUNDARIES, *supra* note 6, at 107–08 (discussing the possibility of fraudulent tort claims involving provisions of CAM therapies).

58. See, e.g., Federal Trade Commission Act, 15 U.S.C. §§ 52, 55 (2000) (prohibiting false advertisements for food, drugs, devices, services, or cosmetics).

59. Humber, *supra* note 2, at 1655.

60. *Id.* at 1655–56.

61. Jonas, *supra* note 21, at 132–33.

62. *Id.* at 140.

63. Humber, *supra* note 2, at 1656.

based on a subjective read of Callahan's book, that the authors are "advocates of CAM" who would ignore scientific evidence.

For instance, as suggested by the above summary of Schaffner's chapter, the charge in this case is untrue. Schaffner honors the "tried and true methodologies," but simply urges a greater skepticism toward their results and a concurrent openness toward factoring in the power of cultural belief systems.<sup>64</sup> Even more disturbing, though, is the reviewer's charge of advocacy.<sup>65</sup> The term implies more than criticism of substance; it functions as a label. More than a critique of methods and conclusions, the label of advocacy leads to a conclusion of bias, which can be the death of one's reputation for conducting objective, scholarly inquiry. And to a scholar of medicine, healthcare policy, and bioethics, advocacy can become a particularly virulent label. Although the term serves as a laudable trait of those involved in attempts to enhance social welfare and justice, in the arena of medical research and policy, advocacy denotes a narrow-minded, pushy, pusillanimous purveyor of dogma, who is intolerant of others' positions and blind to facts and evidence-based realities. An advocate, the reviewer cautions, ignores and defies the results of scientifically valid experiments.<sup>66</sup>

Having affixed a negative label to the book's contribution and therein its intellectual integrity, the reviewer then concludes that it may be "virtually impossible" to be both sympathetic to CAM therapies yet able to objectively evaluate them.<sup>67</sup> Indeed, to be sympathetic is to invoke subjectivity; yet this invokes criticism, as if scholarly inquiry necessarily emerges free from personal resonance or emotional investment in the material. Would the Muse were so pure, and neutrality so assured. One could argue or opine that the rhetoric of the review, while far from historical references to cultists and *Wilk*,<sup>68</sup> still resonates with the legacy of antagonisms, rivalries, and mutual slanders out of which the fraternal twins of conventional and alternative medicine emerged.<sup>69</sup>

The review is far more generous in its concluding lines, which suggest an alternative, possible world of "caveat emptor." In this alternative world, absent significant harm (reportable by law to a government agency), consumers can access CAM therapies at will, provided they are informed in writing that the therapy has no government-recognized evidence of

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64. Schaffner, *supra* note 14, at 12.

65. Humber, *supra* note 2, at 1655-56.

66. *Id.* at 1656.

67. *Id.*

68. *Wilk*, 895 F.2d at 364.

69. For historical background, see CAM: LEGAL BOUNDARIES, *supra* note 6, at 17-21 (discussing historical attitudes towards several CAM modalities).

effectiveness, and that the treatment might produce harm.<sup>70</sup> This position could be criticized, however, as representing abandonment of evidence-based medical decisionmaking in favor of deference to consumer autonomy and choice, a kind of black-and-white thinking that does not represent the approach of "balanced pluralism" that Jonas has urged.<sup>71</sup>

### III. SOME EMERGING POSSIBILITIES

As noted, *Accommodating Pluralism* offers a counterpoint to the historic rhetoric and rivalries between biomedical and CAM practitioners, and infuses the debate with perspectives from disciplines such as philosophy, sociology, and anthropology. In so doing, the book makes a significant contribution to the literature. It substitutes creative thinking for old, hard-fought dogmas on both sides, and recharges a consideration of the potential boundaries of future health care with the replenishing viewpoints of disciplines in the humanities. Such a daring attempt is bound to raise the specter of advocacy and yet to release new potentialities in the marriage of clinical decisionmaking and the making of public policy.

Arguably, both medical and regulatory perspectives on CAM therapies will benefit from such a fresh look—a *meta-analysis* in a true sense—of the way in which medicine and public policy have viewed the debate to date. Biomedicine emerged the victor out of the sectarian rivalries of the late-nineteenth century with developments including: the elimination of homeopaths as the major competitors to the "regular" physicians; the rise of faith in the power of scientific discovery; the growing power of the American Medical Association as the most powerful voice in U.S. medicine; and the issuance by the Carnegie Foundation for the Advancement in Teaching of the *Flexner Report*, which advocated denying philanthropic funds to homeopathic and other medical schools outside a growing biomedical orthodoxy.<sup>72</sup> Medical licensing laws helped enforce biomedical dominance,<sup>73</sup> as did cases broadly interpreting the statutory proscription in different states against the unlicensed "practice of medicine."<sup>74</sup> In large part, since the late-nineteenth century, the legal

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70. Humber, *supra* note 2, at 1656.

71. Jonas, *supra* note 21, at 140.

72. See generally CAM: LEGAL BOUNDARIES, *supra* note 6, at 17–20 (summarizing the developments leading to today's attitude of biomedical dominance).

73. See *id.* at 26–31 (discussing the role of medical licensing laws in marginalizing CAM practitioners).

74. See *id.* at 29–31 (outlining precedent-setting cases that interpreted state medical practice statutes to proscribe therapies facilitated by CAM practitioners).

paradigm has mirrored "biomedicine's historical view of holistic practice as deviant, suspect, or 'on the fringe.'"<sup>75</sup>

In similar fashion, ethical analysis of CAM therapies has reflected biomedical dominance, and continues to echo stale notions of conventional methods versus CAM—the black-and-white, either/or, dualistic approach by which one system typically judges the other. Such analysis

often rests on and builds in the assumptions, premises, and judgments of biomedicine. These include, for example, the following: an inherent skepticism or antipathy toward therapies outside the paradigm of biomedicine . . . ; the assumption that prevailing scientific models are the ultimate arbiter of evidence relating to health; the notion that regulation of complementary and alternative medical providers by and large is nonexistent or is less rigorous than regulation of comparable allied health professionals . . . ; the reliance on the material and physically demonstrable and the concomitant decision to decline to integrate the nonphysical . . . ; and the tendency, criticized even within biomedicine, to view medical events in isolation from sociological, psychological, and religious ones.<sup>76</sup>

One way to move past these limitations would be to regard CAM policy (and related ethical problem-solving) as occupying a potential range of regulatory values, of which interest in controlling deviance by preventing fraud is only a first rung. Policy goals "[i]n addition to (1) fraud control," would include: "(2) quality assurance, (3) health care freedom, (4) functional integration, and (5) human transformation."<sup>77</sup>

Briefly, in this scheme, "fraud control" refers to "preventing dangerous and deceptive practices by complementary and alternative medical practitioners or physicians and allied health providers delivering complementary and alternative medical modalities."<sup>78</sup> "Quality assurance" means "promoting professional standards so that products and therapies are relatively safe for public use and consumption."<sup>79</sup> "Health care freedom" refers to "safeguarding the flow of information so that consumers can feel they belong to a system in which they are allowed to make intelligent,

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75. *Id.* at 23.

76. FUTURE MEDICINE, *supra* note 6, at 19; see also Karen E. Adams et al., *Ethical Considerations of Complementary and Alternative Medical Therapies in Conventional Medical Settings*, 137 ANNALS INTERNAL MED. 660 (2002).

77. FUTURE MEDICINE, *supra* note 6, at 86.

78. *Id.*

79. *Id.* at 87.

autonomous health care choices."<sup>80</sup> "Functional integration" means "advancing the safe, effective and appropriate clinical integration of all world systems of knowledge about healing."<sup>81</sup> "Human transformation . . . involves promoting healing of mind-body-spirit, igniting individuation, advancing human wholeness, and moving toward individual and collective enlightenment on the scale of planetary evolution."<sup>82</sup>

Such a hierarchy of regulatory values is analogized to the hierarchy of human needs hypothesized by psychologist Abraham Maslow.<sup>83</sup> Each regulatory need or value is important; yet each succeeding value can only emerge into the foreground once the preceding ones have been fulfilled.<sup>84</sup> Further, each regulatory value can be viewed as corresponding to one of the basic, human needs identified by Maslow, with fraud control representing Maslow's "physiological needs," and transformation corresponding to Maslow's notion of "self-actualization."<sup>85</sup>

According to Maslow, a healthy society is one in which human beings are able to satisfy all five sets of needs; by analogy, health care regulation facilitates a healthy society when it incorporates the full range of values. On the other hand, focusing entirely on fraud control skews regulation and delivery of health care services in a way that protects biomedical dominance and prevents innovation:

That [CAM] regulation to date has focused on the neurotic, the sick, and the despotic, rather than on the positive potential for human transformation, reflects, in Maslow's terms, the psychological predisposition and collective consciousness of those creating the regulatory structure. . . .

As intellectual hostilities soften, a healthier, more positive dialogue may emerge . . . .<sup>86</sup>

Such a positive dialogue between regulators, providers, and philosophers of biomedicine and CAM therapies may lead to a contemplation of the extent to which the process of seeking health—a word that is etymologically related to wholeness and holiness—involves a search for transcendence and growth. This search extends beyond the cure of the body, whether the tools

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80. *Id.* at 87–88.

81. *Id.* at 89.

82. *Id.* at 91.

83. *See id.* at 93–95 (analogizing Maslow's work to the emergence of CAM therapies).

84. *Id.* at 96–97.

85. *Id.* at 96–98.

86. *Id.* at 98–99.

used are biomedical or CAM therapies, and whether the provider is a physician, allied health professional, or CAM professional.

The acknowledgment and search for transcendence alongside fraud control would transform the delivery of health care. Ultimately, the patient's spiritual quest and journey—with all its nonscientific subjectivity, individuality, and lack of amenability to the certainty and precision of conventional methodologies—would become a critical and valued part of every discussion of clinical practice and policy. The psycho-spiritual health and growth of those administering and regulating delivery of health care services would also become part of this discussion. In such a world, a focus on medical efficacy and quality assurance would be part of the picture; while disciplines such as psychology, sociology, anthropology, and the rest of the humanities would certainly be needed to enrich the conversation. Entirely new frontiers of bioethics might yield groundbreaking insights when opened to worldviews of selected CAM therapies.<sup>87</sup>

#### CONCLUSION

The phenomenon of increasing consumer demand for, and provider interest in, CAM therapies has split healthcare policymakers into adherents and critics, deepening the historical divide between biomedical and CAM. The demand, arguably, has deepened the duality experienced by the patient interested in pursuing wholeness at all levels, as well as physical cure. *Accommodating Pluralism* offers one attempt to help resolve that split, adding valued perspectives from the humanities to the scientific debate. In so doing, the book naturally draws critique for, among other things, attempting the impossible.

It may be, however, that the dialogue is just beginning, and that even the question is not well understood. What is impossible is fashioning practice and policy without being willing to enrich current methods with new models of inquiry. One effort to broaden and deepen the dialogue involves examining the potential range of regulatory activity, focusing on how this might reflect not only health, but consciousness itself.

To this end, an analogy has been drawn between regulatory focus and the hierarchy of basic human needs articulated by Abraham Maslow. The summit of each remains largely unexplored. Maslow defined "self-actualization" as the summit of human experience, a state characterized by "ego-transcendence and obliteration, of leaving behind self-consciousness

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87. See *id.* at 251–76 ("Beyond Living and Dying"), 277–303 ("Reproductive Technologies and Spiritual Technologies"); see also Clyde Jensen, *A Spectrum of Healing in Future Medicine*, HEALTH AFF., May–June, 2002, at 245 (reviewing FUTURE MEDICINE, *supra* note 6).

and . . . of fusion with the world and identification with it.”<sup>88</sup> Whether the possibility of achieving such states has anything to do with health care policy doubtless will be contested among policymakers as well as providers.<sup>89</sup> Nonetheless, the convergence of CAM and biomedical therapies augurs new possible futures. A major challenge is to leave behind the world of constriction, of limiting beliefs, even while remaining appropriately grounded in present methods and values.

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88. ABRAHAM MASLOW, *TOWARD A PSYCHOLOGY OF BEING* 114 (2d ed. 1968).

89. “The goal of empowering transformation is likely to challenge a regulatory system premised on biomedical notions of health and disease and the marginal role assigned to both the individual’s emotional life and spiritual consciousness.” *FUTURE MEDICINE*, *supra* note 6, at 113.

