

COMMUNICATING WITH THE PUBLIC ABOUT INTEGRATIVE MEDICINE

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The responsibility for the content of this paper rests with the authors and does not necessarily represent the views or endorsement of the Institute of Medicine or its committees and convening bodies. The paper is one of several commissioned by the Institute of Medicine. Reflective of the varied range of issues and interpretations related to integrative medicine, the papers developed represent a broad range of perspectives.

ABSTRACT *Communication with the public is a critical component of integrative medicine reaching its full potential and impact. This paper provides context for the significance of this issue. Specifically, discussions include public views of current medical practice, use of integrative medicine including attention to racial and ethnic matters, public views of taking more responsibility and partnering with care providers, and public communications strategies for integrative medicine. The paper explores the roles that health and wellness stakeholders can play in building an improved communications infrastructure and process among them, including physicians, other health care professionals, integrative medicine practitioners, academic institutions, and health care consumers. Several recommendations are provided that highlight opportunities for enhanced public communications, in areas including health information surveys, health services research, professional education and training, provider collaboration, and media relations. The authors argue that the success of a campaign designed to educate consumers and providers on the benefits of integrative medicine is contingent on a standardized definition, a commitment to overcome historical barriers to collaboration among providers, and a respective review of what has already been done to forge consensus for communications among industry stakeholders. Once this phase of the process has been completed, specific pathway opportunities for enhanced communications can effectively be leveraged.*

INTRODUCTION

The potential for changing individual and organizational attitudes and beliefs lies exclusively in the ability to emotionally, economically, and effectively convince those whose change is needed the most. In the field of health care, the potential for integrative medicine to change attitudes about the meaning, delivery, and outcomes of health and illness is significant, and the stakeholders who collectively must drive such a campaign to change extends far beyond the individual patient voice. While the integrative medicine industry's growth over the past decade suggests that some of these efforts have taken root, there remain some challenges that must be overcome for the promise of integrative medicine and its impact on public health to be communicated and fully realized.

A major challenge is the need to establish a core definition of integrative medicine. Over the past decade, national retreats, summits, and roundtables have taken on the task of defining integrative medicine, and what its role in health care education, research, and delivery should be. Despite the collective enthusiasm for establishing a benchmark definition, there are many different—and in some cases, competing—definitions. While one organization defines the approach simply as a combination of conventional and alternative medicine treatments (NCCAM, 2008), there are others that refrain from using the terms “alternative” and “complementary,” perhaps in recognition of the turf issues among professions that these processes have historically raised. Only through a standardized and unified definition can public communications strategies for integrative medicine be realized, and informed decision-making among health care consumers be maximized. To that end, a working definition of integrative medicine is useful. An appropriate baseline is from the Consortium of Academic Health Centers for Integrative Medicine, which states that integrative medicine is “the practice of 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, healthcare professionals, and disciplines to achieve optimal health and healing” (CAHCIM, 2008).

PUBLIC VIEWS OF CURRENT MEDICAL PRACTICE

One need not delve too far into public opinion research to find evidence of deep and widespread dissatisfaction with the American health care system (Jacobs, 2008). Beyond issues of funding and organization, people fault the hurried, uncoordinated, and impersonal delivery of health care in the U.S. (How et al., 2008). That said, dissatisfaction with individual health care professionals is relatively low, indicating a more generalized complaint. There is considerable consis-

tency in research on patient dissatisfaction. Briefly put, patients want better communication with providers about their conditions and their care options. Surprisingly, perhaps, patients prioritize communication and the time required for it higher than providers' technical skills (Otani et al., 2005). Medical schools now include training in physician-patient communication, but this improvement alone focuses more on style than substance. Patients also want options not directly provided by conventional medicine. These systemic shortcomings in the American health care system arise for patients who are and are not being helped by conventional medicine; they pertain to both treatment and care. Insofar as integrative care coordinates a variety of services with a focus on the patient, it addresses these issues.

Recently, providers have begun to pay more attention to patients' views of current medical practices. Their concern stems not only from the importance of consumerism in American health care; it also signals recognition that patient satisfaction impacts health outcomes. A number of organizations have mobilized to produce guidelines advising health care providers on quality improvement measures. They commonly include such items as patient centeredness, assessment of and compliance with patients' desires regarding involvement in decision-making, whole-person orientation, provider collaboration, teamwork that includes nurses, and managed care (Bagley, 2005; Shih et al., 2008). All of these items are components of integrative medicine. However, few if any of the guidelines explicitly recognize the valuable role that integrative medicine could have on health care—despite a major report by the Institute of Medicine (IOM, 2005). There is need for increasing awareness about the role of integrative medicine amongst health professionals, particularly the physician community.

Integrative medicine is entering a new phase of legitimacy with a more solid footing as a partner with and extension of conventional medicine, and providing additional therapies and services that meet the whole person needs of patients. Its transformation has been facilitated by the significant finding that people are using complementary or integrative medical therapies not as alternatives to conventional medicine, but as adjuncts. Moreover, while earlier studies found that patients themselves were primary agents in coordinating various dimensions of their health care, recent studies indicate growing involvement by physicians in encouraging patients' active participation in integrative care programs. This new posture on the part of some members of the medical profession is a positive sign, as research shows that concordance in patient and physician values contributes more positively than the value itself to better health outcomes (Cvengros et al., 2007).

USE OF INTEGRATIVE MEDICINE

Overall use of integrative medicine appears to be increasing, especially among persons with chronic illnesses. However, too few studies of integrative medicine per se exist to establish the point. Accordingly, in the sections that follow, we turn to the most recent comprehensive survey of complementary and alternative medicine (CAM) use conducted in 2002 as a supplement to the annual National Health Interview Survey (NHIS), created in collaboration with the National Center for Health Statistics and the National Center for Complementary and Alternative Medicine. Using a closed list of “alternative health” therapies and questions about use, face-to-face interviews were conducted in several languages. They found that nearly 50 percent of the 31,044 adults in the survey had used any of the therapies, excluding prayer for health (Barnes et al., 2004).

We use the term CAM when referring to studies specifically on “complementary and alternative medicine” and not on integrative medicine. The NHIS found growing CAM use; in addition, responses to a closed-ended question on reasons for using CAM indicated widespread interest in CAM and strong patient expectations of improved health when CAM is used alongside conventional medicine. Numerous smaller-scale studies (cited below), focusing on specific categories of persons and specific medical conditions, confirm these general findings. We can infer from this research that patients are similarly predisposed toward integrative medicine.

Less clear is why people are turning to integrative medicine, because the reasons seem to be many and varied. Some are as simple as needing help in weathering the ravages that accompany certain treatments in modern medicine (e.g., cancer treatment) or in coping with their conditions (e.g., chronic pain); others are more complex and involve personal values and beliefs. Accordingly, it is difficult to be specific about the extent to which patients turn to integrative medicine as a result of perceived shortcomings in conventional medicine. Studies to date suggest patients are seeking a more compassionate and holistic approach to health and healing than they find in conventional medicine. But many patients continue to separate CAM and conventional medicine by not informing their physicians about their use of CAM, indicating that they sense some barriers in the acceptance of CAM by conventional providers. To the extent that this occurs, it is not integrative medicine because CAM and conventional medicine exist as separate realms of meaning and action and not a coordinated continuum of care to best meet patient needs.

Several issues require more comprehensive and nuanced research. Studies to date currently lack elaboration of the circumstances under which and exactly how the integration of CAM and conventional medicine is occurring to improve patient care. Above all, we need to better understand the working relations among

the various professionals involved in patient care and between professionals and patients. Hollenberg (2006), in his exploration of how biomedical and CAM practitioners are working together in the context of integrative medicine settings, found that biomedical practitioners are exclusionary and used closures strategies, thus dominating the practice setting (Hollenberg, 2006). Specifically, physicians were allowed to make referrals to CAM practitioners but not vice versa; CAM practitioners were not allowed to directly document in the patients' medical records and were restricted in access and rights to biomedical diagnostic testing, and conventional biomedical language and terminology dominated patient rounds and provider interactions. In this way, care cannot be considered truly integrative.

Most surveys find that whites use CAM more than racial/ethnic minorities. Because minorities tend to be underrepresented in surveys, the 2002 NHIS oversampled blacks and Hispanics and included more therapies than previous surveys. For example, studies based on the NHIS data confirm the general finding of less overall CAM use by minorities when prayer is excluded (Graham et al., 2005). When prayer is included, a full two-thirds of African American respondents to the 2002 NHIS say they use CAM (Brown et al., 2007). This finding is highly consistent across surveys. The use of CAM by minorities is far from straightforward, however. A closer look at older adults in the NHIS survey found higher use among Asians and Hispanics and, for most therapies, similar use among black and white elders (Arcury et al., 2006). Also, a different survey, focusing on women, who use CAM more than men, showed race and ethnic variation in the use of specific therapies and in reasons for using CAM. For instance, despite overall higher use of CAM by white women, Mexican American women use medicinal herbs, teas, and "other alternative therapies" somewhat more than other groups, and Chinese American women use acupuncture significantly more (Kronenberg et al., 2006). As for motives, white women are more likely to cite personal beliefs as a reason for using CAM, while African American and Mexican American women express dissatisfaction with conventional medicine, meaning, in this case, that conventional medicine did not work or had negative side effects (Chao et al., 2006). Because the questions in these various surveys tend to be closed-ended, they may not be fully capturing either the use of nonallopathic therapies or the relationship between conventional and nonconventional medicine among minorities. It is highly possible that certain groups are engaging in practices that do not readily conform to the terms used in surveys. Even if, for instance, "folk medicine" is listed, respondents may not consider their health and healing practice as an example. We simply know little about integrative medicine and the health care experiences of minorities.

Surveys also find that higher socioeconomic status groups use CAM more than their less advantaged counterparts, both overall and within demographic sub-

groups. This finding speaks in part to the cost of CAM; it is generally either not covered by most health insurance plans or minimally covered. When CAM is covered, its use increases, which is one reason why insurance companies prefer not to expand coverage. The few studies that address cost demonstrate that greater use of CAM need not lead to higher overall expenditures; to the contrary, it can reduce conventional medical costs (Lind et al., 2007). There is no published research on insurance coverage for and cost effectiveness of integrative medicine. Furthermore, studies find that because certain CAM therapies are less expensive than conventional medicine, the uninsured, among whom Hispanics have the highest rate use these therapies instead of visiting a physician (Chao et al., 2006; Graham et al., 2005). We need more investigation of the economic dimensions of health-seeking behaviors in relation to integrative medicine.

Finally, many surveys find that better educated people use CAM more than less educated people. It is dubious whether overall level of education attainment can be disentangled from SES; however, Chao and Wade (2008) found that, controlling for income, education alone had a gradient effect on CAM use for Mexican American and white women (Chao and Wade, 2008). Were education attainment a distinct independent variable, this finding might indicate that lack of knowledge about integrative medicine is a hindrance to its use. However, racial/ethnic minorities, especially Mexican Americans, who are less likely to have a high school education compared to whites, tend to receive information about CAM from family and friends (Chao et al., 2006). A significant proportion of African American women have also read or heard about CAM in the media. Arguably, if we know patients' levels of educational attainment, we can infer their sources of and access to information, but not necessarily their attitudes toward integrative and conventional medicine. Moreover, it is not at all clear and there is no reason to assume that formal education is related to agency, including personal capacity to seek resources for health and healing.

We suspect that were comparable research conducted on integrative medicine instead of CAM, similar findings would emerge. Beyond survey findings, however, there are other issues that research on the use of integrative medicine should address, especially as they pertain to racial/ethnic minorities and people with lower socioeconomic status and education. A general theme that is emerging in the literature on patient-physician relations is that patients' perceptions of personal similarity with physicians, especially in beliefs and values, and physicians' patient-centered communication build trust on the part of minority patients and respect on the part of physicians (Street et al., 2008). Differences in race, ethnicity, sex, and age are immutable, but those pertaining to beliefs and values can and must be better understood by health care providers.

PUBLIC VIEWS OF TAKING MORE RESPONSIBILITY AND PARTNERING WITH CARE PROVIDERS

Increasingly, people are taking charge of their health and the care they receive (Wall Street Journal On-line/Harris Interactive, 2008) despite some controversy associated with this issue, particularly as it relates to health insurance (Steinbrook, 2006; Wall Street Journal Online/Harris Interactive, 2003). While many patients are strongly influenced by their health care practitioner's recommendations and some even prefer to have practitioners choose their treatments, others prefer to take a more active role in their health behaviors and therapeutic decision making process (Gurmankin et al., 2002; McKinstry, 2000). Inherent in this notion of taking responsibility for one's health is engaging in an active, wellness-oriented lifestyle including physical exercise, balanced and wholesome nutrition, stress management, and preventative care, which are at the core of integrative medicine.

Individuals who seek and use integrative medicine practices are generally self-directed and actively obtain information from different sources before choosing their health care options (Caspi et al., 2004). Such persons embrace a holistic perspective of health and recognize that lifestyle and nutrition play significant roles (McCaffery et al., 2007). Additionally, desire for control over one's health and treatment decisions is a trait common to those who use integrative practices, which is less prevalent among those who follow only a conventional medicine path (Montbriand, 1993; Ono et al., 2008).

In the process of actively exploring therapeutic options, considerable time may be spent researching and integrating the best available evidence from scientific studies, professional input from practitioners, and the lived experiences of self and others. Personal values and severity of illness and symptoms also weigh into patient treatment decisions, ultimately choosing what is right and best for oneself (Verhoef and White, 2002). Ideally, patients are not alone in this decision-making process, but rather have the opportunity to partner with knowledgeable and receptive practitioners to make informed health care choices consistent with individual values. However, oftentimes that is not the case.

Persons who are considering or are regularly using integrative health practices favor open dialogue about the range of therapies with their care team. They want guidance and time to be listened to and to engage in a process of shared decision making (McCaffery et al., 2007). However, patients and practitioners alike are overwhelmed by the volume and complexity of information from myriad sources with varying degrees of evidence, ranging from anecdotes to randomized studies. Knowledge and time deficits create the greatest challenges to engage in meaningful conversation about treatment options. Health decision aids have potential to foster communication and facilitate the collaborative decision making process.

Patients also seek guidance in identifying what integrative therapies are regulated, finding credentialed practitioners and reputable clinics in their community, and knowing the right questions to ask. While published and internet guides can be very helpful (Pinder et al., 2005), talking with highly knowledgeable members of the health care team who are able to make recommendations and referrals would be valuable.

Insufficient practitioner knowledge about therapies outside the scope of their practices, for both allopathic and integrative care practitioners, contributes to shying away from such discussions with their patients. One way to narrow this knowledge gap is through better communication between the different practitioners. Frankel and colleagues (2007) found that an educational initiative designed for CAM specialists was helpful in providing practical tools to effectively communicate with conventional providers (Frankel et al., 2007). Since terminology, philosophical principles, and treatment approaches differ, educational interventions aimed at cross training allopathic and CAM practitioners, as well as patients, are warranted to promote mutual understanding and to more effectively communicate with one another.

Besides lack of knowledge, other barriers to successful discussions about integrative therapies include provider indifference or opposition and patient anticipation of negative physician response (Tasaki et al., 2002). Inhibited conversations in this manner are not respectful of patient autonomy and are inconsistent with patient-centered care. Such poor provider-patient communication severs the possibility of partnership and integration. Unfortunately, some patients are turned off by poor communication to the extent that they pursue a limited and purely “alternative” route that prevents them from receiving comprehensive care and potentially helpful conventional treatments (Shumay et al., 2001; Verhoef and White, 2002). Beyond information, nonjudgmental attitude, words, and demeanor are essential to effectively manage discussions and guide patients in decisions about integrative health practices. The U.S. National Center for Complementary and Alternative Medicine (NCCAM) instituted the Time to Talk campaign, urging health care providers to talk about integrative therapies (NIH, 2008). The NCCAM Web site also includes tips on how to talk with patients (NIH, 2008).

PUBLIC COMMUNICATIONS STRATEGIES FOR INTEGRATIVE MEDICINE

With every organization that defines integrative medicine as mechanically integrating the conventional with the unconventional, there will be others that argue that the very spirit of integrative medicine will be compromised if the focus is limited to the use of specific therapies for specific conditions. A campaign to con-

vey the powerful impact that integrative medicine has on the nation's public health must be inspired by a unified definition that clearly identifies the goal of the approach—health promotion, disease prevention, and comprehensive disease management—and the resources that are available and should be harnessed to reach that goal. A whole-system approach is required to earn public trust in integrative medicine that professional turf issues have the potential to impede. For example, the movement to enact state licensure for naturopathic physicians (NDs) has been successful in 15 states and the District of Columbia (AANP, 2008), and that success can be attributed to the campaign themes of trust and accountability that naturopathic licensure represents.

Another challenge is the need to continually empower the wide range of integrative medicine providers to work collaboratively to educate the public about its importance. There have been a number of collaborative initiatives designed to do this, but a more formal and better funded effort is required, perhaps through a public-private partnership that invests federal funds in the development and distribution of educational collateral. Specific recommendations for consumer education among providers have included broadening consumer knowledge of the full array of health care options and promoting practices that preserve the unique contributions of modalities (Quinn and Traub, 2002), and promoting public accountability and standards of practice that emphasize patient-centered care and practice competencies as proposed by the Academic Consortium for Complementary and Alternative Health Care (2008). Among the most visible of the efforts to educate the public on integrative medicine, through collaboration among providers, was coordinated by the Bravewell Collaborative. Recognizing the importance of public awareness and knowledge to the growth of the field of integrative medicine, Bravewell contributed philanthropic funds for the production of a documentary called *The New Medicine*. This program, broadcast on a number of public television stations across the country, earned acclaim from local, regional, and national media. Another successful provider initiative to educate the public about the benefits of integrative medicine is the national media campaign spearheaded by the Cancer Treatment Centers of America. The campaign is designed to showcase the range of choices that are available to individuals having been diagnosed with cancer, focusing on the integrative medicine model that its hospitals promote as the most effective tool in fighting the disease (CTCA, 2008).

Mutual respect and collaboration among the range of providers, who each has a stake in partnering with their patients to promote health and prevent disease, is an essential element to a successful public communication strategy for integrative medicine. Central to this is professional education. The Consortium of Academic Health Centers for Integrative Medicine proposed facilitating the incorporation of teaching of integrative medicine into all levels of medical education, as well as

facilitating the application of integrative medicine principles and practices to all health care disciplines. Similarly, the Academic Consortium for Complementary and Alternative Healthcare proposed promoting interdisciplinary health care education to ensure mutual understanding among disciplines. Perhaps the best known program designed to educate providers on integrative medicine was developed by the University of Arizona Center for Integrative Medicine. For more than 10 years, the center has hosted residential fellowships and distributed learning designed to equip a broad spectrum of health care providers on the principles and practices of integrative medicine (Arizona Center for Integrative Medicine, 2008).

The success of a campaign designed to educate consumers and providers on the benefits of integrative medicine is contingent on a standardized definition, a commitment to overcome historical barriers to collaboration among providers, and a respective review of what has already been done to forge consensus for communications among industry stakeholders. Once this phase of the process has been completed, specific pathway opportunities for enhanced communications can effectively be leveraged.

SUMMARY AND RECOMMENDATIONS

Recommendation: The term integrative medicine should be changed to integrative health care.

Explanation: Health care is a much broader and more inclusive term than medicine. It connotes a more equal partnership among all of the actors in the process of healing.

Actors: All stakeholders, led by the Institute of Medicine

Recommendation: A standardized and unified definition should be established and agreed upon by key integrative medicine organizations.

Explanation: Only through a standardized and unified definition can public communications strategies for integrative medicine be realized, and informed decision making among health care consumers be maximized.

Actors: Consortium of Academic Health Centers for Integrative Medicine; National Center for Complementary and Alternative Medicine; Academic Consortium for Complementary and Alternative Healthcare

Recommendation: The CAM component of the NHIS should be repeated on a regular basis, at least every 5 years, and should be expanded to include specific questions on integrative health care and medicine.

Explanation: In order to convince stakeholders that they have a role in furthering knowledge about integrative health care, we need updated and continuing information on its use.

Actors: The National Center for Health Statistics and the National Center for Complementary and Alternative Medicine

Recommendation: Researchers must pursue more in-depth studies of integrative medicine—specifically, deeper exploration of the various reasons for using integrative medicine; the characteristics of patients who express different motivations, including their perceived health needs and personal beliefs; and the roles of conventional providers, integrative medicine practitioners and patients in integrating treatments.

Explanation: In order to make specific suggestions about how providers ought to approach their role in the process of integration, we need to have nuanced information about what they are currently doing.

Actors: Funders of health care research, including NCCAM, and academic researchers

Recommendation: More in-depth research should be conducted on the use of integrative health practices by race/ethnic minorities, including greater exploration of specific practices, perceptions of integrative medicine and conventional medicine, and factors motivating the use of integrative health care.

Explanation: It is not at all clear that the use of integrative health practices among minorities mirrors the more robust information we have about its use within the majority population.

Actors: Funders of health care research, including NCCAM, and academic researchers

Recommendation: Use and beliefs about integrative health care and medicine by race/ethnic minorities must be part of the cultural competency training of all health care providers.

Explanation: Medical and nursing schools are teaching the value of cultural competency in helping physicians and nurses understand the health behaviors, health beliefs, and health choices of their minority patients; hospitals and other providers are also engaging in cultural competency training for their staff for similar reasons. To the extent that integrative health care is a component of the health care of minorities, it is integral to cultural competency training.

Actors: Academic institutions (medical and nursing schools), hospitals, clinics, and other organizations that engage in provider education

Recommendation: More research should be conducted on the cost effectiveness of integrative health care.

Explanation: In order to ground suggestions that insurance coverage be expanded to include integrative health practices, we need more information on its cost-effectiveness.

Actors: Funders of health care research, including NCCAM, and academic researchers

Recommendation: Health decision aids for integrative therapies should be developed and tested with the goal of facilitating collaborative therapeutic decision making.

Explanation: With the plethora of treatment options and varying degrees of evidence, both practitioners and patients need concrete aid to guide the shared decision-making process.

Actors: Clinicians and academic researchers; funders of health care research, including NCCAM

Recommendation: Educational initiatives for cross training of conventional and integrative care practitioners should be created to promote mutual understanding, respect, and communication.

Explanation: Conventional medicine and integrative health professionals do not have adequate understanding about one another. Terminology and philosophical differences inhibit communication, which ultimately have negative consequences on the patient who is stuck in the middle.

Actors: Academic Consortium for Complementary and Alternative Health Care; Consortium of Academic Health Centers for Integrative Medicine; Health Professions and Nursing Education Coalition; Council on Graduate Medical Education; and national associations representing the broad range of education and training programs in the conventional medicine and distinctly licensed CAM professions

Recommendation: Health care professionals should have up-to-date reference guides on integrative health practices to share with their patients. These guides may be in paper or electronic format and include information of state regulations, lists of credentialed practitioners and credible local centers, and checklists of what to look for and ask upon visiting an integrative medicine clinic.

Explanation: Patients often do not know where to begin when they initiate seeing an integrative health practitioner. They would welcome practical guidance to ease the process and to ensure they are spending their money and time wisely and are not putting themselves at risk for harm. Written or electronic guides will facilitate discussion with the physician or nurse.

Actors: NCCAM; regional, state, and local consortiums comprised of different types of providers and health care consumers from a variety of health care, academic, and community organizations

Recommendation: Efforts must be made to educate writers, editors, and reporters—both inside and outside of the integrative medicine “beat”—on the values of integrative health care, to shape and inform their future coverage.

Explanation: The effort to educate the public on integrative health care comes with a responsibility to educate those who are uniquely equipped to convey the message. The media represents the primary audience in this regard.

Actors: Small consortium of public relations professionals with proven experience and success in the national integrative medicine market

Recommendation: Through an integration of earned media (i.e., publicity) and paid media (i.e., advertising), a formal and funded national public awareness campaign on integrative health care should be planned and launched, with the following elements:

- Production and placement of television and radio public service announcements
- Production and placement of print advertisements in major daily newspapers and consumer health publications
- Development of 1-800 number hotline to fulfill inquiries and make referrals
- Development of consumer health information packet, with associated collateral
- Scheduling of a Congressional staff briefing on integrative health care
- Development of a series of health professional Webinars that interactively explore the range of issues in integrative health care
- Partner with sponsoring organizations on coupon or other discount premium opportunities for consumer advantage

Actors: Small consortium of public relations and advertising professionals with proven experience and success in the integrative medicine market

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