THE ETHICAL JUSTIFICATION OF EXTENDING HOLISTIC CARE TO
COMPLEMENTARY AND ALTERNATIVE MEDICINE

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ABSTRACT

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By

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Dissertation supervised by Henk ten Have, MD, PhD

The doctoral project presents an argument for the inclusion of complementary and alternative medicine in the provision of holistic care. Over the course of history the practice of medicine has evolved with developments in science and technology and transitioned away from its holistic origins to a more fragmented practice. The project includes relevant literature on shortcomings of conventional medicine that are in part a catalyst for the trends of increasing complementary and alternative medicine utilization. The doctoral project concludes that the benefits of complementary and alternative medicine’s inclusion in care, and more specifically holistic care, is of value and further research will be of benefit to further the utilization of complementary and alternative medicine.
DEDICATION

This project is dedicated to my parents, my mom Dr. Carol Allen and dad Mr. Orvin Allen, whose constant love, prayers and support provide me sustenance.
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I would first like to give all praise and honor to God in the completion of this doctoral project, for without Him, none of this would be possible. With the deepest gratitude I would like to acknowledge my committee. To Dr. Henk ten Have, department chair and advisor, thank you for your knowledge, patience and understanding throughout. To my committee, Dr. Gerard Magill and Sr. Rosemary Donley, thank you for your guidance and support. To Glory Smith, thank you for your words of encouragement and assistance through the years.

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Chapter 1 – Introduction

Western medicine, largely based on pure science, evolved through Grecian developments into the modern medicine of this century. Although, many landmark advancements have occurred in medicine across the world (specifically in Western society); Western society continues to see increases in mortality rates for many diseases and illnesses. As a result, health care is constantly changing and evolving due to advances in science and technology that improve the way illness and diseases, at a minimum, are addressed; however there are still opportunities for improvement. Significant gains can be achieved by incorporating holistic care (through complementary and alternative medicine) into the health care provided to all who seek care. Consideration also needs to be given to those who do not actively seek care, due to challenges with access. Access to health care is a large variable in the delivery of care and is largely influenced by cost, insurance, socioeconomic factors and culture. Governmental priorities and polices (such as the Patient Protection and Affordable Care Act which seeks to provide more Americans access to health care through quality affordable health insurance) that surround health care can have a large impact.

Holistic care, simply defined, is care of a patient that acknowledges the connection between mind, body and spirit and addresses the health concerns of the patient as they pertain to the whole person.\(^1\) Science has shown linkages between emotions and chemicals in the body, and changes in either of these elements can, and do, impact health. As understanding of these linkages develops, it lends to the incorporation of the holistic piece into western medicine by changing the current approach of purely focusing on an individual with a disease, and providing them medication and treatment
for that particular disease. The singular approach may be successful in treating the
disease, however falls short in the area of healing as the underlying causes of the disease
are not addressed. As a result, patient perception of the shortcomings of Western
medicine has led to the increased use of holistic care, as evidenced by the use of
complementary and alternative therapies. Should the focus shift to the whole person and
the underlying issues leading to disease, the benefits can go beyond just the individual.
Benefits can be gained by shifting from, the way western medicine focuses on a singular
approach (treatment of disease), and looking towards a more global approach, through
holistic care that addresses the needs of the whole person.

Addressing health care more holistically through complementary and alternative
medicine will lead to improvements in health care quality. Health care quality is quite
important to society and is evaluated by organizations such as the Joint Commission, the
Office of the Inspector General, Health Departments, the Institute for Healthcare
Improvement and the World Health Organization. Although, quality of care can improve
by the appropriate implementation of holistic care, one must be cautious of what is
incorporated and how, because the outcomes can lead to the converse, a decrease in
quality. The implementation of holistic care goes beyond disease treatment to a true
holistic system and approach that looks a health care prior to the onset of disease, during
and post disease.

According to the Center of Disease Control and Prevention there has been an
increase in the number of deaths in the United States (2,403,531 in 2000, and 2,596,993
in 2013). The number of deaths in 2013 exceeded the number of deaths in 2012 by
53,714. The crude death rate for 2013 (821.5 deaths per 100,000 population) was 1.4%
higher than the 2012 rate (810.2), and higher than the crude death rate in 2011 of 806.6 per 100,000.

The 15 leading causes of death in 2013 accounted for 79.3% of all deaths in the United States. While this report showed a significant decrease in the age adjusted death rates in five of 15 leading causes of death in the United States, the age adjusted death rate increased significantly in six of the 15 leading causes of death in the United States. The age-adjusted death rate increased significantly between 2012 and 2013 for six leading causes: Chronic lower respiratory diseases (1.4%), Influenza and pneumonia (10.4%), Septicemia (3.9%), Chronic liver disease and cirrhosis (3.0%), Hypertension (3.7%), and Parkinson’s disease (4.3%). Mortality and morbidity data are paramount to the understanding of the health status of a population, while the data may not present the whole picture, it is telling.

Although, there are many in society that do not support holistic care, more specifically complementary and alternative medicine, holistic care should be provided to all who seek care, especially when western medicine cannot cure or alleviate disease, due to the impacts on quality of care and the benefits to society as a whole. The data presented illustrates that more needs to be done to improve the health status of the individuals in the United States. Holistic health care defined as the focus on mind body and spirit through methods that incorporate, complementary medicine, alternative medicine and traditional medicine will lead to an increased quality of care, and therefore these is a duty to provide holistic care. If a holistic health care system is implemented, that moves beyond providing care to address singular issues and begins to address the
whole patient, prior to disease, during and post disease, there is an opportunity to improve the health of the nation.

Complementary and alternative medicine is widely used in health care to aid in the treatment of an extensive range of ailments. There are numerous factors that have led to the increased utilization of complementary and alternative medicine in the United States. Those who utilize complementary and alternative medicine do so due to perceived shortcomings in modern medicine, dissatisfaction with the healthcare system, interest in obtaining a more broad spectrum of care opportunities, or personal philosophies on holistic care. While utilization has increased since the early 1990s, barriers to further expansion of complementary and alternative medicine, in a more broad sense, and its incorporation into holistic care exist. Those barriers can be overcome with healthcare reform, legislative changes, increased formulated curriculum and education regarding complementary and alternative medicine approaches and continued research efforts.

In Chapter 2, an overview of the history of western medicine will be used to understand modern western medicine and show linkages to holistic health care. The links established in Chapter 2 will allow for a definition of holistic health care with a focus on spirituality as it relates to holistic health care. Chapter 3 will also frame a construct for quality that will lead into chapter 4 where the ethical justification for holistic care is formulated. In Chapter 5, existing models of care will be examined to determine, what if anything can be learned from their journey. In Chapter 6 the implications and opportunities will be defined.
Chapter 2 – Development of Western Medicine

A review of the origins and history of Western medicine aids in the understanding of the phases of development of health care and how the evolution of Western medicine touched on varying degrees of holistic care. Throughout the review of history, major developments and contributors impacted modern medicine and the influenced holistic care. More specifically the works of Hippocrates, Galen and Descartes, explored over the course of Greek antiquity through modern medicine, also referred to as Western medicine, provide foundational constructs.

Modern medicine is practiced utilizing evidence based medicine as a result of developments in science and research. Evidence based medicine is the use of current evidence to make health care decisions, a process that entails a five step process. While evidence based medicine in practice is utilized for individual patients, underlying concepts can be applied to health care more broadly through evidence based health care or evidence based practice. Through an understanding of the history of medicine, the concepts of disease, illness, health, healing and wellness will be explored to create a context for understanding the goals of care in western medicine, one will better be able to assess health care in the United States, as it exists today.

Greek and Roman Origins of Medicine and Developments

The ancient origins of medicine are firmly grounded in physical and biological information and beliefs. The work of Hippocrates and subsequently Galen will begin the exploration of medicine beyond the physical and into the birth of concepts that link the impact of the mind on the body. As one proceeds through the works of Hippocrates in regards to health and illness, the differences between his ideas and modern medicine are
immense. Hippocrates brings the notion of disequilibrium of ‘humors’ within the body as the root of disease, later proved to be incorrect. He focused mainly on biological reasonings, but at times diverged from physical causes into potential psychological explanations. Disagreement exists regarding which writings were actually authored by Hippocrates, but there is general consensus that writings by students (trained and influenced by him) and the Hippocratic school (Coan school, a school governed by his tenants) are credited to him. The following information regarding Hippocrates follows the same trend. The work fathered by Hippocrates diverged from past thought and changed the course of medicine, through an increased knowledge of the human anatomy and he was therefore able treat disease and shape practice.

Prior to Hippocrates the belief was that diseases were a result of superstition and gods. He argued that disease was not a punishment sent by the gods, but that disease resulted from lifestyle choices and the environment. His argument distinguished medicine from the historic religious views. Prognosis and patient care were central to the Hippocratic approach, while the opposing Cnidian school focused on diagnosis. To them the body was only a combination of isolated parts and disease only affected the part of the body in which it originated therefore only that portion of the body was treated. Hippocrates fervently believed that the human body functioned as one unified organism, or physis, and must be treated as one coherent, integrated whole regardless of existence of disease. In order to remain in health the four humors (blood, phlegm, yellow bile, and black bile) had to remain in harmonious balance, pepsis, and was pivotal to the holistic understanding of the human organism. Hippocratic medicine was in essence a holistic healing system, concerned with and focused on treating the whole patient, and
not just the disease. Hippocrates believed the body contained within itself the power to re-balance the four humors and therefore heal itself. The physician was to allow nature to take its course facilitating rest, a clean environment and nutrition.\textsuperscript{20}

Hippocrates favored treatments that were conservative as opposed to extreme radical options. He emphasized prevention of disease by strengthening the body’s natural resistance to disease through lifestyle adjustments to diet, exercise massage and hydrotherapy. He also favored dietary adjustment for the treatment of disease as he believed the origin of disease was the result of poor diet, whether grounded in a lack of food, poor nutrition or an over indulgence in food. The poor diet creates wastes that spread throughout the body and cause disease, which could eventually lead to a point where the patient would begin to overcome the disease and heal or succumb to disease and die. The aforementioned tipping point between overcoming disease versus death, called crisis, was identified via symptoms that occur during critical days. Depending when crisis occurred in relation to the critical days in disease progression a relapse might be expected.\textsuperscript{21} Additionally, Hippocrates systematically categorized disease as acute, chronic, endemic and epidemic, based on the similarities and differences between them.\textsuperscript{22}

Hippocrates also crafted the role of the physician and an ethical standard that detail requirements for lifestyle, discipline and professionalism, which included honesty and understanding of the patient.\textsuperscript{23} The physician was to aid the natural resistance of the body and restore health and harmony by overcoming the imbalance that caused the disease.\textsuperscript{24} Ancient Medicine and Hippocrates’ other works highlighted the empirical study of medicine through data collection and experimentation. The methodology he
employed demonstrated the natural process of disease and that natural bodily reactions lead to signs and symptoms of disease.

Hippocrates believed that observation of a patient (both objective and subjective symptoms) was a vital aspect of medical care and developed a more systematic period of observation and recording methodology of what was observed (clinical observation). Hippocrates urged physicians to document specific symptoms that were observed daily. The belief was that clear and objective documentation would allow for predictions of future developments in disease. Hippocrates himself carefully noted symptoms such as complexion, pulse, fever, pains, and excretions and included family history and environmental factors into his clinical observations. Hippocrates and his followers strove to promote scientific medicine based on statistical data, rational concepts and thought. The techniques and processes of observation, documentation and synthesis they utilized improved greatly upon those that preceeded Hippocrates, in that these mechanisms allowed for review and identification of mistakes.

Galen further advanced the theory and practice of medicine from the foundations laid by Hippocrates. Through Galen’s commentaries of Hippocrates a better understanding of Hippocratic works is gained. He was one of the most significant commentators of Hippocrates. He considered the study of philosophy to be essential to a physician's training, which differed from Hippocrates belief that the physician needed to place priority on the understanding on the nature of the whole person. Galen believed that the body was the physical housing for the soul. Galen expanded on the four humors described by Hippocrates as well as presented his theories of the three varieties of \textit{pneuma}, or vital energy, and the Four Faculties of the organism. Similar to Hippocrates,
Galen understood health to be a function of harmonious balance of the body’s systems, however he went much further in the understanding of anatomy. He believed that the only way to understand the true function of a part of the body one must first study and understand the form. Through dissection he gained a better understanding of how the body worked (studying their bone structure and muscles) with a concentration on the movement of blood and the workings of the nervous system.

Similar to Hippocrates, Galen emphasized clinical observation through a thorough exam of the patient and documenting their symptoms. Galen also accepted the view that disease was the result of an imbalance between blood, phlegm, yellow bile and blood bile. Galen also believed in the healing power of nature and he developed treatments to restore the balance of the four humors. Galen furthered Hippocrates scientific rational medicine by developing and a system of degrees that allows physicians to gauge the effects of substances provided to patients for medicinal purposes. He developed natural medicine and thought that the quality of the ingredients made for a more effective treatment as opposed of lack of quality ingredients which often would require greater amounts of medicine. He pursued medical excellence through the same fundamentals as Hippocrates, observation and investigation, however he far exceed Hippocrates in his experimentation.

Throughout Galen’s works on diseases and their symptomatology (Malingers) one can ascertain that he was skilled as a diagnostician, much more so than Hippocrates. Unlike Hippocrates, Galen had no students nor did he establish a school, however Galen’s doctrines (Galenism) was paramount during the Middle Ages. Galen’s authority was seriously questioned during the Renaissance, but in spite of Galen’s authority being
questioned, many of his theories survived for a long time as definitive proof of the criticisms were not readily accepted.

Those that followed Hippocrates, remained in alignment with his overall theories and further explored the structural components of the body and developed therapies to bring the body back into balance. Galen, was able to discern and diagnose the difference between illness caused as a result of physical origins versus mental (or emotional), and hence he stood out from the rest of the physicians and philosophers of this era. The work of Hippocrates and Galen were studied and further refined until the linkages between keeping the physical and mental faculties in balance were clearly expressed in writers to follow such as Maimonides. In summary, the works of each of these physicians and scholars laid the foundation for modern medicine, but also began unearthing what would later become the underpinnings of holistic care.

Throughout the 15th to the early 17th centuries physicians and writers of medical science, documented their findings with a predominant focus on the body or the mind in spite of the findings of linkage between the two. The writings of the premier physicians of the centuries prior continued to be the foundations in medicine and were evident in writings of Thomas Wright and others. Furthermore, those writings focused on understanding the condition of the mentally ill. Amidst the development spurred by Descartes, the understanding of anatomy developed through further investigative works, however beliefs regarding effects of the mind on the body, or the converse, remained.

**Modern Medicine**

Some believe the writing and philosophy of Rene Descartes had an immeasurable impact on the modern medicine. Throughout the history of medicine there existed a
strong belief in a linkage between the mind and body. Descartes challenged this by stating the mind and body were different. He did not completely abandon their connection, but he reframed it into a philosophy now called Cartesian Dualism.38 Cartesian Dualism on its face appeared to uproot the holistic views of medicine that had formed, but in fact attempted to show that people had more control of their health and emotions than what was written prior by past philosophers. Eventually, biological approaches superseded approaches that were once the gold standard. This portion of the analysis will juxtapose the different eras of medicine and specific philosophers of those eras and show how fundamental changes had varying impacts on medicine.

Post Descartes a split in the study of medicine occurred that created those who allowed for greater psychological influences on disease in medicine and those who focused more on anatomy.39 The psychological piece of medicine also changed and developed. Sigmund Freud and others at times reframed the classic medical mind-body relationships in psychoanalytic terms. As discoveries were being made in biochemistry and genetics, psychology transitioned to a less centralized focus of disease causation.40 This separation eventually led to the medicine of today where physicians specialize in various organ systems.

The culmination of these developments by the turn of the twentieth century was the effective separation of mind from body in much of modern medicine, with a focus on, scientific, evidence based medicine and practice.41 Modern medicine or western medicine differ from complementary medicine and other approaches towards the treatment of sickness, disease, and other physical and mental ailments. For the purposes of this project
the term western medicine (or modern medicine) incorporates the terms allopathic medicine, biomedicine, conventional medicine and scientific medicine.

Western medicine is practiced by those who have a medical doctor or doctor of osteopathy degree, and by their allied health professionals (physical therapists, psychologists, registered nurses, etc.). In current clinical practice the information is obtained from the patient via physical exam, followed by an interview and then all the information obtained is placed in the medical record. The history presented here is an oversimplification, however the advances that have been highlighted throughout history that have led to evidence based modern medicine must not be understated, as society has benefited from this history and what has been gleaned will continue to impact the delivery of health care.

During the late 20th century the existing approach of clinical decision making began to show flaws, such as clinician bias and lack of clinical trials that supported the decisions that were being made. The lack of consistent supportive information and trials lead to variations in how providers practiced medicine. These shortcomings lead to evidence based medicine. The definition of evidence-based medicine has changed from its inception to how term is used today. Initially, the term referred to improving physician’s decisions regarding individual patients and the approach to teaching medical practice. Over time the term began to refer to the emphasis of utilizing evidence from high quality research protocols and study to inform decision making in medical practice. Eventually, conclusions and evidence, borne out of research, shaped guidelines and policies that impacted groups of patients and populations and formulated evidence based
practice. Evidence Based Medicine (EBM) was defined by Sackett as “the integration of current best research evidence with clinical expertise and patient values/circumstances.”

Regardless of the field of application, evidence based medicine promotes that decisions and policies should be based on evidence wherever possible, as opposed to pure clinical judgement in healthcare decisions. It is important to note that all medical practice is not based on evidence that meets the highest standards of research (meta-analysis and randomized trials) but there is empirical support for medicine practice.

Figure 1: The Evidence Pyramid

Through formal methods data is analyzed to produce evidence for decision makers with the goal of informing and overcoming the providers’ bias and knowledge gaps. The formalized process in evidence based medicine allowed for decisions by an individual provider about individual patients to be assessed more broadly and applied to groups of people or even more broadly to populations.
The term “evidence-based” was first published by the American College of Medicine in an article that presented the principles of evidence-based guidelines and population-level policies. Eddy described evidence based medicine as follows, "explicitly describing the available evidence that pertains to a policy and tying the policy to evidence. Consciously anchoring a policy, not to current practices or the beliefs of experts, but to experimental evidence. The policy must be consistent with and supported by evidence. The pertinent evidence must be identified, described, and analyzed. The policymakers must determine whether the policy is justified by the evidence. A rationale must be written." The term “evidence-based medicine” was published subsequently in relation to medical practice and how evidence based medicine is applied to improve health care. Both of the aforementioned publications by Eddy initiated the development and expansion of evidence based medicine that would grow rapidly and develop into evidence based practice.

Initially evidence based medicine had two main focuses, 1) evaluation of evidence of effectiveness when providing clinical guidelines and other polices that could impact populations and 2) individual patient decisions making and epidemiological methods in medical education. Many definitions presented for the definition of evidence based medicine in the context of decision making at the individual patient level. The definition that best summarizes evidence based medicine as it pertains to health care at the individual patient level is, "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. ... [It] means integrating individual clinical expertise with the best available external clinical evidence..."
from systematic research.” This definition embodies the goal of making decisions as they relate to individual patients more structured as opposed the variation that was found in the late 20th century. Recognizing the complexity of maintaining multiple definitions of evidence based medicine, a unifying definition was crafted by Eddy, “Evidence-based medicine is a set of principles and methods intended to ensure that to the greatest extent possible, medical decisions, guidelines, and other types of policies are based on and consistent with good evidence of effectiveness and benefit.”

Organizations such as Kaiser Permanente, the American Cancer Society, Blue Cross and Blue Shield, and US Agency for Healthcare Research and Quality began issuing guidelines based on evidence of effectiveness in the 1980s, a practice which continued. It was essential that the guidelines and the recommendations therein were classified by the strength of the recommendation and the strength of the experimental design for which a specific method was utilized. There are many methods of measuring levels of evidence and likewise recommendations. A few examples of measurement systems are the Strength of Recommendation Taxonomy (SORT), the Grading of Recommendation Assessment, Development and Evaluation (GRADE), Appraisal of Guidelines Research and Evaluation (AGREE) tool, Assessment of Multiple Systematic Reviews (AMSTAR) tool, or the tool from the Centre for Evidence-Based Medicine.

The key to evidence based medicine is emphasis on the importance of incorporating evidence from formal research in medical policies and decisions, whereby the evidence and recommendations have met quality standards. Although, Hippocrates and Galen conducted experiments, focused on observations and documented what they observed in a detailed fashion, modern medicine has developed vastly since, activities
essential to evidence based medicine are quite similar to the rational science of experimentation, observation and documentation or duplication and future use.

**Limitations of Western Medicine**

In spite of health gains in the United States though increased knowledge, expanding healthcare systems and healthcare innovation, limitations exist. Reports from the Institute of Medicine have pointed to problems in the United States health care system such as poor quality, issues of safety, the high cost of healthcare with a corresponding question of value for that cost, and health disparities based on income race and ethnicity. Additionally, the growing complexity of the health care system can lead to a lack of coordination.59

In 2011, a survey conducted on patients with complex care needs highlighted the challenges of poorly coordinated care for patients with serious illness or injuries or chronic disease in eleven high-income countries, including the United States.60 Patients with more complex care needs tend to see multiple providers in various locations. The growth and development of more specialized care lends itself to more fragmented delivery systems. Providers face inefficiency and fragmentation which are impediments to clinicians working together to provide the best care.61 Due to lack of effective communication among providers, patients are potentially subject to experiencing ineffective care and errors. Medicare patients see an average of seven physicians, including five specialists, split among four different practices. A medicare patient with type 2 diabetes (a chronic disease) but no comorbidity saw an average of 5.6 physicians in a year, a patient with 10 comorbidities saw 28.2 physicians,“62 which could increase the likelihood of errors. Well-coordinated care is important for all patients, but becomes
more critical for sicker patients with multiple comorbidities. Increasing the number of care providers and locations increases the risk for complications and medical errors due to a lack of communication, which in turn can lead to lack of necessary clinical information. Overall, 20%-50% of the sicker individuals in the survey reported coordination gaps related to medical records or tests, or communication failures between providers. In the United States, 25% report gaps with medical records or tests and 20%-25% of United States patients reported experiencing at least one type of error in the past two years. The study also demonstrated that the likelihood of an error increased with the number of doctors seen.63

Healthcare “is marred by significant shortcomings and inefficiencies that result in missed opportunities, waste, and harm to patients.”64 Other limitations are the existence of false positives in diagnostic testing; existing treatments are not efficient as sometimes the side effects outweigh the perceived benefits and the cost of healthcare. The system of health care in the United States is costly, for example, “55% of Part D enrollees who used at least one specialty-tier drug reached ‘catastrophic’ levels of out-of-pocket spending, compared with only 8% of all Part D beneficiaries who filed claims but did not use any specialty-tier drugs”.65 The aforementioned indicates the impact of the pharmaceutical industry on health care. In fact, 50% of investment in biotechnology and 25% of biotechnology revenues came from Big Pharma as of the early 2000s.66 Health care costs are prohibitive, due to inflated and unnecessary medical expenses. While costs in the United States are generally higher than in most developed nations in the world, the United States healthcare outcomes don’t excel in the same fashion.67 The Institute of Medicine estimated that $750 billion—about 30 percent of all health spending in 2009—
was wasted on unnecessary services and other issues, such as excessive administrative costs and fraud.\textsuperscript{68}

Access to health care is a challenge in Western Medicine, more specifically in the United States, however the Affordable Care Act has sought to address some of these access issues. There are issues with quality as identified through medical errors and other harms to patients receiving medical care.\textsuperscript{69} According, to an article written by Budetti in 2008, it was estimated that some 47 million Americans lack medical insurance.\textsuperscript{70} An increasing proportion of Americans postpone or forgo required medical treatment and are less likely to receive preventive services or consistent care for chronic conditions, due to their lack of insurance and in ability to afford basic treatment.\textsuperscript{71} The passage of time did not change the picture of the uninsured in the United States. According to the United States Census Bureau 16.3 percent of the American people lacked insurance in 2010, or 49.9 million people. 9.8 percent of children under age 18 (7.3 million) and the rate for uninsured children in poverty was 15.4 percent.\textsuperscript{72} In spite of knowledge expansion and innovations in health care, health disparities continue to exist in the United States. The Institute of Medicine “found that a consistent body of research demonstrates significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable.”\textsuperscript{73}

Research is costly and does not always yield findings that can be utilized for improving medicine, which points to issues of resource allocation.\textsuperscript{74} On average, the cost of current research is $15-$20 million for larger studies.\textsuperscript{75} While this process is good in terms of maximizing safety and therefore quality, the process and data required to demonstrate that a medication, treatment or intervention is safe and effective is rigorous
and time consuming. When outcomes are reached they are standardized; given that condition X, condition Y and condition Z are met the correct care is Q. This type of system does not account for the individuality of the patient or their situation. The patient’s values and priorities are not taken into account and physician judgment is limited. The limitation of effects of physician judgment can be viewed as a positive in that it limits the physicians risk and exposure to liability. However, one of the successes of medicine is the human component of judgment. There are aspects of care that no amount of evidence can support. Additionally, standardization of care is sometimes viewed as a piece of quality care.

Evidence-based medicine is regarded as the standard of clinical practice that is ideal; however there are criticisms and limitations of evidence based medicine, such as a focus on evidence that can impact society at the population level and a definition that is too narrow in the definitions focus at the individual physician and provider level. Transition to a focus on evidence based practice inherently shifts focus away from and individual patient focus and that individual’s uniqueness. As stated earlier, evidence based medicine sought to address the issue of clinical practice variation. One methodology in implementing evidence based medicine is the development of clinical practice guidelines. The Institute of Medicine defines clinical guidelines as “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.” By implementing guidelines, the expectation was that the guidelines would lead to consistent changes in provider behavior. However studies have shown nonadherence to practice guidelines continues to be a barrier.
Another limitation in Western Medicine is the tendency to focus on a singular factor. Providers focus on individual parts of the body and treat those parts independently rather than as an integrated whole. This way of thinking also leads to the separation of treatment of the mind from the treatment of the body, which can impede healing. Similarly, the focus on parts of the body lends itself to the treatment of individual diseases. Focus on each disease or condition an individual has and treatment of each of those diseases or conditions singularly, results in additive treatments and lack of understanding in the interplay between each. Providers treat the disease, not the patient. This type of approach leaves marginal space for contextual information, such lifestyle choices and behaviors (sleeping habits, diet, living condition, comorbidities, physical activity and stress). That speaks to the view of health as a static (stable relatively constant condition) or homeostasis. Disease as a failed homeostatic mechanism, requires providers to address and correct deviations. Correcting the deviation again narrows the providers focus to one variable instead of the entire individual as a system and ignores that some form of a dynamic situation can also be stable. Providers look for a singal remedy instead of all the possible factors that make up the total condition of the individual which is causing the underlying imbalance, disease or illness. Without understanding of the entire condition of the individual there exists and assumption that information about individual parts is sufficient to explain the whole.83

The Institute of Medicine’s Best Care at a Lower Cost report also pointed to a system of rewards that is not patient centered nor focused on the needs of the patient. The existing incentive system rewards volume of appointments and procedures over the value provided to the patient, quality of care and outcomes. This misaligned focus hinders
improvements in safety and quality of care. The report points to the tendency of providers who are reimbursed for each episode of care or procedure are more likely for recommend more appointments and services than providers who are reimbursed or incentivized via alternate payment methods. Treatments have the potential for harm, and subjecting patients to increased and potentially unnecessary treatments and tests have the potential for side effects and harm.84

Modern health care allows for various intricate procedures including vaccination, acute injury intervention, treatment of disease and chronic illness, but financial barriers to access issues limit the number of people cared for. Medicine has failure, errors, risks and complications.85 When medical interventions have side effects, do not yield the desired outcome, any meaningful improvement or relief for the patient, patients sometimes turn to holistic care such as complementary and alternative medicine and spiritual approaches,86 while waiting for research and development to offer other medical options. Patients also pursue complementary and alternative medicine due to too little time being allotted for their clinic appointment, such that the patient felt their health issues were not able to be expressed fully. By seeking complementary and alternative the patients feel empowered,87 or an increased sense of autonomy.

From the origins of medicine in Grecian and Roman times, through the developments of science, research, evidence based medicine and practice the face of modern medicine has developed. While the benefits in these areas are important and valuable to how medicine is practiced today and the care patients receive, there is still a generally narrow focus on components of the patient or disease. Western medicine contains numerous specialties and practices and their approach on disease, health and
healing varies. This variation in practice ideas did not always exist. Over time we began
to learn new treatment options and new modes of delivery. Those additions added to the
range of care available to patients. A similar process of change should allow for the
expansion of care from a practice more focused on specific parts of an individual and a
particular disease and condition, to care that is more holistic and incorporates
complementary and alternative approaches. Although, there is controversy related to
holistic care and complementary and alternative approaches due to limited research and
scientific basis, there are benefits to these more inclusive approaches. These approaches
seek to embrace patient uniqueness (which can sometimes be overlooked or marginalized
with to stringent adherence to scientific evidence) by including them in the health care
decisions making process and take into account the interrelatedness of the mind, body
and spirit.
Chapter 3 – Overview of Holistic Care

Exploration of the concept of holistic care will point to added quality benefits of complementary and alternative medicine. Reductionism is limiting in its attempts to reduce things to most basic parts. Valuable information about what is trying to be understood can be lost, such as understanding of the properties of the system as the parts are looked at as whole. Holism is a way to look at parts and the whole and in turn leads to holistic care where there is a focus on mind body and spirit. The acceptance of the holistic care model is contingent upon a more comprehensive definition of holistic care, and modes of delivery. Holistic care is carried out by various methods of complementary and alternative medicine. The modalities of complementary and alternative medicine address mind body and spirit. A criticism of complementary and alternative medicine is that is not evidence based and many argue that due to a lack of evidence (based out of randomized controlled trials) should not be utilized. There are also benefits of added quality defined by increased patient satisfaction, increased patient participation in health care decision making and increased time spent with the complementary and alternative medicine practitioner. All decisions about health care and health promotion should be guided by the best available evidence in order to ensure quality. Quality of life and, for many, a sense of active participation and empowerment are also important. This is where the discussion around complementary approaches becomes more relevant.

The Problem of Reductionism

Throughout history science had a focus that changed to varying degrees between concepts of reductionism and holism. The philosophical background of holism can be traced back to Aristotle, who is said to have observed that “the whole is more than the
sum of its parts.” On the other hand, reductionism reemerged when Descartes suggested that the world was like a clockwork machine, which could be understood by taking its pieces and studying the individual components. Subsequent to Descartes reductionist approach Smuts turned the focus away from reductionism when he devised the term “holism” as “a tendency in nature to form wholes that are greater than the sum of the parts through creative evolution. Smuts took a broad look at the study of life, which differed from the approach of scientific medicine, that was at one time, very narrow as it mainly focused on organic causation and utilized cell biology. In order to understand the complexity of human organisms with many levels of organization, one would potentially have to start at the most basic level of an organism, the atom and work through each sequential level of complexity; molecular, cellular, organic, populations and eventually to the societal level.

Cell biology focused on discovering the causes of disease at the molecular level. By focusing and understanding the organism and disease at this basic level, one would also be able to explain the nature of a disease at the more complex levels. Reductionism seeks to reduce concepts like disease and health to the most elemental level, and extrapolate the understanding gained at that level to explain all relevant factors that are found at the more complex levels. It can be said that scientific medicine took a reductionist approach to health and disease. The medical sciences are inundated by reductionism and this affects how providers diagnose, treat, and prevent diseases. Across history there have been significant improvements in modern medicine, as a result of reductionist concepts and thought in cell biology, in the treatment of disease. Advancement in knowledge of cell proliferation pathways and the completion of the
human genome project embody how reductionism leads to better comprehension and therefore developments in science and treating disease and illness by being able to pinpoint its source.

While the reductionist method has been responsible for tremendous successes in explaining the chemical basis of numerous living processes, there are limits to reductionism, and an alternative methodology was needed.93 “The biology, development, physiology, behavior or fate of a human being cannot be adequately explained along reductionist lines that consider only chemical composition.”94 The reductionist approach cannot address the complexity of biological systems.

Reductionism encompasses three related but distinguishable themes: ontological, methodological and epistemic. Ontological reductionism is the idea that each system is composed of solely molecules and the interactions of those molecules establish a hierarchy of chemical, biological and physical properties. The idea that biological systems are most productively investigated at the lowest possible level constitutes Methodological reductionism. Epistemic reductionism implies that knowledge of a higher domain can be always reduced down to a lower more fundamental level.95

Numerous sources cite issues and potential problems with a reductionist approach.96 Reductionism can lead to distrust on the part of the layperson as the explanation of disease at the molecular and sub molecular level are quite difficult to conceptualize. There exists a risk of oversimplification of the process of reducing things down to the base component. The act of reducing things down to the base component can potentially eliminate key items in describing what reductionism seeks to simplify. The potential exists for reductionist explanations to lead to confusion over cause and effect.97
Another shortcoming of reductionism is that by reducing disease to organic dysfunction causes, reductionism eliminates factors of health and disease when it comes to holistic approaches. Clinical medicine is perceived as reductionist while clinical medicine in its implementation is systems oriented. Clinical medicine focuses on a singular factor of disease and illness thus eliminating effects from the environment that impact disease and illness. Additionally, treatment of disease follows a similar course. As opposed to understanding multiple factors of a disease or illness and how they interact and affect one another, and treating their symptoms in concert, each is treated separately.

According Ahn et al. the systems perspective, based on systems biology, complements the reductionist approach. Instead of dividing a complex problem into its component parts, the systems perspective appreciates the holistic characteristics of a problem and evaluates the problem as a whole. The principle of reductionism differs greatly from an alternative, the systems oriented approach. Whereas reductionism believes the biological behavior of a system can be explained by the properties of the parts that make up the system, the systems approach states that that whatever properties exist can only be possessed by the system as a whole and attempting to isolate a part detracts from the functionality of the biological system, and therefore the ability to understand the system is limited. In the systems approach many factors are evaluated simultaneously to understand the systems dynamics. The characteristic of the systems model are not linear or predictable, but non-linear, chaotic and sensitive to internal conditions. Systems biology is an integrative approach partially made possible by development in the fields of chaos theory, nonlinear dynamics, and complex systems science. Advancement in computational science, mathematics, and physics allowed for
the combination theoretical modeling and direct experimentation. Given the limits of reductionism, there is value in understanding alternative concepts holism and holistic care.

**Concept of Holistic Care**

The framework of this chapter is predicated on developing an understanding of the concept holistic care. Throughout the literature, holistic medicine, holistic care, holistic health care and holistic health are used frequently to describe care provided to person, systems of providing that care and a way of looking and the health of the whole person. The common piece of each term is the word holistic, which sometimes used as a way of thinking to establish meaning. Merriam-Webster defines holistic as relating to, or concerned with complete systems rather than with individual parts; of or relating to holism; relating to or concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts. According to Beresford holism is the opposite of reductionism. The inclusion of complementary and alternative medicine in holistic care (based on Smut’s definition of holism) is about quality. For the purposes of this project complementary and alternative medicine goes beyond just medication to include treatment or simply health care, and there are many times medication is not involved at all.

Though the Merriam Webster definition defines holistic as having its origins in holism, however a more in depth analysis of holism is crucial to the understanding of the various ways holistic is used to describe care and will be largely accomplished utilizing the work of Smuts. In order to define and frame holistic care, the work of Jan C. Smuts (1926), regarding holism will be examined and analyzed as preparatory point. Second,
multiple definitions and constructs of holistic will be presented to further illustrate the broad scope of the word in literature. Through an examination of the text, a working definition of holistic care will be finalized, by synthesizing components of the reviewed literature.

**Smuts’ Holism and Application to Complementary and Alternative Medicine**

During the early 20th century there was a division in the study of life, the mind and matter. As a result Smuts began to explore the origins and foundational concepts and determined a need existed to rethink the concepts of mind, matter and space and time.

“Among the great gaps in knowledge those which separate the phenomena of matter, life, and mind still remain unbridged. Matter, life, and mind remain utterly unlike each other. Apparently indeed their differences are ultimate, and nowhere does there appear a bridge for thought from one to the other. And their utter difference and disparateness produce the great breaks in knowledge, and separate knowledge into three different kingdoms or rather worlds. And yet they are all three in experience, and cannot therefore be so utterly unlike and alien to each other. What is more, they actually intermingle and co-exist in the human, which is compounded of matter, life, and mind.”

Throughout the first five chapters of “Holism and Evolution” the concepts of matter, life and mind which he initially described as being so disparate, begin to come closer to one another, so much so that the concepts begin to overlap. According to Smuts the concept of life exists in the cell and in the organism, and organisms being composed of cells and
cell being composed of matter, bring the concept of matter closer to the concept of life. Holism is a process of creative synthesis that goes beyond the biological domain; the resulting wholes are not static but dynamic and include the human spirit.

A whole is comprised of a unity of parts (not something additional to the parts) and the parts in their synthesis define the whole. Wholes are composites of parts and the whole cannot exist without the parts. The parts form a definite structural arrangement and function in mutual appropriate activities that constitute the whole and function towards to the whole. This synthesis of whole and parts is reflected in the holistic character of the functions of the parts as well as of the whole, or wholeness. Wholeness is about the relationship between parts carry out the purpose of the whole. The character of wholeness is everywhere and is therefore universal. The whole is not a result of its parts and is its own active agent and works in relationship with the parts; such that the whole is influenced by the parts, and whole influence the parts. This relationship created a continuous interaction of parts and whole maintaining the moving equilibrium of structure and functions which is the organism. In a living whole, all action “is holistic, not only that of the whole itself, but also that of the parts. The stamp of holism is impressed on the activities of the parts no less than on the individual whole itself. The individual and its parts are reciprocally means and end to one another; neither is merely self-regarding, but each supports the other in the moving dynamic equilibrium which is called life.”

Smuts ability to look at the scientific concepts of his time, called for change in the concepts and as a result of his findings he asserted that the mind is a critical piece of the domains of life and matter. He also believed that the mind, matter and life are intertwined.
through the creativeness of matter. In review of Smuts work, the domain of life, the domain of matter and the domain of the mind did not have clearly defined boundaries. Each domain overlapped to some degree, therefore allowing for the creation of the principle of holism; the process of the universe making wholes. Wholes are not mere artificial constructions of thought; they actually exist; they point to something real in the universe which was a way to explain the linkage of the physical (matter), mental (mind) and biological (life). Holism, the creation of wholes, and ever more highly organized wholes, and of wholeness generally as characteristic of existence, is a fundamental process in nature.

The goal of care is to optimize health for each individual, and as a result people with the same disease can be treated differently. According to the World Health Organization (1986) health is a “state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” The stability and wellness of the components of health, as defined by the World Health Organization, are also crucial to health. According to the aforementioned definition of health a disease specific focus will not lead to health as it does not address the whole person. An earlier review of reductionism also pointed to similar limitations.

An examination of the definitions of holistic health care and holistic medicine, as defined by World Health Organization, will further justify the concept of holistic care. Holistic health care is defined as “the art and science of healing that addresses care of the whole person - body, mind, and spirit, by prevention and treatment-to promote optimal health.” Holistic health care describes the system of delivery that considers the whole person. A sound biological system (holism) depends on physical, mental, social and
spiritual well-being, in other words the health of the whole person. Holistic medicine addresses the psychological, familial, societal, ethical and spiritual, and is anchored in the requirement that each patient is a unique individual (mind, body and spirit) and all care delivered should consider that relationship with the environment. The common theme in each definition is care for the body, mind and spirit. Holistic care, in pursuit of holistic healing and health, emphasize a mind, body, spirit focus to supporting or restoring well-being and wholeness. This affords a natural link to include complementary and alternative medicine in holistic care as these practices incorporate mind and spirit in healing.

The provider-patient relationship is key to healing. The involved patient and provider must develop a partnership, where the autonomy of the patient is respected and the provider does not trump the rights and choices of the patient. Caring for the whole person involves addressing the emotional, environmental, intellectual, physical, social, and spiritual needs of the person; therefore, a holistic approach incorporates methods such that all the needs of the person are addressed in the care delivered. Historically, such confidence was placed in Western medicine that there was little space for complementary and alternative medicine, and therefore little believe that complementary and alternative medicine could be effective. A holistic approach incorporating complementary and alternative medicine has value.

In extending holistic care to include complementary and alternative medicine the provider-patient relationship is important, as communications about all medication and therapy is necessary for a medical provider to make informed recommendations about care. A nationally representative, random-household telephone survey indicated that
approximately 63% to 72% of complementary and alternative medicine users did not disclose at least one type of complementary and alternative medicine therapy to their medical provider. 507 of those interviewed shared their rationale behind nondisclosure. Among 507 respondents who reported their reasons for nondisclosure; the most common reasons were, "It wasn't important for the doctor to know" (61%), "The doctor never asked" (60%), "It was none of the doctor's business" (31%), and "The doctor would not understand" (20%). Interestingly, less than 14% of the respondents chose not to disclose because they thought their doctor would disapprove of or discourage complementary and alternative medicine use. Overall the interview respondents personally believed that complementary and alternative medicine therapies were more helpful than solely conventional care for the treatment certain ailments (headache, neck and back pain).126

Modes of Delivery

One of the ways holistic care can be delivered is through complementary and alternative medicine. In 1993 a study first documented a significant rise in the use of unconventional medicine in the US. That same study defined alternative therapies as “interventions neither taught widely in medical schools nor generally available hospitals.”127 More than 30% of United States adults utilize health care approaches developed outside of mainstream Western, or conventional, medicine. Since the 1993 study, the terms “alternative” and “complementary” are oftentimes used interchangeably, however that is inaccurate. ‘Complementary’ describes “a non-mainstream practice is used together with conventional medicine” and ‘alternative’ describes “a non-mainstream practice is used in place of conventional medicine.”128
According to Graham-Pole (2001) complementary and alternative medicine includes (but is not limited to): acupuncture, biofeedback, homeopathic medicine, naturopathic medicine, Ayurvedic medicine, and traditional Chinese medicine meditation, yoga, chi gong, music and art therapies, and prayer. The reasons that people seek complementary and alternative medicine are just as varied as evidenced by studies. A national survey suggests that millions of adults in the United States use some of the aforementioned complementary health approaches to manage painful conditions such as arthritis, back pain, and fibromyalgia. Those individuals who sought complementary and alternative medicine for back pain cited “frequent, disabling, or chronic back pain,” and the “severity of back pain” as a significant reason for complementary and alternative medicine use.

A nationally representative, random house-hold telephone survey sampled 831 adults who saw a medical doctor and used complementary and alternative medicine therapies in 1997 in the 48 contiguous U.S. states, in attempt to document perceptions about complementary and alternative medicine therapies among persons who use complementary and alternative medicine and conventional therapies. 79% of the participants perceived the combination to be superior to either one alone. Perceived confidence in complementary and alternative medicine providers was not substantially different from confidence in medical doctors. Based on the National survey, the data does not support the view that use of complementary and alternative medicine therapy in the United States primarily reflects dissatisfaction with conventional care. A alternative study of complementary and alternative medicine utilization in a population of patients suffering from back pain indicated a dissatisfaction with general practitioners’
availability, length of waiting for appointments with general practitioners’, or lack of benefit from conventional medical treatments for back pain were noted as reasons for complementary and alternative medicine use.\textsuperscript{135}

As the two studies above reflect, the various factors that motivate individuals to use complementary and alternative medicine vary and can generally be categorized into internal and external influences. Individuals have positive and negative motivations for utilizing complementary and alternative medicine.\textsuperscript{136} The decision making process is complex, likewise are the internal influences on said process. In the U.S., when the choice is made to pursue complementary and alternative medicine the internal driving factor appears to be based less on dissatisfaction with conventional medicine, but more a closer alignment of values that coincide with principles in complementary and alternative medicine.\textsuperscript{137}

Some individuals have a need for a natural, holistic approach that is safe and effective, especially when there is dissatisfaction with Western medicine due to a perceived lack of effectiveness and the presence of adverse effects.\textsuperscript{138} Perceptions of conventional medicine are changing, patient involvement in their health care is increasing, and some members of society are looking for a more holistic approach.\textsuperscript{139} The patient–provider relationship also plays a role. Just as good relationship will pull patient towards the provider and therapy, similarly a poor relationship with the provider could push a patient away.\textsuperscript{140} The influence of cost and perceived benefit and delays in getting an appointment are other driving forces.\textsuperscript{141} Research has begun to show that family, friends and others (social networks) and the internet shapes behavior, more specifically health behavior.\textsuperscript{142} Those who already utilize complementary and alternative medicine
are likely to influence non-user in their social sphere as interactions provided opportunities to share information on treatment opinions.\textsuperscript{143}

Although, complementary and alternative medicine is utilized, critiques of complementary and alternative medicine arise. A particular criticism, that has ethical implications, is that complementary and alternative medicine is not evidence based and does not utilize evidence based practice.\textsuperscript{144} While there may be a possibility that some methods may be used without the basis of research, research and evidence based approaches exist.\textsuperscript{145} The examination of methods of complementary and alternative medicine illustrate how each mode addresses the whole person, and there is evidence based medicine involved and decisions are made utilizing evidence.\textsuperscript{146} Other disparagements of complementary and alternative medicine include the inconsistent use of empirical data, potential for patients to be harmed and that the validation required for medicine cannot be met by complementary medicine.\textsuperscript{147}

There are those who present complementary and alternative medicine in opposition and in competition with Western medicine.\textsuperscript{148} However, the rise in complementary and alternative medicine training and education, and the work of hospitals and other healthcare institutes to incorporate complementary and alternative medicine demonstrate a movement away from pitting one against the other to a more integrated approach.\textsuperscript{149} It makes sense that if complementary and alternative medicine methods enhance human healing, then they should be incorporated and utilized.\textsuperscript{150}

While the standard of Western medicine aims to be evidence-based,\textsuperscript{151} it is important not to place too much emphasis on evidence in dealing with complementary and alternative medicine. The process of healing is complex and so too are the systems in
the body that impact health. Quantitative methods alone cannot be used to understand the benefits of complementary and alternative medicine as they are limiting in their nature. In order to gain the best possible understanding quantitative and integrative qualitative studies are essential.152

Barrett conducted two interview based qualitative studies to probe complementary and alternative medicine practitioners and users, across multiple fields of complementary and alternative medicine, for a qualitative understanding. The two studies sought the following information (at a minimum) of complementary and alternative medicine: 1) what is it, 2) how are goals accomplished, 3) how is it different from Western medicine 4) can complementary and alternative medicine approaches be integrated with Western medicine, 5) what are the barriers, and 6) how can the barriers to integration be overcome? While the author has summed the purposes of the two studies into one summary, it is important to note that according to Barrett the first study was to be more explorative and descriptive, “aiming for an in depth understanding of knowledge, beliefs, and behaviors of practitioners and users of complementary and alternative medicine.”153 The second study sought, “descriptive overviews of practices, for thoughtful comments about the relations between complementary and alternative medicine and conventional, and for perceived barriers to integration.”154
Attributes that separate complementary and alternative medicine and conventional medicine.

As a result of both study interviews the following primary themes emerged: holism, empowerment, access, and legitimacy (HEAL). The belief amongst those interviewed was that complementary and alternative therapies are more holistic because of their approach to health. Their claims were consistent that the mind, spirit and body were cared for in complementary and alternative medicine. Users who participated in the interviews cited enjoyment of the individualized treatment plans and they felt empowered. The reasons for utilization by those seeking complementary and alternative medicine varied one from another, but remained consistent with what practitioners believed the reasons were. In summary, the desire was for a more integrated, holistic individualized modality of care.
Quality

Complementary and alternative medicine is utilized to address many ailments and emphasize the mind, body, and spirit connection. Incorporating the various modalities and integrating those modalities into the current healthcare system in the United States can provide quality care to patients. While research and evidence in the field of complementary and alternative medicine is increasing, the inclusion of complementary and alternative medicine should not solely rely on research or evidence-based data. In spite of the availability of evidence (or perceived lack thereof) patients are citing benefits and satisfaction with complementary and alternative medicine in some instances. For example, patients cite satisfaction with chiropractic, massage, relaxation techniques, yoga, acupuncture and herbal medicine for treating back pain. Quality of care looks to the degree to which health services meet patients' need and expectations of patients.

There are also challenges in the pursuit of evidence-based data from clinical trials that provide challenges to research in general and research as it relates to complementary and alternative medicine. In general, there are challenges with enrolling eligible patients into the trials, as few individuals are willing to accept the risk as research subjects. There are also methodological challenges, such as development of appropriate controls and placebo interventions. Development of individualized versus standardized approaches also present research challenges, as well as tools and measurement issues. Developing research around complementary and alternative medicine requires researchers to adapt existing research methodologies because of the nature of complementary and alternative medicine often utilized more than one method to address the whole person. For example, complementary and alternative medicine often use more than one procedure/technique,
and often address the whole person rather than specific symptoms. There are times when a patient achieves overall improvement, but the primary concern does not resolve. According to research standards a well-designed randomized control trial is based on established research as it supports the formation and design of new studies. There are multiple complementary and alternative approaches where there is limited or no such research to utilize. These challenges can delay research that meets the highest quality standards and therefore impact the benefits of satisfaction to patients who desire to utilize different complementary and alternative medicine approaches.

Care needs to be broader, whether or not there is evidence because sometimes the evidence that is requested can never be provided, thus the need to incorporate complementary and alternative medicine. Even though the evidence may never be provided, quality remains an important factor in incorporating complementary and alternative medicine, and as such quality must be considered. Quality in health care is important, and by extending care to include complementary and alternative medicine, it is important to look at definitions and conceptualizations of quality (and how they relate to, apply to, complementary and alternative medicine).

A relationship exists between quality of care and ethics, which is embodied in the personal ethics of the providers in relation to the patient; and the overall quality of the healthcare system. Donabedian described measures of health care quality; technical quality, service quality and ethics quality. Measures of technical quality help ensure that patients only receive the procedures and services that they need. Technical quality is comprised of efficacy, effectiveness, efficiency and optimality. Service quality measures and assesses aspects of care such as respect and cultural awareness. Ethics quality is
comprised of legitimacy and equity. According to Donabedian, the legitimacy component of quality is defined as “conformity to social preferences as expressed in ethical principles, values, norms, laws and regulations.” Conceptualization and determination of quality may vary depending on the perspectives and priorities. While society may view and desire certain components of quality, the individual, who may have differing priorities and perspectives, could define quality another way. The equity component of quality looks at what is just and fair in the distribution of health care in a population.

Conceptualizing quality

Analysis of the relationship that exists between ethics and quality through organizational codes of ethics, standards such as those set by the Joint Commission and specific measures of quality will support the relationship. The American Medical Association and the American Nurses Association have established codes of ethics that guide behavior and set standards that place patients’ well-being at the center. Therefore physicians and nurses have the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable. Organizations establish ethical guidelines in attempt to ensure quality through codes that address appropriate staffing, requirements for documentation and its content (American Nurses Association), credentialing and privileging and informed consent (American Medical Association). Each code provides for the protection of the vulnerable patient, respect for their rights and autonomy.

The Joint Commission establishes standards for ambulatory health care, behavioral health care, critical access hospital, home care, and hospital care to promote
patient safety. The different standards address protection and safety for the patient by ensuring a verification process for correct patient and correct site and standards relating to infection prevention, such as hand hygiene standards. There are also specific measures of quality that can be demonstrated through improved clinical outcomes. Additionally, awards exist that acknowledge successes in quality, like the Malcolm Baldrige National Quality Award.

**Impacts of Holistic Care on Quality**

The standards mentioned in the prior section as well as many of the guidelines and underlying principles that apply to mainstream medicine apply to holistic care, such as standards related to patient safety, which are included the guidelines. The Institute of Medicine proposes that the aims of quality care are that it is safe, effective, patient-centered, timely, efficient, and equitable, which support the incorporation of patient safety in the guidelines. It is important that the underlying purpose of focusing on quality is not lost by focusing solely on the metrics. In the cases of certain diseases and conditions where no cure exists, and medications produce side effects, holistic care offers patients ways to deal with the disease and symptoms, until medical research develops a medication with less side effects or a cure.

Patient centered care is an important goal of ethics and requires the respect of the patients’ autonomy. Holistic care is patient centered, as it honors a patient’s right to choose whichever individualized course of care works for individual. In other words holistic care is individualized. Effective communication and involvement in decision making as essential to quality care. A study of the Institute of Medicine’s perspectives on quality, contribute to a more thorough understanding of quality and demonstrate that
the various factors of quality have an ethical basis. Patients also seek complementary and alternative medicine for a sense of an improvement in their quality of life.\textsuperscript{182} Furthermore, Donabedian created a model that through understanding of the relationship between structure, process and outcomes, and the ability to explain said relationship allows for inferences to be made about quality of care as it relates to ethics. The analysis of holistic care against these frameworks will demonstrate the impact that holistic care has on quality.\textsuperscript{183}

In understanding the quality impacts of complementary and alternative medicine it is important to understand what metrics and measure were taken into consideration when looking at improvement and by what quantitative or qualitative amount those measures will improve. The indicators for improvement should demonstrate (or at least indicate) how incorporating complementary and alternative medicine is better for the individual, and if possible better for providers and policy makers as well. The importance of demonstrating betterment cannot be understated as Western medicine has a hold on reimbursement because of requirements of the Federal Drug Administration and the need for evidence in order for a new idea, new mode of treatment to be reimbursed. The model of reimbursement essentially eliminates the poorer section of society from obtaining complementary and alternative medicine due to limitations insurance coverage (lack of coverage of complementary and alternative medicine). Many who obtain complementary and alternative medicine pay out of pocket (a whole spectrum of people exist who cannot afford). Identification of these indicators and methodologies to measure them will further the inclusion of complementary and alternative medicine.
The reductionist approach yielded benefits to science but had the limitation of only looking at parts, while the model of holism allowed for more systems based review and an evaluation of systems function. That conceptualization of interrelatedness is the underpinning of holistic care. Holistic care is achieved through complementary and alternative therapies. Those therapies impact the quality of care that patient’s experience through satisfaction’s with complementary and alternative medicine treatment modalities. While, the evidence base for complementary and alternative medicine is limited, it is expanding. As the research is being developed it is important to include the methodologies in care for patients as there are benefits that patients are experiencing in the absence of clinical trials that demonstrate efficacy. The reasons for extending complementary and alternative medicine to care go beyond the quality impacts and benefits to patient, to the ethical justification for the inclusion of complementary and alternative medicine in care.
Chapter 4 – Ethical Justification of Holistic Care

In this chapter the topic is the ethical justification of holistic health care.

According to Miles, medicine has drifted away from its holistic foundations, and is incomplete as a result of increased reductionism in medicine, which in turn was a catalyst for things such as the evidence based medicine focus and an increased interest in complementary and alternative medicine. Holistic care is utilitarian in its implementation, as utilitarianism can be conceptualized as maximizing happiness and reducing suffering, in other words holistic care makes people feel good. The ‘golden rule’ provides a check for proceeding with holistic care. Holistic care is universalizable according to Kant’s categorical imperative and therefore morally justifiable. This chapter will demonstrate that it is ethical to perform holistic care. “Most therapeutic approaches of complementary and alternative medicine are built on a holistic ontology of health and illness, in which nonmaterial aspects like spirit, emotion, mind, or balance and equilibrium, inner resourcefulness of the organism, connection, meaningfulness, hope (or their lack) are rated as inseparable from the physical state of health.” The holistic nature of complementary and alternative medicine, will allow for those treatments to serve as practical application of holistic care and a means to conduct the ethical analysis. The foundation of the argument will be made by presenting the need for the justification of holistic care due to the perceived risk of complementary and alternative medicine, and the ethical ways providers can address the perceived risks. After addressing methods to mitigate the perceived risks, ethical arguments can be made for the provision of health care through the exploration of the right to health care and as a result there is a subsequent duty to treat. Given the purpose of treatment is to attempt to obtain health,
and the definition of health is grounded in addressing the mind, body and spirit, it
naturally follows that the holistic nature of complementary and alternative medicine is
suited for the treatment. The right to health care can be general or specific. The duty to
provide health care to Veterans is an example of a specific right to health care and is
justified by a category of moral ideals, supererogation. Finally, vulnerability, provides an
overarching construct that calls action to be taken due to vulnerable nature of the sick.

Assessment of Risk

Providing holistic care through complementary and alternative medicine, has been
challenged because there are claims that there is limited or no scientific proof of the
effectiveness of various complementary and alternative medicine therapies. However
there is a high degree of clinical legitimacy, which describes the acceptance of treatments
by society. If clinical and scientific legitimacy, are met for a certain treatment, then that
treatment could be included into the regular treatment options offered to patients.

“Complementary and alternative medicine practices are consistently described as being
therapeutically beneficial without, or with comparatively minimal, harm.” For
example, according to Nahin et al, Institute of Medicine reported that the Cochrane
Collaboration conducted 145 reviews of complementary and alternative medicine and
determined that 66% had insufficient information to make a determination. There are
still risks to patients when considering medical treatments, and there are also risks with
complementary and alternative medicine treatments and potential harms. Examples of
harm include: the desired treatment is hazardous, patients choose a less effective
complementary and alternative medicine therapies when there is a more efficacious
conventional medicine treatment, or due to provider bias the provider does not share a
complementary and alternative medicine approach that could have been beneficial.\textsuperscript{191} According to Cohen et al, consideration should be given to the available evidence. The evidence should be evaluated to determine if it, 1) supports both safety and efficacy; 2) supports safety but is inconclusive about efficacy; 3) supports efficacy but is inconclusive about safety; or 4) indicates either serious risk or inefficacy.\textsuperscript{192}

Adams et al, present a risk-benefit framework that providers can utilize to determine the appropriateness of proceeding with (or referring a patient to a complementary and alternative medicine practitioner) a complementary and alternative medicine treatment in various situations. The Risk-Benefit analysis framework provides seven areas of consideration when assessing a complementary and alternative versus conventional medical treatment. The framework looks at 1) severity and acuteness of illness, 2) curability with conventional treatment, 3) degree of invasiveness, associated toxicities, and side effects of conventional treatment, 4) quality of evidence of safety and efficacy of the desired complementary and alternative medicine treatment, 5) degree of understanding of the risks and benefits of complementary and alternative medicine treatment, 6) knowledge and voluntary acceptance of those risks by the patient, and 7) persistence of the patient’s intention to use complementary and alternative medicine treatment.\textsuperscript{193} This risk framework for complementary and alternative medicine therapies allows the physician to assess varying degrees of each area of consideration, engage the patient in shared decision making, after a thoughtful, ethical, and medically responsible evaluation, that will be evidence based, ethically appropriate, and legally reasonable.\textsuperscript{194} Applications of the risk-benefit framework to situations will lead to different recommendations by the provider. For example, if there is evidence that supports safety
and efficacy, the provider should recommend the therapy and provide monitoring. Another application could be if there is no evidence that leans either towards or against the therapy, and in those instances the provider could discourage the use or tolerate the use and monitor the patient.

The provider’s evaluation of treatment options and the disclosure of the risks and benefits is a part of the informed consent process, which is marked by the patient’s autonomous choice regarding how to proceed. Informed consent is a three-step process. The first requires the patient to have capacity to make decisions. The second requires pertinent information about the proposed treatment, including risks and benefits to be clearly disclosed. The disclosure on the part of the provider must meet the patient’s informational needs. The third step requires the patient to authorize proceeding with treatment. Informed consent should also be sought when there are significant risks to treatment. Informed consent should be obtained for complementary and alternative medicine treatments. In instances when the treatment has not been validated, this should be made clear when consenting the patient.

When providers are discussing potential treatment options with patients it is important for them to keep the principles of autonomy, nonmaleficence, beneficence and justice in mind. Autonomy is in part grounded in the concept that individuals have intrinsic worth and as such they have the right to choose how to proceed in their life. This is a Kantian ideal. Everyone has the right to make choices about medical treatment. Autonomy recognizes and emphasizes that one has the right to self-determination and the right to make decisions without interference, to be left alone. Autonomy also rests in one’s capacity to make decisions. Capacity requires that the
individual has awareness of self, the independence to make decisions (free from interference) and the ability to make decisions rationally.

There may be instances when patients choose complementary and alternative medicine treatments when there is a lack of evidence showing benefit or clear evidence exists showing that the desired treatment is ineffective. Of note, if the patient makes a decision that is not the decision another individual would make this does not mean the decision is irrational. As long as the patient making the decisions understands the factors surrounding the decision, can formulate and evaluate alternatives and can evaluation the potential consequences of the decision based on truthful personal values and beliefs; the decision is formed rationally.

A patient with capacity has a right to choose the quality of life that is consistent with his values. The autonomous agent is entitled to decide for himself what values and goals will guide his care. There is also the negative right allows patients the choice to forgo care based on the principle of autonomy. Should the autonomous agent decide on a medical intervention or to forgo a medical intervention for a holistic complementary and alternative medicine therapy, the provider should ensure the patient is informed of the options and the potential risks and benefits in proceeding with the requested course of action. As complementary and alternative medicine is a way holistic care is provided, the conventional medicine provider does not have to provide the complementary and alternative medicine therapy, but the provider should have at least a general knowledge of complementary and alternative medicine and be able to guide the patient as requested. The provider should also be knowledgeable about complementary and alternative medicine treatments to engage the patient effectively in shared medical decision making.
and to accurately carry out the informed consent process. The autonomous patient also partners with the provider in shared medical decision making (based on both autonomy and beneficence).

Nonmaleficence, the obligation not to inflict harm to the patient or others. If the justification exists to provide care, furthermore holistic care, then justice demands the provider (and even more globally society) to treat people fairly. Therefore, individuals who are similarly situated should be treated equally and those who are not similarly situated should be treated unequally. Ethical decisions should be consistent unless circumstances exist that can justify a different decision. Nonmaleficence would support the treatment of choice to be provided to the patient (especially if holistic care is being sought due to the ineffectiveness of medication) because not doing so would constitute a harm to the patient through a loss in quality of life and the potential depression due to the patient’s incurable medical condition. In attempts to avoid harm to the patient, the provider should ask the patient about the patient’s complementary and alternative medicine use.

Analysis of the principles of beneficence (‘doing good’) and nonmaleficence begins to frame the requirements to provide care, the goal is for the two principles, when considered together, to yield a net benefit. There is an obligation to ‘do good’ unto others. Another explanation of beneficence is the obligation to prevent harm, to remove harm or evil, and positively to promote good to others. Promoting good always requires an assessment of potential negative outcomes or harms. Beneficence trumps autonomy in situations where the rational capacity of the patient is impaired or non-existent.
Right to health care

The right to the highest attainable standard of health was first reflected in the World Health Organization’s Constitution (1946), and emphasized in the World Health Declaration by the World Health Assembly in 1998. According to the World Health Organization (1986) health is a “state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”

Health care can be viewed as a fundamental human good because it affects “our opportunity to pursue life goals, reduces our pain and suffering, prevents premature loss of life, and provides information needed to plan our lives.” Everyone has a right to health care although this right is not absolute. Article 25 of the Declaration of Human Rights states, “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”

From a Christian standpoint health care is essential for maintaining health and health is essential to the dignity of human life. Human dignity holds that every human has an inherent right to respect and ethical treatment. There is an obligation to providing healthcare. Additionally, there are several other Christian based organizations that support the obligation to providing healthcare such as the U.S. Bishops and the Seventh Day Adventists. The U.S. Bishops would also say that “access to that health care which is necessary and suitable for the proper development and maintenance of life must be provided to all people, regardless of economic, social or legal status.” The U.S.
Bishops did however explain that health was not only physical, but that health demanded a wholeness that included spirituality and psychological health as well. The U.S. Bishops concept of justice in terms of health care is more clearly defined. They call for every person to have adequate health care because it is a basic right and that each individual has unique human dignity which is affected by ones health status and dignity must be maintained. They have also determined that the health care system should use multiple resources including, but not limited to public, private, and religious sectors, and that a pluralistic approach is essential. The national health care policy should maintain and promote good health, treat disease and disability, and there should be uniform standards throughout the healthcare system. They believe a national health insurance program should be developed. Their approach takes an egalitarian view, promoting equal health care rights for all people. For those who believe in health care for all, the U.S. Bishops tout that everyone has a part to play in the health (physical, spiritual and psychological) for the individual and society.

According to the General Conference of Seventh Day Adventists, Seventh Day Adventism is a faith based religion. They believe firmly in The Bible as their only creed and hold certain fundamental beliefs to be the teaching of the Holy Scriptures. They believe in the Bible as a whole, both the Old and New Testaments. These beliefs, as set forth here, constitute the church's understanding and expression of the teaching of Scripture. The Holy Scriptures provide the foundation and validate the various belief’s of that faith. Seventh Day Adventists are committed to caring for the whole person. They are concerned not only with physical ailments, but also emotions and spiritual issues as well. The belief is that the truth about the patient’s condition should be shared with the
patient as long as they are capable of understanding.\textsuperscript{219} Christian compassion is desirous of alleviation of suffering. There is a responsibility to relieve pain and suffering.\textsuperscript{220}

Two other arguments from a spiritual perspective are presented by Koslander et al and Polzer Casarez and Engebretson. Koslander et al also base their argument on a holistic perspective. Their position is that “a human being is understood not merely as a physical or biological being, but also as a person with intentions and ambitions and endorsing values, who lives in a social context and who strives to fulfill his or her life plans or vital goals.”\textsuperscript{221} Koslander et al define health based on Nordenfelt’s concepts based on a humanistic view of the human being. This view characterizes the human as consisting of body, soul and spirit. Additionally, the humanistic view approaches health care in a way that addresses more than the human biological component, but also addresses the psychosocial, existential and spiritual dimension of the human individual.\textsuperscript{222} Koslander et al, also emphasize that health is a human right. The second portion of their pragmatic argument is that most humans experience a link between religion and health. Based on the right to health and the linkage of health to religion, Koslander et al conclude that it is legally and morally wrong to deny patients their need as it violates human dignity.\textsuperscript{223} Koslander et al goes on to add a third piece to the argument that states that a majority of the world experiences and recognizes spiritual needs and by positively meeting those needs there will be an influence the individual’s health.\textsuperscript{224} These three points formulate Koslander’s argument for a holistic view of health care which includes patients’ existential and spiritual needs.

Polzer Casarez and Engebretson, also view spirituality as an important element of health.\textsuperscript{225} They point to the use of spiritually in health care literature, and its use of the
terms ‘spirituality’ and ‘religion’ interchangeably. The concepts are different, although related. Polzer Casarez and Engebretson also point to the integration of spiritual and religious practices, as Koslander et al did, as that integration maintains a holistic approach. Polzer Casarez and Engebretson differ in their argument by presenting specific ethical concerns regarding omission and commission of spiritual care. They proceed to detail provider preferences in offering spiritual care strategies to integrate spiritual care. They state outright that in terms of ethical concerns of omission that it is outright “unethical for health care providers to omit spiritual care.” Reason being that patients “are holistic human beings, including physical, psychological, social and spiritual aspects of the self.” Given their position, providing patient care without a spiritual component is lacking, therefore creates an ethical duty to provide spiritual care. In providing spiritual care there is an ethical concern of commission (coercion or overstepping one’s competence in offering spiritual care). Polzer Casarez and Engebretson refer to Pesut and Sawatzky to identify two approaches to spiritual care. Descriptive is what the provider does in response to a patients spiritual needs versus prescriptive, where a provider attempts to modify patients spiritual needs. When providers provide spiritual care it should be descriptive in nature. The right to health care can be viewed as a positive and negative right. For the purpose of providing care to patients the right to health care is viewed as a positive right. This positive right requires that actions are taken to improve health. Given the right to health and therefore the right to health care, and health is defined in terms of the whole person, holistic health care defined as “the art and science of healing that addresses care of the whole person - body, mind, and spirit, by
prevention and treatment-to promote optimal health.” 233 is aligned in addressing whole person’s health.

Duty to Treat

There is a duty to treat individuals seeking care from medical professionals. To what does the duty to treat extend and what are the limits of the duty to treat? In the United States there is not a legal duty to treat beyond the scope of the Emergency Medical Treatment and Active Labor Act (EMTALA), for hospitals who receive payment from the Centers of Medicare and Medicaid (42 U.S.C Section 1395). There is an moral and ethical duty to treat and provide care because healthcare is a right. Ethics describes the various ways of understanding and examining the moral life, 234 and morality refers to norms that are widely shared regarding right and wrong human conduct. 235 In the Veterans Health Administration there is not only a moral duty but a legal duty to provide care when Veterans and their families qualify for Veterans Administration Benefits.

Veterans have volunteered to serve the United States of America, and in so doing are asked to give of themselves in excess. Their service is of great value and most Americans would not serve their country in such a capacity. Because of Veterans, we as Americans are free. Veterans sacrifice, life, limb and liberty, so we as nation can maintain our liberty. “The essence of the military service is the subordination of the desires and interests of the individual to the needs of the service.” 236 Members of society find the most enjoyment in life in the ability to pursue whatever goal or desire, at whatever time, for however long and with whomever they choose. Whether is the pursuit of education, a spouse, a family or a simple as some lay activity. Those who already have families and those they love and care for, leave them behind for the duty to care for and
protect the nation. Due to their service to the nation, we as a nation have a duty to provide them with healthcare in a supererogatory manner, beyond what is due. This is not to say we are giving Veteran’s more than what they deserve, but that in striving to provide more than what is due should ensure above adequate care, and due to the damage suffered by veterans, their care is of the highest priority.

An article in the *Pittsburgh Post-Gazette* stated that the Iraq war has increased America’s debt to those who served. They sighted the surge of troops, “producing a record year for US deaths.” Americans keep an enduring covenant with their soldiers. These men and women put their lives at risk by fighting, and sometimes killing, others for the nation’s security. In return, the United States promises to take care of them according to the needs they acquired during their service. The Iraq war has greatly increased that debt. An estimated 700,000 American soldiers have served there. More than 3,800 are dead and thousands more are wounded. Due to the increased sophistication of medical care, some wounded will live who in previous wars would have died.

“The Golden Rule” as presented in the New Testament’s Matthew 7:12 states, "Therefore all things whatsoever ye would that men should do to you, do ye even so to them: for this is the law and the prophets." This text is further substantiated by Luke 6:31, “And as ye would that men should do to you, do ye also to them likewise.” This context is governed by the command/charge to “love one another as I have loved you.” Ricoeur’s utilizes a “logic of superabundance” – the idea that we should treat others with overflowing generosity – as God has treated us – not just as we consent to being treated or are (minimally) willing to be treated ourselves. God gave of himself expecting nothing in return, but love. There is nothing that human kind could ever offer to Him that
could ever, repay God for His unending gifts and blessings. The bible portrays many parables of the actions God has done in favor of humanity, sinful and imperfect. He sent his Son to die for the salvation of the world. Jesus then provided healing of the lame, lepers, the blind and raised the dead. We too should give with such generosity.

Ricoeur argues that the Golden rule is a refinement to the law of retaliation, which some used to undermine the Golden Rule.242 This retaliation is initiated by the doer. The doer is charged to do good, and based on the laws of reciprocity the recipient in turn should do good as well. Once the recipient does good to the doer and or another the cycle of good acts is bound to continue as long as the golden rule is central to society, whether consciously or subconsciously. The golden rule along with God’s command to love as I have loved you, but rely on the basis of because, for the reason that (or since), I have done, do the same. Reciprocity therefore can have an exponential effect on good actions, leading to a concept of generosity (logic of superabundance) or supererogatory treatment. The act of promising itself is supererogatory, then so is its fulfillment, even though the expectation created by the promise means that after being made it must be fulfilled.243

Supererogation

“Supererogation is a category of moral ideals pertaining principally to actions.”244

There is a specific moral and legal right to health care in the aforementioned Veteran population, from a justice perspective, and supererogation is the foundation for the discussions on the Veterans Health Administration in the chapter to follow.245

Supererogatory comes from Latin supererogare, "to spend over and above," from super, "over, above" + erogare, "to ask for," from e-, "out" + rogare, "to ask, to request."246 The ethical definition of supererogation must include a condition that the

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action be of a particularly moral value. The source of this particular value is double: the good intended consequences on the one hand, and the optional nature of the act on the other.\textsuperscript{247} Supererogation is the performance of more than is asked for, the action of doing more than duty requires. Supererogatory, in ethics, indicates an act that is good but not morally required to be done. It refers to an act that is more than necessary, when another course of action, involving less, would still be an acceptable action. It differs from a duty, which is an act that would be wrong not to do, and from acts that are morally equivalent. For example, state prohibitions on killing, stealing, and so on originate from the state's duty to protect one's own citizens. However, a nation state has no duty to protect the citizens of an adjacent nation from crime. To send a peacekeeping force into another country would be (in the view of the nation doing it) supererogatory.

Moral conversation is concerned with guiding behavior rather than describing the world, normative. There are two categories of normative ethics, axiological (goodness, ideals and virtues) and deontological (what ought to be done, to duties and obligations, to justice and rights). Axiological assessment deals primarily with states of affairs and human agents, whereas the object of deontological evaluation is human actions. Deontology generally describes the minimal conditions of morality, the basic requirements of social morality that secure a just society, while the axiological sphere aims at higher ideals which can only be commended and recommended but not strictly required. Many (like Aristotle, Kant and utilitarianism), if not most, ethical theories maintain some form of this two-tier structure of the moral system. Supererogation lies at the intersection of the axiological and the deontic, the ‘good’ and the ‘ought’.
The good promoted is typically of an altruistic nature and thus an act may be supererogatory even if the overall good is not promoted (as might be the case in extreme acts of self-sacrifice for the sake of another). Supererogatory behavior is typically other-regarding: even if there are duties “to oneself” (which many ethical theorists doubt), they cannot be transcended in a supererogatory way. In that respect, most definitions of supererogation in modern ethics diverge from the Christian tradition: whereas for the latter paradigm examples of supererogation are piety and chastity, for the former these are altruistic deeds of extreme beneficence. There are, however, contemporary non-religious views which leave room for self-regarding actions of supererogation.248

As for the second source of value of supererogatory action, its optional nature, it should first be noted that supererogatory action must be voluntary (unlike obligatory action, which is often forced or enforced). The agent has full discretion whether to go beyond what is required and makes a personal choice to do so. One is neither under any external constraint (like the law), nor under internal demands (of rationality or of the Kantian moral law). In other words, supererogatory behavior is fully optional.

Doing one's duty does not win the agent any credit. He only did what he had to do. But going beyond the call of duty is meritorious exactly in the sense that the agent did something “extra,” breaking the balance of justice or that of respect for claim-rights and the fulfillment of duties. Furthermore, the traditional idea of merit (or “superabundance”) associated with supererogation is reflected in secular ethical theory in the duty of *gratitude*: acknowledging the meritorious nature of a gift or any non-obligatory well doing is the morally obligatory response (irrespective of the moral praise which might or might not accrue to the agent of the supererogatory act). While the general population
of the United States operates under the guidance of the “Golden Rule;” the military operates under the principle of supererogation, and always has. Based on the concept of supererogatory treatment the government works to continue to meet the needs of those veterans who have served this country, and exceed that need. Public Law 104-262, the Veterans’ Health Care Eligibility Reform Act of 1996,\(^{250}\) is an example of such behavior. The government looked at how they were providing care to the nation’s veterans and the means through which care was being provided was inadequate. The government reworked the system, the criteria for care and implemented a system of groups to determine how care would justly be distributed among the veteran population.

When individuals seek out health care patients expect that their health care needs will be met. Patients presume that the clinician’s decisions regarding their medical care will not be motivated by reasons other than the patient’s best interest in light of shared decision making. The ethics of care acknowledges the importance of establishing and maintaining practices that help people to meet their needs; develop and protect basic capabilities for emotional functioning and social interaction; and avoid pain and suffering.\(^{251}\) The duty to treat does not require that each patient, receive every potential treatment option regardless of efficacy, especially of the care is futile. As demonstrated earlier in this chapter, there is a right to health, a right to health care, that is mind body and spirit and we have a legal and moral obligation to provide holistic care to veterans as well. Care provided to Veterans through and integrated and holistic health care system will be further explored in chapter 5.

**Vulnerability**

Individuals become vulnerable due to decreased health. Daniels argues that
because health is so central to the enjoyment of all other primary goods, society has an obligation to ensure its equitable distribution above all else. He also insists that society is unjust if it does not try to raise everyone to the level of “normal” as defined “by nature.” So should modern medicine fail to achieve this, more is required to return the patient to a level of “normal”. Clearly, the costs involved in trying to achieve that noble end might well be prohibitive. Daniels’ contented that satisfying persons medical needs should take precedence over satisfying other needs, because without health the other needs cannot be fully realized. Many have cited their desire to utilize complementary and alternative medicine is due to modern medicine’s inability to meet their care needs. Based on Daniels something more should be provided, and as complementary and alternative medicine have proven effective when modern medicine has not succeeded, holistic care should be pursued.

Professionals have a fiduciary relationship to patients this relationship is defined based on the patient’s vulnerability and the need to submit to the care of the physician through trust. Due to this relationship health care providers are held to a higher standard. The individual seeking care is vulnerable. This individual is vulnerable because the patient has sought care to return to his standard of health, or as close to that standard as reasonably possible. Due to this vulnerability there is an obligation to provide care. This obligation is morally rooted and is embodied in the Hippocratic Oath. The duty to treat is also a portion of the informal contract with society. In exchange for providers services to individuals and society, providers have professional autonomy and generally public responsibility amongst other privileges.
Vulnerability can be conceptualized in many ways but the common use of the term describes situations that should be avoided through intervention or protection. The term vulnerable as defined by Webster Dictionary and other sources define vulnerable, as capable of being physically or emotionally wounded, or open to attack or damage. Senior citizens are a vulnerable group as they often look to complementary and alternative to relieve symptoms of chronic disease and maintain overall health. This vulnerability requires outside forces beyond the vulnerable group. Goodin expands on the concept of vulnerability by stating one is “vulnerable either to manmade threats or natural ones... or to speak of someone's being vulnerable either to harms that come about through others’ omissions or neglect or to harms that come about through others' positive actions.” He defines vulnerability even further by including harms that arise through inaction. Agrawal offers another definition that incorporates the increased potential that an individual’s interests cannot be protected. This broad definition incorporates various interests that might require protection, and any of those interests can be at risk at any time.

Evidenced by the multiple definitions and conceptualizations of vulnerability, defining the term yields challenges, because one is at risk of to defining the term too narrowly or broadly, which can further complicate an already challenging concept. The more broad definitions look at humanity. Utilizing the definitions of the term from Wisner, one can make the argument that human beings are all vulnerable at one point or another, and vulnerability implies some form of dependency and due to this vulnerability are subject to some form or protection or moral or political action. Taking such action raises issue of social inclusion or exclusion which can lead to public policy.
The conceptualizations of vulnerability that make obligations to individuals families, friends and others of importance especially strong, can also give rise to similar responsibilities or special attention toward a much larger group of people and populations. Vulnerability, dignity and integrity can perhaps be more accurately understood as anthropological descriptions of the human condition. According to Morawa, the terms ‘vulnerable’ or ‘vulnerability’ are often used to describe a population, segments of a population or groups. Vulnerability as a term pertains to a population, a smaller subset of a population or down to the level of an individual or a patient whereas the required protection that results from vulnerability is required from an agent. Vulnerability, in terms of being at risk of harm is something that should be reduced.

Attempts to ground obligations directly in vulnerability have been made in bioethics. The present proposal accepts that the vulnerable have a claim to protection; but this claim is grounded in other claims that would lead to action. According to Levine, “If everyone is vulnerable, then the concept becomes too nebulous to be meaningful.” A vulnerable group must be identified in order to apply special interventions or protections. The identification of the vulnerable group can have positive and negative impacts.

The positive effect of defining a population as vulnerable is that it provides this group with special attention and protection to limit the vulnerability. The special attention leads to the care the individuals need. On the other hand, labeling a group as vulnerable can have negative impacts on the group as well. The impacts could be similar to that of stigmatization. However depending on the reason for the vulnerability or the size of the group defined as vulnerable could limit the negative impacts. Defining the group of
individuals that is vulnerable has no negative implications in regards to being classified as such.

The typical 15 minute primary care visit for the socially disadvantaged virtually ensures the perpetuation of health care disparities. Socially disadvantaged patients often referred to as vulnerable, are defined groups who because of shared social characteristics are at higher risks for multiple risk factors. Members of racial and ethnic minority groups and persons with low literacy and socio economic status are especially vulnerable.

According to trends, those who utilize complementary and alternative medicine are more likely to be from higher socioeconomic classes, but this does not mean those in lower classes are not utilizing complementary and alternative medicine as a mechanism for holistic care, but justice calls for fair equitable treatment of all people, and given the vulnerability of those who are ill and moreover in a lower socioeconomic status, special attention should be given.

Holistic care is ethically justified when the risk to patients are addressed with the patient through shared decision making and the competent patient makes an autonomous choice. Holistic care is further justified by the definitions of health that include the whole person, and in defining health in this fashion (addressing the mind, body and spirit) calls an holistic approach to care through complementary and alternative medicine. There is a right to health, a right to health care and therefore a duty to treat vulnerable patients.

There are instance when the right to health care moves beyond a general right, such as the supererogatory service of Veteran requiring society to respond to their needs for health care in kinds. In order to further understand the applications of complementary and alternative medicine in holistic care the field of holistic nursing and the Department of
Veteran’s Affairs will be explored.
Chapter 5 – Review of Existing Models of Holistic Care

This chapter will describe two existing models of holistic care, and an overview of the chosen models will be provided. The principles of each model will be evaluated against the established definition of holistic care and specific pieces of the model will be demonstrated through research studies, or practical application of the model. As a portion of the description of each model, examples will be provided that aid in a better understanding of the model and how the models can provide insights into incorporating complementary and alternative medicine into holistic care.

Holistic Nursing

The American Holistic Nurses Association (AHNA) began 1980, with the mission “to advance holistic nursing through community building, advocacy, research, and education.” The founding of this national group was a catalyzing factor in the holistic nursing movement. Holistic nursing is defined as “all nursing practice that has healing the whole person as its goal.” Given the overarching definition of holistic nursing, the practice welcomes all nursing that enhances healing of the whole person as its goal. Holistic nursing bases is practices of both views of holism: the interrelatedness of the dimensions of the whole person (mind, body, spirit), and understanding the whole person in relation to the environment. They believe they can meet the goals of nursing in either framework, the whole person as its premier goal. Although all nursing practice can have a biopsychosocial perspective, holistic nursing is indeed its own specialty because, “there is a philosophy, a body of knowledge, and an advanced set of nursing skills applied to practice that recognize the totality of the human being, the interconnectedness of body, mind, emotion, spirit, energy, social/cultural, relationship, context, and
Their role as a holistic nurse goes beyond just the care provided; it is a way of being, living, and a way of practicing that can be transformative to the nurse’s life and work. A qualitative study by Sharoff, explored the journey and motivations of experienced holistic nurses becoming certified holistic nurses. The first step in the process that the study identified was the health care provider having the self-awareness (a holistic nursing core value), to note their need to work in a nursing paradigm that is in alignment with their own beliefs.

Holistic nursing is centered around the person and relationship with a focus on healing. Self-care, presence, mindfulness and therapeutic use of self are a few of the practices that holistic nursing places emphasis on as essential for the facilitation of healing. Throughout diagnosis and treatment, the holistic nurse focuses on “protecting, promoting, and optimizing health and wellness, assisting healing, preventing illness and injury, alleviating suffering, and supporting people to find peace, comfort, harmony, and balance.” The holistic nurse functions as an instrument of healing and a facilitator in healing, and can function in any setting (ex: hospital, private practice, education, research). For example, Nathenson presents a conceptual model of holistic nursing that can assist with holistic nursing application in other nursing subspecialties. He especially thought rehabilitation was a subspecialty where the competencies of holistic nursing are comparable and can even align with the principles and practice of rehabilitation nursing. Rehabilitation can be viewed as a holistic specialty because comprehensive services are delivered within a holistic framework which emphasizes and values the intimate connections between mind, body, and spirit. Rehabilitation is deeply rooted in high touch interventions that encourage, coax, and inspire people on their journey to rehabilitation.
and wellness in addition to other sophisticated approaches of science, neuroscience, and engineering. According to Nathenson, holistic nursing is a perfect fit for the rehabilitation setting because holistic nursing theory is based in and has an established framework that provides care in accordance with bio-psychosocial-spiritual concepts. The bio-psycho-social-spiritual framework is a cornerstone in holistic nursing. Incorporating holistic nursing to rehabilitation will provide a benefit to the patient because the patient will receive care that promotes health and wellness in all aspects of the patient as whole.

Holistic nurses seek to honor each individual's health experience, health beliefs, and values. As an instrument of healing, holistic nurses partners with individuals, families and even broader to the community, and utilize their knowledge and skills “nursing knowledge, theories, research, expertise, intuition, and creatively incorporating the roles of clinician, educator, consultant, partner, role model, and advocate.” Each holistic nurse is required to integrate self-care, self-responsibility, spirituality, and reflection in their own lives. The rationale is that once the nurse obtains as better awareness of interconnectedness with self, others, nature and God, the nurse will therefore have an enhanced understanding of others and their relationship with their surroundings. This awareness facilities the healing process.

This is especially relevant when incorporating spiritual care into clinical practice. Ethical concerns of omission (omitting spiritual care) and ethical concerns of commission (inappropriate application of spiritual care), were explored in chapter 4. Nurses are positioned in a different relationship the patient as the foundation of nursing is caring for the whole person over the health continuum, and are pivotal in managing patient care.
in every healthcare setting. Holistic nursing practice takes into account the impact of
the nurse on the patient and the healing process. As finite sacred beings, the energy
fields we emit affect each other, therefore negative interactions with patients will
potentially thwart the healing process. A requirement of providing holistic care
according to the American Holistic Nurses Association is self-care, which includes deep
insights into personal health on all levels (physical, mental, spiritual) and an individual’s
own truth.

As spirituality is an important element of health, spiritual issues may be important
to the patient while pursuing healthcare as a result of illness. To that end nurses are
knowledgeable about, and use spiritual interventions. Polzer Casarez and Engebretson
found that ethical concerns of omission occurred when nurses feared personal discomfort
in dealing with spiritual issues. In omitting spiritual care, in an area that is of vital
importance to some patients, can impede healing and is an example of maleficence.

The ethical principle of justice is often referred to as advocacy in nursing. Nurses can
assist patients in achieving autonomy as an advocate, and increase the likelihood of
patients voicing their spiritual needs.

There are 5 core values of holistic nursing: 1) Holistic Philosophy, Theories, and
Ethics, 2) Holistic Caring Process, 3) Holistic Communication, Therapeutic Environment,
and Cultural Diversity, 4) Holistic Education and Research and 5) Holistic self-care. The
core values in conjunction with the standards of practice to reflect the dynamic art
and science of holistic nursing practice. The core values of holistic philosophy,
theories and ethics speak to the relationship that the field of holistic nursing has to the
principle of holism, as nurses recognize the complexity of the human health experience,
and the fluid relationship of health illness and wellness in the value of healing. This core value also speaks to the ability of the nurse to choose which nursing therapies are applicable in each individual patient’s situation. In the same fashion as nurses apply nursing theories, holistic nurses also apply other perspectives of healing and theories of wholeness to guide their individual nursing practice. As explored in chapter 2, holistic health care describes the system of delivery that considers the whole person. A sound biological system (holism) depends on physical, mental, social and spiritual well-being, in other words the health of the whole person. The core value of holistic philosophy, theory and ethics ties directly into the established definition of holistic care. The final piece of the first core value is about ethics. This portion of the value states that holistic nurses “recognize and honor” that the individual is the authority of these own health experience. This value speaks directly to the ethics principle of autonomy which should be respected and valued at all times in its relationship to human dignity.

The second core value of holistic nursing is the holistic caring process. The six steps are assessment, diagnosis, outcomes, therapeutic plan of care, implementation and evaluation. In practicing the six steps, the holistic nurse continues to recognize the totality of the human person. This includes considering the relationship of the mind, body, spirit, social/cultural and environment in the care process. The holistic nurse focuses on the values (cultural and spiritual) and the emotions of the patient while addressing the physical aspects of healing. Like Hippocrates, this value speaks to the individual’s own healing process, where the care giver (nurse) does not produce or focus on the outcome, but facilitates the process. The concept of holistic care is based on the whole person (mind, body and spirit). This core value of the caring process also speaks to
appropriate and evidence based information related to health condition, treatments, and therapies. There are many therapies that are frequently incorporated into holistic nursing, and some are characterized as complementary and alternative therapies. Some examples of these therapies are meditation, relaxation therapy, energy-based touch therapies such as Therapeutic Touch, Healing Touch, Reiki, acupressure, massage, guided imagery, biofeedback and prayer. Snyder and Lindquist speak on these complementary and alternative therapies (and others) in nursing. They specifically explore each therapy by defining the therapy, providing the scientific basis of the therapy, how the nurse plays a role in the therapy and techniques utilized as a part of the therapy. In addition to that information they provide measures of outcome, specific uses of the specified complementary and alternative medicine therapy, evidence from literature and propose future research. In is important to note that research is a part of holistic nursing’s core values as well.

The third core value is holistic communication, therapeutic environment and cultural diversity. The communication piece focuses on the conscious intention of the holistic nurse to provide sincere, authentic, caring and compassionate communication in encounters with the patient without distraction. Through this level of presence the nurse is able to provide each patient with an interpersonal encounter that enhances the patient’s healing experience and process. The nurse conveys the value of the patient beyond the treatment encounter and nursing interventions the individual may be receiving as a part of care. The nurse is to create a therapeutic environment that values holism, caring, social support, and integration of conventional and complementary and alternative therapies. Holistic nurses are to have knowledge and understanding of numerous cultural traditions.
and health care practices from various racial, ethnic and social backgrounds.\textsuperscript{308} Through the holistic nurses deep listening to the patient, they are able to combine the patient’s priorities and values in care, healing and environment that are most conducive to the patient while emphasizing the cultural components of the individual.

The fourth holistic nursing value is education and research. Based on the holistic nurses education (both formal academic and continuing) the nurse has a broad knowledge and understanding of cultural norms, health care beliefs, health care practices and values of individuals and their families and even broader to communities. This informs the nurse in such a way that helps them help others to know themselves and enhances growth, wholeness and well-being. This knowledge and their education enable holistic nurses guide patients in their health care decisions especially regarding complementary and alternative medicine.\textsuperscript{309} The guidance they provide requires them to be knowledgeable about the best evidence available (reflected in holistic nursing core value holistic caring process) regarding complementary and alternative medicine and conventional practices. As the holistic nurses place value in proceeding with evidence the nurse conducts and evaluates research. An example of holistic nursing incorporation of research and education is the \textit{Inventory of Professional Activities and Knowledge Statements of a Holistic Nurse} study.\textsuperscript{310} The American Holistic Nurses Association furthered the holistic nursing movement by completing a role delineation study called the \textit{Inventory of Professional Activities and Knowledge Statements of a Holistic Nurse} (also known as the IPAKHN Survey) in 1997. The completion of the study enabled them to more efficiently and effectively develop holistic nursing curricula that addresses specific professional activities that like to knowledge, practice and research. The study also aided in the
development of certification exams that truly test the knowledge and skills of the nurse. The information gained from this study can aide in conference planning, clinical objectives and course requirements that shape holistic nurse training.

The last core value of holistic nursing is nurse self-care. Self-care, self-awareness and self-healing are essential to holistic nursing. Not only should holistic nurses have personal awareness of their role in facilitating healing, but they should also maintain a continuous focus on that role. To that end holistic nurses should consistently incorporate self-assessment, pursue continuing education and incorporate activities such as yoga, meditation, and nutrition practices. “Nurses cannot facilitate healing unless they themselves are in the process of healing.”

The American Holistic Nurses Association also points to the importance of the holistic nurse in care through measurement criteria that are a part of the 15 standards of holistic nursing. The first 6 standards relate to nursing practice, while the remaining 9 deal in professional performance. Each of the standards (inclusive of the measure of each standard) are reflective of the five holistic nursing values. Recall the ethical impact of omission and commission, holistic nurses would have the core values, and thus the resulting standards and competencies to avoid this ethical concerns that Polzer Casarez and Engebretson presented. They present that by offering spiritual care in a descriptive fashion, listening and being respectful, neutral and sensitive towards the patient’s spiritual wishes. The first step, clinical application, calls for self- awareness and personal reflection of the nurses values and cautions against those value imposing beliefs on the patient. Additionally, good communication skills will allow for better understanding of the patient. The holistic nursing core values of holistic
communication, therapeutic environment, and cultural diversity; holistic education and research; and holistic nurse self-care are particularly relevant. The corresponding standards and competencies position the holistic nurse to navigate spiritual care in accordance with the recommendations from Polzer Casarez and Engebretson.

The American Holistic Nurses Association describes each of their five core values in a way that provides practical understanding of holistic nursing. Moreover, the descriptions appear to embody the concept of holistic care, a system of delivery that considers the whole person, and depends on physical, mental, social and spiritual well-being. Holistic nursing has a natural link to complementary and alternative medicine as both holistic nursing philosophies and practices incorporate mind and spirit in healing. The major difference between the two is that holistic nursing is not therapy, but a way of living and practicing that continues far beyond providing direct patient care. Holistic nursing calls for self-evaluation to increase self-awareness and care.

Holistic nurses integrate complementary and alternative modalities into clinical practice to treat people's physiological, psychological, and spiritual needs. According to the American Holistic Nurses Association's position statement on complementary and alternative medicine, they believe the integration of complementary and alternative medicine into conventional care will enable patients to benefit from the best treatments. Their belief is that while certain complementary and alternative medicine therapies can be utilized by nurses in the care of their patient, the intervention should be a part of comprehensive holistic nursing practice. This belief not only integrates holistic care, which is embedded in the holistic nursing values with holistic care, but it also ties in complementary and alternative medicine. Holistic nurses, through their knowledge and
understanding of complementary and alternative medicine therapies can guide their patients through subtle energy healing, guided imagery, nutritional counseling and other appropriate interventions to aid in healing.\textsuperscript{319} The holistic nurses association made it clear that practicing in a holistic nursing framework does not imply competency in using complementary and alternative medicine, safely and effectively. The nurse must have the requisite education, skills and credentialling (including licensure where applicable) and practice in adherence to the laws where the nurse practices. Doing so does not negate the validity of conventional medical therapies but serves to complement, broaden, and enrich the scope of nursing practice and to help individuals access their greatest healing potential. Integration rather than separation is advocated. Standards of Holistic Nursing Practice were first developed in 1990 by the American Holistic Nurses Association, and later recognized in 2006 by the American Nurses Association as a distinct specialty,\textsuperscript{320} after the development of a core curriculum, certification exam and a multitude of revisions to the Standards of Holistic Nursing Practice. The entire process included a three-year role delineation study, the Inventory of Professional Activities and Knowledge of a Holistic Nurse (IPAKHN Survey). In this practice analysis study the activities and knowledge basic to current holistic nursing practice were determined through administration of a structured inventory to a representative sample of holistic nurses. In addition to the study, literature reviews and expert reviews were conducted. The American Holistic Nurses Society created a Standards of Practice Taskforce that synthesized the learnings from literate and the survey. The survey reflected the most recent holistic nursing professional activities, knowledge, and caring-healing modalities at the time the standards were being created. The standards were drafted and reviewed
multiple times by the task force. The standards were subsequently reviewed by the advisory committee. The advisory committee provided additional comment, modifications and recommendations. The standards were also reviewed multiple times at this level prior to sending to the American Holistic Nurses Task Force Committee for review. That committee also provided comments and modifications. Finally, an American Holistic Leadership Council provided additional comments, modifications and recommendations. After the draft standards were voted approved and accepted as the Standards of Holistic Nursing Practice, the America Holistic Nurses Association noted an increasing number of graduate programs with a holistic nursing focus and a new task force was formed to develop standards for advanced nursing practice. The steps mentioned here by no means are an exhaustive list, nor are they all inclusive of what was required to develop the standards, but a representation of the process. The standards allowed for the creation of nursing competencies that are required for each standard. Core competencies are essential to effective nursing performance, and by meeting and demonstrating competencies is a portion of what a nurse requires to achieve an exceptional level of performance.

The American Holistic Nursing Association continues to support and promote holistic nursing through collaboration, education of the public on holistic practitioners, and development of evidence-based holistic practice through research, and advocating for a focus on wellness, health promotion, and access to affordable care. The structured approach that the American Holistic Nurse Association took to have holistic nursing become a recognized specialty by the American Nurses Association provides a guide that others can use as a model or framework to create standards, process, or to integrate
complementary and alternative medicine into conventional care through literature review, research and collaboration at multiple levels of an organization to ensure desired outcomes are obtained.

Therapeutic massage is an example of holistic nursing and an complementary and alternative medicine therapy. Smith conducted a study on the effects of therapeutic massage on perception of pain, subjective sleep quality, symptom distress, and anxiety in patients hospitalized for treatment of cancer. While the sample was small and the study looked a very specific population of patients, 41 patients admitted to the oncology unit for chemotherapy or radiation therapy, therapeutic massage showed a benefit to those patients. The nurse was the provider of care in this study. The results showed that mean scores for pain, sleep quality, symptom distress, and anxiety improved from baseline for the subjects who received therapeutic massage.

**The Veterans Affairs Model**

The Veterans Health Administration (VHA) is America’s largest integrated health care system with over 1,700 sites of care, serving 8.76 million Veterans each year. The Veterans Affairs healthcare mission covers the continuum of care providing inpatient and outpatient care; and a wide range of services, such as pharmacy, prosthetics, religious and mental health; long-term care in both institutional and non-institutional settings; and other health care programs such as CHAMPVA and Readjustment Counseling. Veterans Affairs has modeled their healthcare systems and networks around quality, physiological quality and mental health quality. Veterans Affairs realized the importance of holistic care including mental health. VHA delivers health care through 21 Veterans Integrated Service Networks (VISNs) that manage 153 medical centers, 731 community-based
outpatient clinics, 135 nursing homes, 209 readjustment counseling centers (Vet Centers) and 47 domiciliaries. In 2007, VHA provided healthcare services to approximately 5.5 million unique patients, up from 3.8 million in 2000. VHA staff is treating more outpatients than ever before, increasing from 53.4 million outpatient visits in 2006 to 55.7 million in 2007.

When President Hoover created the Veterans Administration in 1930, the purpose was to consolidate and coordinate all government activities affecting war veterans. The Veterans Administration, now known as the Department of Veterans Affairs, has three departments:

1. Veterans Benefits Administration (VBA) which manages home loans, veterans educational benefits, insurance, and compensation benefits (disability benefits, pension benefits and survivors benefits).
2. National Cemetery System which manages the national cemeteries.
3. Veterans Health and Research Administration (VHA) which manages and provides medical benefits.

The process of disability determination can involve both the Veterans Benefits Administration and Veterans Health and Research Administration. The VBA makes the determination whether an individual has a service-connected disability and the extent of that disability, but many times the VBA will request VHA to perform a medical examination to assist the adjudication officer in making that decision.

The United States Department of Veterans Affairs serves 25 million veterans currently alive. In addition 70 million individuals are potentially eligible for VA benefits and services due to the fact that they themselves are veterans, family members or
veteran’s survivors. 328 Veterans of the United States armed forces may be eligible for a broad spectrum of programs and services including health benefits, compensation and pension, education, home loans, life insurance, vocational rehabilitation, survivors’ benefits, pharmacy benefits, and burial benefits. Title 38 of the United States Code outlays these benefits.329

The eligibility for most benefits is based of discharge from active military service. Active service is defined as, “full-time service, other than active duty for training, as a member of the Army, Navy, Air Force, Marine Corps, Coast Guard, or as a commissioned officer of the Public Health Service, Environmental Science Services Administration or National Oceanic and Atmospheric Administrations, or its predecessor, the Coast and Geodetic Survey.” Discharge from the military for any dishonorable behavior could possibly result in no Veterans Affairs benefits, including health benefits. The Veterans Health and Research Administration’s strategic goals are to: restore the capability of veterans with disabilities to the greatest extent possible, and improve the quality of their lives and that of their families; ensure a smooth transition for veterans from active military service to civilian life; honor and serve veterans in life, and memorialize them in death for their sacrifices on behalf of the Nation; and contribute to the public health, emergency management, socioeconomic well-being, and history of the Nation. The Veterans Health and Research Administration’s overarching goal that focuses all their other goals and the care they provide is to deliver world-class service to veterans and their families through effective communication and management of people, technology, business processes, and financial resources.331
VHA has enhanced overall mental health resources to meet the influx of veterans of all service eras with mental and emotional health care needs. The VA also provides complementary and alternative medicine via guided imagery, hypnotherapy, mantram repetition, mindfulness based stress reduction, meditation, massage therapy, Native American healing, Pilates, Reiki, reflexology, relaxation techniques, Tai Chi, therapeutic healing or touch, and yoga. The integrated network of the Department of Veteran’s Affairs allows for broad research in the veteran population as it relates to complementary and alternative medicine. The integrated system has an electronic medical record that provides access to care providers which can enhance research regarding complementary and alternative medicine. Review of complementary and alternative medicine outside of the Veterans Health Administration is more challenging, due to inconsistent complementary and alternative medicine therapy implementation. For example, Cohen et al conducted 2 different studies related to complementary and alternative medicine in 2005. One was a descriptive study of 19 integrative health care centers in the United States and their credentialing practices, liability policies, and other guidelines regarding dietary supplements. The other study looked at a random sample of 39 academic health centers and their policies related to complementary and alternative medicine. Both studies found a lack of consistency in approaches. In the study of 19 integrative health centers, there was no consistent approach to provider mix and authority and no consistent approach to the minimum requirements for hiring. There was also no consistent approach to minimum requirements for professional liability insurance and informed consent. Less than a third of these hospitals had formal policies regarding dietary supplements. The other study showed that half of the institutions (with more than one complementary and
alternative medicine therapy) did not have formalized written polices or procedures regarding the use of complementary and alternative medicine. There was considerable variability across the hospitals regarding the types of complementary and alternative therapies offered. The lack of written policies enhances the clinical liability risks. While the findings of these studies show the potential vulnerabilities, the population size is not reflective of the number of hospitals in the country. Due to the hierarchical setup of the VA, reviews of polices, programs and complementary therapies can be conducted in a way that can greatly inform about complementary and alternative medicine utilization and practices.

VA Field Advisory Committee on Complementary and Alternative Medicine conducted a survey in 2011. The survey quickly identified the spread of complementary and alternative medicine within VA. 125 facilities provide and/or refer patients to complementary and alternative medicine service providers, and on average the facilities offer more complementary and alternative medicine then they did in 2002, more specifically the increase was among mind-body medicine modalities than any other National Center for Complementary and Alternative Medicine category. The survey also quickly highlighted vulnerabilities similar to what Cohen et al reported in 2005 in the private sector. There was no consistency in the credentialing and privileging process for complementary and alternative medicine modalities and 21 facilities had no process at all. On a more positive note 70 percent of the facilities did have a clinical executive board for acupuncture. The availability of this national data allowed the VA make recommendations for improvement that would benefit the VA as a whole.
Veterans’ Health Care Eligibility Reform Act

Public Law 104-262, the Veterans’ Health Care Eligibility Reform Act of 1996, which was first established in 1958, was a reflection of healthcare at that date. Healthcare was more focused on hospital care and its delivery. The Veterans Eligibility Reform Act of 1996, required the VA to establish and maintain a patient enrollment system in order to manage the provision of VA hospital and medical services authorized under Title 38 United States Code (U.S.C.) Section 1710, Eligibility for hospital, nursing home, and domiciliary care. Provisions of enrollment for the VA Health Care System (VAHCS) are regulated in Title 38 Code of Federal Regulations (CFR) 17.36 through 17.38, and require certain veterans to enroll into the system in order to receive VA health care (US Code).

History

Prior to the Veterans’ Health Care Eligibility Reform Act of 1996, medical services were only provided to veterans who were service-connected with conditions greater than 50%, care for service connected conditions, care to prevent the need for hospitalization and pre-hospitalization or post hospitalization care. Hospital services and nursing home care was available to veterans who required care for service-connected conditions and veterans who had service-connected conditions rated 50% or greater for any condition. Hospital services and nursing home care was also provided for those whose discharge was for a disability incurred or aggravated in the line of duty; who were in receipt of 1151 compensation; former prisoners of war; veterans of the Mexican border war or WWI; veterans were exposed to toxic substances or radiation (for resultant conditions); and who were under the VA-determined means test were eligible for
hospital services were entitled to hospital care and eligible for nursing home care (PL 104-262).  

These restrictions as to whom care was provided caused prolonged hospitalizations, because veterans who were hospitalized for a service connected condition, but also need post hospitalization care for a non service related condition were kept in the hospital to provide them with post hospitalization care. The Veterans Affairs could not provide ongoing outpatient care or prescription drugs to many for the purpose of managing the veterans’ chronic conditions, such as hypertension, diabetes, or schizophrenia. Instead, these veterans’ conditions often had to reach a crisis point at which time VA could admit them to a hospital bed for treatment. The need for such care could have been pre-empted by routine care management, nor were they able to provide preventive vaccinations or primary care for basics such as smoking cessation or weight loss and control.

Public Law 104-262 required the VA to establish an enrollment process to manage demand. Between 1997 and January 17, 2003, VA elected to enroll all eligible veterans for health care services, and provide them with prescription drugs, prosthetics, and sensory aids (such as eyeglasses and hearing aids), in a standard “basic benefits” package. The VA also restructured its outdated service delivery, added outpatient clinics (at least 800 new community based outpatient clinics were opened, each one attracting an average of about 60% new users), and provided incentives to managers to recruit new veteran patients and to expand access to additional benefits which, in turn, created new demand from veterans. As a result of these changes quality and cost effectiveness improved.
VA’s new funding allocation system, required under a contemporary (FY 1997) appropriations act, does encourage managers to enroll “high priority veterans”. It funds networks according to the number of Priority 1-6 veterans VA served and the types of services these veterans required. This system is known as the Veterans Equitable Resource Allocation (VERA) system.

Over 3.7 million veterans and beneficiaries receive compensation or pension benefits from the VA. In 2007, VA processed nearly 825,000 claims for disability benefits and added almost 250,000 new beneficiaries to the compensation and pension rolls. The VA's healthcare mission covers the continuum of care providing inpatient and outpatient care; and a wide range of services, such as pharmacy, prosthetics, and mental health; long-term care in both institutional and non-institutional settings; and other health care programs and Readjustment Counseling.

Veterans who enlisted after Sept. 7, 1980, or who entered active duty after Oct. 16, 1981, must have served 24 continuous months or the full period for they were called to active duty in order to be eligible. This minimum duty requirement may not apply to veterans discharged for hardship, early out or a disability incurred or aggravated in the line of duty. For most veterans, entry into the VA health care system begins by applying for enrollment. The following four categories of veterans are not required to enroll, but are urged to do so to permit better planning of health resources:

1. Veterans with a service-connected disability of 50 percent or more.
2. Veterans seeking care for a disability the military determined was incurred or aggravated in the line of duty, but which VA has not yet rated, within 12 months of discharge.
3. Veterans seeking care for a service-connected disability only.

4. Veterans seeking registry examinations (Ionizing Radiation, Agent Orange, Gulf War/Operation Iraqi Freedom and Depleted Uranium).

**Elaboration and Practice of the Model**

The Veterans Affairs healthcare mission covers the continuum of care providing inpatient and outpatient care; and a wide range of services, such as pharmacy, prosthetics, and mental health; long-term care in both institutional and non-institutional settings; and other health care programs such as CHAMPVA and Readjustment Counseling. Veterans Affairs has modeled their healthcare systems and networks around quality, physiological and mental health. Veterans Affairs realized the importance of holistic care including mental health. VHA has also enhanced overall mental health resources by over $500 million in FY 2007 to meet the influx of veterans of all service eras with mental and emotional health care needs.

Veterans Affairs hired suicide prevention counselors at each of its 153 medical centers to help support the national suicide prevention hot line. The hot line puts veterans in touch with trained, caring professionals who can help them cope with emotional crises. The hot line is available 365 days a year, 24 hours a day. Veterans Affairs established 100 new patient advocate positions to help severely injured veterans and their families navigate VA’s systems for health care and financial benefits, providing a smooth transition to VA health care facilities. Veteran Affairs led the way in care for traumatic brain injury (TBI) veterans by developing a mandatory TBI training course for select VA health care professionals. Additionally, VA instituted a program to screen all patients who served in the combat theaters of Afghanistan or Iraq for TBI.
Sadly the conditions at one of America's showcase veterans' facilities, Walter Reed Army Medical Center in Washington, were revealed in February by The Washington Post to be shamefully substandard. Fortunately, that spotlight on the situation has prompted new attention to Walter Reed and other veterans' medical facilities. In July 2007, Secretary of Veterans Affairs Jim Nicholson announced plans to begin locating some of the Department's mental health programs closer to places where primary care is provided. “Given the reluctance of some veterans to talk about emotional problems, increasing our mental health presence in primary care settings will give veterans a familiar venue in which to receive care -- without actually going to an identified mental health clinic,” he said.339

Acknowledging that VA officials expect to see increasing numbers of newly returned combat veterans with PTSD and other mental health issues, Nicholson said mental health care is currently provided at each of VA’s 153 medical centers and 882 outpatient clinics with $3 billion devoted to mental health services. “We let veterans know that mental health issues and other military-related readjustment problems are not their fault -- that we can help them -- and that they can get better,” he added.340 Hull et al, conducted a study as a result of the movement towards incorporating complementary and alternative medicine within the Veterans Health as integrative complement to care for veterans. The Integrative Health and Wellness Program is a comprehensive complementary and alternative medicine clinic offering services such as integrative restoration (iRest) yoga nidra, individual acupuncture and group auricular acupuncture. Through a prospective cohort design, aspects of physical and mental health were tracked. Of the 740 consult the clinic received 226 veterans enrolled in the study. The outcomes
were measured via veterans self-report and review of the electronic patient medical record. While the survey did not capture the benefits of each therapy it did show the demographics of those who used complementary and alternative medicine within the VA where the study was conducted. Hull’s et all, pointed to preliminary data from the War Related Illness and Injury Study Center in Washington DC. They have been a leader in integrative and patient centered care within VA and provided complementary and alternative medicine modalities, such as acupuncture and integrative restoration (iRest) yoga nidra to veterans for years. The preliminary data shows that a majority of the veterans noticed symptom improvement and would recommend the care to others. As presented earlier in this chapter the Department of Veterans Affairs places a priority on mental health. Mental health disorders, chronic disease, and chronic multisymptom illness are common among veterans. This study amongst others is an attempt to understand complementary and alternative medicine utilization among veterans.

There are several other research study’s within the federal government such as the Epidaurus Project within the military health system. Although, this project is not within the Department of Veteran’s Affairs, the Department of Veterans Health Administration and the Military Health System share ideas and experience that impact the care of veterans. The Veterans Health Administration is undergoing a cultural change to radically enhance care and experience of the veteran. The Veterans Health Administration is working to make spaces feel safe, comfortable and peaceful for veterans and are updating construction guidelines such that the Veterans Health Administration can create spaces within their facilities that are healing spaces. The first phase of the Epidaurus Project made changes to military facilities that enhanced the
healing environment. They created 100% private rooms at certain facilities, implemented noiseless paging systems, natural light filled spaces and gardens all to aid in the healing environment. The outpatient clinic areas were redesigned to operationalize interdisciplinary care allow for mind-body medicine and complementary and alternative medicine to be incorporated into routine clinic encounters.\textsuperscript{345} In the second phase of the project they utilized holistic clinicians and advanced mathematicians to design five core metrics to measure whole body healing effects. As a barrier to holistic care has been the lack of metrics to directly measure the whole-body effects of complementary and alternative medicine.\textsuperscript{346}

The holistic nursing section clearly demonstrated through the core values that holistic nursing goes beyond a practice, but is a broad philosophy. Examples of how holistic nursing plays a role in holistic care, specifically in regards to spiritual care were shown. The American Holistic Nurses Association promotes holistic nursing through core values and standard creation. Their utilization of research (a holistic nursing core value) was a foundational step in standard creation and the process the followed can be useful as it provides a practical process that can be used to incorporate complementary and alternative medicine into holistic care. The Department of Veterans Affairs is an integrated system that delivers holistic care to the nations veterans. The system demonstrates that the government is capable of providing health care to large group of people in an integrated way. The presentation of the organization’s structure, veterans benefits and how veterans obtain care in the VA system highlight the level of complexity the organization has and in spite of the complexity, individualized holistic care is provided through complementary and alternative medicine.
Chapter 6 – Care Coverage and the Utilization of Complementary and Alternative Medicine

Throughout this project the origins of medicine were explored to better understand conventional medicine, the origins of holistic care and the focus on mind, body and spirit. Hippocrates believed in the interrelatedness of the mind, body and spirit, therefore the underpinnings of holism as a concept were a part of the Father of Medicine’s framework at medicine’s origins. Although, the mind-body-spirit approaches appeared to wane with the emergence of reductionism, the concept remained of value in health care through utilization of complementary and alternative medicine in their pursuit of holistic care. Complementary and alternative medicine add quality to patients experience in health care. The modern view of health care quality values the patient’s subjective opinion on how health care services (did or did not) meet the patients’ needs or expectations. Patient satisfaction with care is a valuable outcome measure in health care quality.\textsuperscript{347} The philosophy and practice of holistic nursing and the Veterans Health Administration have demonstrated mechanisms of holistic care and the incorporation of complementary and alternative medicine. In spite of the quality impacts of holistic care through complementary and alternative medicine, there are still barriers in complementary and alternative medicine delivery, such as insurance and the ability to pay. These barriers are not unique to complementary and alternative medicine but persist across healthcare in the United States. The Patient Protection and Affordable Care Act, although not specifically for complementary and alternative medicine, seeks to address the issue of the insured in the United States as well as the cost of healthcare. Success of
the Affordable Care act, an increasing number of American’s insured and a reduction in health care costs, could and will likely impact complementary and alternative medicine.

As more patients are able to obtain health care in the United States, as a result of the Affordable Care Act, the role of the provider in health care becomes increasingly important. Based on review of existing models of holistic care that incorporate complementary and alternative medicine, growing interest and research in the field of complementary and alternative medicine indicates that the United States is already moving to a greater acceptance of extending holistic medicine and medicine to include complementary and alternative medicine. For example, in 1991 the number of visits to complementary and alternative practitioners was approximately 425 million and grew to about 629 million in 1997. These figures exceed the number of primary care visits in the same timeframe (390 million).348

**Access to care and Insurance (Patient Protection and Affordable Care Act)**

Overall barriers to health care would also be barriers to the inclusion of complementary and alternative medicine in a holistic system. Timely access to care can prevent the onset of disease and offer more control of illness and increased management of chronic illness.349 Although, approximately 38 percent of adults, and approximately 12 percent of children are using some form of complementary and alternative medicine, a large majority of the users are women and those with higher levels of education and higher incomes.350 and only a limited number of complementary therapies are covered by third party payers.351 Nonetheless, there are still financial barriers to access. The United States insurance system is a mix of privately and public funded; there is a lack of national standards on benefits and a high percentage of uninsured people. In the U.S. today it is
estimated that some 47 million Americans lack medical insurance. According to the United States Census Bureau 16.3 percent of the American people lacked insurance in 2010, or 49.9 million people. 9.8 percent of children under age 18 (7.3 million) and the rate for uninsured children in poverty was 15.4 percent.

The Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) were signed by President Obama and became law in March 2010. Together these laws are referred to as the Affordable Care Act. The Affordable Care Act has projected impacts to decrease the number of uninsured and that runs the gamut of health care, healthcare delivery and quality. The law seeks to reform health care in the United States by addressing health insurance shortcomings and regulations, incentivize healthcare institutions and professionals to improve care, healthcare spending, benefits, rights and protections for individual seeking and utilizing healthcare services, taxes and tax breaks. The Center for Medicare and Medicaid published provisions that impacted the insurance market to address discriminatory action. Additionally, the Department of Health and Human Services published provisions on Essential Benefits as well as Wellness Programs (the Labor and Treasury Departments also play a role here).

The Affordable Care Act sought to increase transparency in health insurance by creating the Health Insurance Marketplace that was to allow individuals to compare health plans down to the minimum essentials. According to section 1302 (b) there are ten essential health benefits that must be a part of every plan sold on the Health Insurance Marketplace. They are emergency services, hospitalizations, laboratory services, maternity care, mental health and substance abuse treatment, outpatient, or ambulatory
care, pediatric care, prescription drugs, preventive care, rehabilitative and rehabilitative (helping maintain daily functioning) services, and vision and dental care for children. As of January 1st, 2014 these services must be included at no lifetime or annual dollar limits on the amount of care an individual can receive, however there are a couple exceptions to this which are not relevant here.

The Affordable Care Act provides for various benefits and protections based on income as an individual’s of family’s income compares to the poverty level. Cost assistance is available to individuals, families and small businesses through the Health Insurance Marketplace. For example, if an individuals makes less than 400% of the federal poverty level that individual may be eligible to receive subsidies for reduced premiums via tax credits offered on their homes State’s Health Insurance Exchange. If an individual makes less than 200% of the federal poverty level that individual may be eligible for help with out-of-pocket costs on health insurance purchased on the Health Insurance marketplace. Other benefits and protections include, the requirement for large employers to offer insurance coverage to full-time employees, individuals cannot be denied coverage, or be charged more based on gender or health circumstance. Moreover individuals cannot be denied coverage for pre-existing conditions. The Affordable Care Act also extended coverage for dependents on their parent’s health plan until the dependent is 26 years of age (page 14 of Affordable care act). This change had a large impact on the number of uninsured Americans decreasing by 1.3 million in 2011.\textsuperscript{354}

Improving the Quality and Efficiency of Healthcare (Title 3) highlights the high level priority of quality in the healthcare. The title calls for the establishment of a national strategy to improve quality in health care delivery, patient health patient outcomes and
Development of interagency workgroup of health care quality which calls for collaborations between federal agencies in developing and disseminating strategies avoid inefficiency duplication of efforts and resources assess alignment of quality efforts in private and public section initiatives. The interagency workgroup also assesses quality measures, standards of measuring performance, improvement of population health and health plans providers in service delivery. Quality measures will be identified though consultation with the Agency for Healthcare Research and Quality and the Centers for Medicare & Medicaid Services, locating gaps where no quality measures exist and review of existing quality measures that need improvement, updating, or expansion. Quality measures should be made available to the public through the Federal Register and should include rationale for the use of the quality measures, assessment of the impact and performance information summarizing data on quality measures. In the development, improvement or expansion of quality measures, prioritization will be provided to grants and contracts that prioritize health outcomes, management and coordination of care, safety appropriate effective patient centered care that is timely efficient and patient satisfaction.

The Affordable Care Act provided the law that empowered other agencies (Centers for Medicare and Medicaid, Labor and the Treasury and Health and Human Services) to implement provisions of the Affordable Care Act and continue health care reform. The Department of Health and Human Services drafts a strategic plan every four years to describe its efforts in addressing issues of health in the American people. The document defines the goals of the department and provides a means of progress tracking and measurements of success. The overarching mission of the Department of Health and
Human Services is “to enhance the health and well-being of Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.” In order provide the greatest positive impact the Department of Health and Human Services analyzes what needs to be changed and how changes can be made most effectively, efficiently and less expensively with the ultimate goal of more Americans achieving quality affordable health care. Health and Human Services administers 115 programs that promote patient safety, quality in the health care environment and among providers and works to eliminate disparities in health, health care access and protects vulnerable individuals and populations. Each of the programs is described in the central inventory of federal programs. In working to improve the health of Americans Health and Humans Services evaluates and examines each programs performance in and communicates the progress towards the goals broadly. The Affordable Care Act speaks to the involvement of complementary and alternative medicine practitioners in the establishment of community health teams. These teams are to provider support to primary care providers. This explicit inclusion speaks to the understanding the availability of complementary and alternative medicine services to those seeking healthcare and the benefits it can provide.

Beyond the number of uninsured individuals in the United States the healthcare system has other challenges including growing and high health care costs without comparative quality outcomes compared to other countries. The current fragmented state of health care, characterized by redundancies and excesses, is costly and inefficient. According to Hoffman, Klees and Curtis (2008) approximately $4.3 trillion will be spent in the United States on health care in 2017 if this trend continues. The Organization for
Economic Co-operation and Development (OECD) focuses on economic development by promoting collecting data, analyzing it, developing and promoting policies that will improve the economic and social well-being of people around the world. The Organization for Economic Co-operation and Development shares their comparative data, and trends, online and in publications such as Health at a Glance. According to their most recent report on health, the United States spends $8,713 per capita ($8,233 per capita in 2010) on health which is more than other countries listed in this report. The next closet is Switzerland which spends $6,325 per capita. The United States total health spending 16.4% of GDP (2.0% out of pocket, 7.9% public, 8.5% private) in 2013. The next is the Netherlands and Switzerland at 11.1% of the GDP. Netherlands (0.6% out of pocket, 9.7% public, 1.4% private). Switzerland (2.9% out of pocket, 7.3% public, 3.7% private). OECD Average is 8.9% (slightly over had that of the United States) of GDP (6.5% public and 2.5% private) for the same time frame. There are many indicators for health, such as infant mortality, heart disease and obesity. Heart disease is the leading cause of death in the United States. About 610,000 people die of heart disease in the United States every year (about 1 in every 4 deaths). In 2012, 68.6% of the United States population 15 years and older are overweight and obese. The only country that exceeds this rate is Mexico with a rate of 71.3%

The number of those uninsured in the United States as well as the cost of health care in the United States prompted the Affordable Care Act. That in conjunction with how the United States compares with other countries on various indicators of health demonstrates a need for change in healthcare. With more Americans gaining access to the healthcare system there is an opportunity to address the health needs of more Americans.
The inclusion of complementary and alternative medicine practitioners provides an opportunity for those practitioners to be more involved in healthcare in the United States. As people will access care through multiple avenues, including their conventional medicine provider it is important to future understand the role of the provider.

**Role of the provider**

The patient provider relationship is important to care delivery, as the provider’s role in a patient’s health and health promotion cannot be understated. Literature shows that the current demand on healthcare providers is great; there are conflicting interests at play for provider time which point to limited resources and resource allocation issues.\(^\text{366}\) Cited barriers are appointment time, knowledge of patient, leading to lack of open communication.\(^\text{367}\)

Based on the prevalence of complementary and alternative medicine utilization, the provider’s overall responsibility must be defined. According to the National Health Statistics Report, generated by the U. S. Department of Health and Human Services, 34% of adults (non-institutionalized civilians) over the age of 18 used some form of complementary healing approach in 2012. This report combined three data sets the produced a sample size of 88,982 individuals.\(^\text{368}\) The trends and healing strategies revealed in this sample and others will be discussed in another section.

Providers have an ethical obligation to assist patients in reaching the care goal,\(^\text{369}\) but in order to conceptualize the providers role in relation to the patient and the use of complementary and alternative medicine patient autonomy, beneficence and nonmaleficence must also be considered and evaluated.\(^\text{370}\)
Studies across various patient populations have shown that a large number of patients who are utilizing complementary and alternative medicine, combine it with conventional medicines and do not tell their physicians.\textsuperscript{371} However only 40\% of total number of complementary and alternative medicine users report the use to their physicians. Adults who use both appear to value both conventional medicine and complementary and alternative medicine and tend to be less concerned about their medical doctor's disapproval than about their doctor's inability to understand or incorporate complementary and alternative medicine therapy use within the context of their medical management.\textsuperscript{372}

These ethical guidelines serve as a framework to protect those who cannot fully protect themselves.\textsuperscript{373} Moreover the physician responsibilities and duty to the patient are outlined by Hippocrates and the American Medical Association. Other sources like the American Nurses Association, American Academy of Physician Assistants, outline similar duties for nurses and other providers. If the providers were to achieve a greater understanding of the reasons what patients look to complementary and alternative medicine, that understanding could lead to a stronger patient-provider relationship and that relationship could in turn foster the patients healing, both physically and emotionally.\textsuperscript{374}

History has shown that implementing change is a process and to maximize the potential of success of change, recommendations are made for stakeholder involvement. The provider will also need to take on some personal responsibilities for training and development of self, to better be able to educate patients.\textsuperscript{375} Additionally, the leadership role of the provider in the health care environment must be cultivated further.\textsuperscript{376} The
provider’s role is also to develop trust which supports the flow of information between
the patient and physician.\textsuperscript{377} Promoting awareness is essential, and building linkages
between the fragmented arms of health care, yielding a consideration of all things
together, aides in a more holistic approach to health care.

Research demonstrates that the specific reasons individuals utilize complementary
and alternative approaches vary, but can generally be categorized into three overarching
goals of health promotion: either treatment, treatment and wellness, or solely wellness.\textsuperscript{378} Various research studies and surveys have evaluated complementary and alternative care
utilization across gender, age, racial groups, the data shows that women, people aged 35-
60, those who are more educated and of higher socioeconomic status use these
approaches more.\textsuperscript{379}

Holistic providers, in their role of promoting whole-person wellness and
wellbeing across the mind body and spirit, utilize and promote non-vitamin and non-
minerals, deep breathing, yoga, meditation, chiropractic manipulation and a host of other
approaches.\textsuperscript{380} All providers need to know what medications, products and approaches
their patients use,\textsuperscript{381} in order to provide care and to protect against herb-drug interactions,
and to be aware of potential toxicity in their patients.\textsuperscript{382} Providers need to maintain their
competencies as well as expand their knowledge base to maximize their ability to address
patient’s interest in complementary and alternative medicine. The provider should also
have an awareness of trends in health care that include the utilization of complementary
and alternative medicine. Provider knowledge impacts the provider relationship as it
enables the provider to properly engage with the patient and offer education and useful
recommendations.\textsuperscript{383} Patients desire a strong therapeutic relationship with their providers;
relationships where the providers listen effectively, relationships that allow providers
time to listen to the patients, relationships in which the patients beliefs are respected.\(^{384}\) In
addition to provider knowledge about complementary and alternative medicine, providers
need to be aware that patients views of what constitutes complementary and alternative
medicine can differ radically from their own views. Careful attention needs to be paid to
these conceptualization to communicate in the most effective way.\(^{385}\)

**Trends in Complementary and Alternative Medicine**

Over the years there has been increased use of complementary and alternative
medicine,\(^{386}\) while the definitions or the approaches included in complementary and
alternative medicine have changed. The prevalence of complementary and alternative
medicine use was 33.8% in 1990.\(^{387}\)According to Eisenberg, in 1993 complementary and
alternative medicine was called ‘unconventional medicine’ and was defined broadly as
“medical interventions not taught widely at U.S. medical schools.” Based on this
definition it was estimated that 34% of Americans used a complementary and alternative
medicine therapy in 1991. The estimated cost of those services was $13.7 billion.\(^{388}\)
Eisenberg conducted another study in which estimated that complementary and
alternative medicine use in 1997 was 42%, at an estimated cost of $27.0 billion.\(^{389}\) Out-
of-pocket expenditures on complementary and alternative medicine professional services
was estimated to be $12.2 billion dollars in 1998, which exceeds the cost of
hospitalizations in that year. Out-of-pocket expenditures on complementary and
alternative therapies were estimated to be $27 billion dollars in 1997, which exceeds the
cost projected out-of-pocket expenditures for all US physician services.\(^{390}\) This data is
evidence that there is need for a devolvement of a system as the demand exists.
According to Barnes, there were close to 40% of individuals were using some form of complementary and alternative medicine in 2007 as opposed to 33% in 2002. In 2007, United States adults spent $33.9 billion out of pocket on visits to complementary and alternative medicine practitioners and purchases of complementary and alternative medicine products, classes, and materials.

Complementary and alternative medicine encompasses a range of products, practices, and providers, almost all of which have a wellness or health promotion component. Wellness is increasingly becoming more important to health in the United States, because it has “considerable public health significance with respect to health promotion and disease prevention in light of the burden of lifestyle diseases in the United States.”

The importance and priority placed on wellness is evidenced by the inclusion of the promotion of wellness and methods to increase its use among Americans in the Affordable Care Act.

Historically, researchers have framed reasons for use in the context of a problem-based, treatment focused group who have chosen to forgo conventional medicine. Those who utilize complementary and alternative medicine are sometimes people who have chronic or terminal health conditions who also use conventional medicine services, or those who chose to utilize complementary and alternative medicine as a part of a healthy lifestyle or maintain a holistic health philosophy. Other reasons for use of complementary and alternative medicine include dissatisfaction with conventional medicine while others don’t feel dissatisfied, but are looking to maximize the range of treatment options available to them. Some complementary and alternative medicine users are wary of conventional medicine and have difficulties trusting any component.
Those individuals who have chronic conditions often utilize complementary and alternative medicine due to a lack of conventional medicine’s effectiveness,\textsuperscript{402} and achieve greater participation in treatment decisions.\textsuperscript{403}

The 2007 National Health Interview Survey took a cross section of the United States population and obtained a nationally representative sample of 23,393 adults. According this survey 86\% of those surveyed had utilized complementary and alternative medicine in the past 12 months for wellness or wellness and treatment combined. 51\% stated purpose was for wellness, 35\% utilized it for wellness and treatment combined and 14\% for treatment alone.\textsuperscript{404} According to this survey the use of complementary and alternative medicine is influenced by four domains: 1) predisposing factors (knowledge, attitudes and beliefs), 2) enabling resources (income, health insurance, and accessibility), 3) need (subjective and objective) and 4) personal health practices and these domains will differentiate those who use complementary and alternative medicine across wellness, wellness and treatment and treatment only.

Of those surveyed, 38.9\% reported using complementary and alternative medicine in the past 12 months with significant differences between the recent users and those who didn’t use complementary and alternative medicine across the four domains (predisposing factors, enabling resources, need and personal health practices). Women, those with higher levels of education and income were higher utilizers of complementary and alternative medicine in the past 12 months.\textsuperscript{405} Additionally, those who perceived themselves as having better health and practicing a greater number of healthy behaviors also had higher percentages of recent use.\textsuperscript{406} (There are also linkages between predisposing factors, need and personal health data distinguish whether users pursue
complementary and alternative medicine for wellness, for wellness and treatment, or for treatment alone, however enabling resources do not distinguish between types of use. Those users with poorer health were more likely to report use for treatment than for wellness. Additionally, those users of complementary and alternative medicine that participated in more healthy behaviors were also more likely do so for wellness and the combination of wellness and treatment as opposed to treatment alone.\textsuperscript{407}

In 2007, 17.7\% utilized non-vitamin, non-mineral and natural products (18.9\% in 2002). The second most frequently used therapy was deep breathing (11.6\% in 2002, 12.7\% in 2007 and 10.9\% 2012), mediation (7.6\% in 2002, 9.4\% in 2007 and 8.0\% in 2012), chiropractic (7.6\% in 2002, 8.6\% in 2007, 8.4\% in 2012) massage (8.3\%) and yoga (6.1\%). Most often complementary and alternative medicine was used for back pain or problems (17.1\%) followed by neck pain or problems (5.9\%), joint pain or stiffness (5.2\%) arthritis and other musculoskeletal conditions.\textsuperscript{408, 409}

As the use complementary and alternative medicine continues those practices become more incorporated into lifestyle choices and the American society sees them as more conventional activities as opposed to alternatives\textsuperscript{410} as most individuals who utilize complementary and alternative medicine as a true complement, not an replacement of conventional care.\textsuperscript{411}

**Increase Utilization**

Although there appears to be strengths in conventional medicine such as its scientific base; exorbitant costs and limitations in dealing with chronic disease \textsuperscript{412} point to the need for another focus being added to conventional medicine. Complementary and alternative medicine is generally described as more holistic and empowering than
conventional medicine, but barriers exist in its more expansive incorporation in the United States healthcare system. Due to the growing use of complementary and alternative medicine, Congress initiated a process to gain better understanding of complementary and alternative medicine by passing legislation to fund an establishment of the National Center for Complementary and Alternative Medicine within the National Institute of Health to investigate and evaluate promising unconventional medical practices in 1991. Many research projects have been funded by the center that lead to essential information on the effectiveness and safety of complementary and alternative medicine. Moreover they identified strategies for increasing access and awareness of complementary and alternative medicine by addressing the need for more research in the field. The National Center for Complementary and Alternative Medicine’s name was recently changed to the National Center for Complementary and Integrative health due in part to the rarity of alternative medicine usage in place of conventional medicine.\textsuperscript{413}

Integrative health care is defined as a “comprehensive, often interdisciplinary approach to treatment, prevention and health promotion that brings together complementary and conventional therapies”. The use of an integrative approach to health and wellness has grown within care settings across the United States, including hospitals and other health facilities\textsuperscript{414}.

There was a time when society, as a whole, and physicians distrusted and dismissed complementary and alternative medicine modalities leading many practices to be overlooked as lacking credibility due to limited evidence.\textsuperscript{415} Scientific research on the safety and efficacy of complementary and alternative has contributed to its acceptance and continued research will continue the trend of increasing acceptance.\textsuperscript{416} Advances in
research should continue regarding complementary and alternative medicine, while adhering to ethical principles for biomedical research as described by Beauchamp and Childress.\textsuperscript{417} To maintain public welfare, ensure the safety of complementary and alternative medicine research on complementary and alternative therapies should seek to produce reliable evidence of the safety, efficacy, and effectiveness of complementary and alternative approaches. There are many whose emphasis on proof implies that the research must meet the standard of randomized controlled trials, however while researchers aim for this standard while researching complementary and alternative medicine, some studies can be constructed as a double-blind, placebo-controlled investigation. For others, this format cannot be applied and researchers must develop creative modifications of standard randomized controlled trials methods provide evidence of safety and efficacy. Randomized controlled trials should be sought whenever possible.\textsuperscript{418}

There are some complementary and alternative medicine approaches that show evidence of usefulness and safety, particularly in relieving chronic pain. A few examples include acupuncture for osteoarthritis pain; tai chi for fibromyalgia pain; and massage, spinal manipulation, and yoga for chronic back pain.\textsuperscript{419} A careful balance must be struck between the desire and demand for evidence that meets the rigors of randomized controlled trials and benefits to patients. Care needs to be broader whether or not there is evidence because sometimes the evidence that is requested can never be provided.

Changes in the way health care is delivered starts, at least in part, with the way providers are educated. Complementary and alternative approaches need to be taught as a part of the curriculum and residency.\textsuperscript{420} Studies have been conducted and found that 34
percent of United States schools taught complementary and alternative medicine in 1995, and 28 percent of family practice residency programs. The number of medical schools offering courses on complementary and alternative medicine related topics rose from 45 of 125 schools in the 1996–1997 academic year to 75 schools in 1998 and 98 medical schools in the 2002–2003 academic year. Consensus needs to be established on what to teach in these programs. Several suggestions have been made on how to teach courses on complementary and alternative therapies and what content should be covered. Awareness to the public should also be addressed. The scope of complementary and alternative medicine should be made available to the public by providing education through advertising via avenues that people trust. The education geared toward the public should address risks with utilizing complementary and alternative therapies without a physician’s guidance (safety implications), available therapies that are evidence based, and a focus on education.

The regulatory environment in the United States impacts the utilization of complementary and alternative medicine, with the goal of protecting individuals from harm. Legal conditions surrounding licensure, scope of practice, third party reimbursement and access to treatment are a few related areas that impact the increase utilization of complementary and alternative medicine. State law dominates licensure, scope of practice and third-party reimbursement while federal law dominates access (example: Affordable Care Act).

As licensure is handled at the state level, requirements for licensure vary across states and complementary and alternative medicine modalities. For example, in order to qualify for a license to practice acupuncture, applicants must satisfy a pre professional
education requirement (from an approved university), complete a professional program and then pass a licensing exam. However the regulations surrounding practice vary amongst states. Unlike acupuncture, there are not Homeopathy boards in every state. As of the World Health Organizations report on the states of Arizona, Connecticut and Nevada had specific licensing boards for homeopathic physicians. Homeopathic remedies are regulated by the Food and Drug Administration and are manufactured under strict guidelines.425

Trend analysis of those who utilize complementary and alternative medicine demonstrate that those from higher socioeconomic groups are more likely to use complementary and alternative medicine can indicate the challenges of affordability in the absence of insurance coverage. Even when health insurance coverage is available, it is generally limited such that individuals will still have to pay substantial amounts out of pocket.426 According to the World Health Organization427 annual out-of-pocket expenditure on complementary and alternative medicine is $2.7 billion in the U.S.428 Insurance continues to be one of the greatest barriers to complementary and alternative utilization. Insurance agencies are slow to provide reimbursement for complementary and alternative medicine services.429

Managed care in its inherent functionality places the primary care physician in the role of “gatekeeper,”430 and demonstrates the hold that conventional medicine has on reimbursement. The primary care provider provides referrals to their patients for potential treatment options. In many cases, lack of the primary care provider’s referral will lead to denial of reimbursement by the patient’s insurance.431 If new ideas or modes of treatment are conceived they must obtain Food and Drug Administration approval; which is
associated with some form of evidence base. Small but growing numbers of insurers and employers are including complementary and alternative medicine in their health care packages. The coverage remains low and varies considerably across plans. Consumer demand drives insurance benefits and the specific therapies covered. Some managed care organizations have offered complementary and alternative services for years, however insurance generally does not cover most complementary and alternative medicine or any at all. In the instances where complementary and alternative medicine therapies are covered, there are often associated with high deductibles and co-payment, and limits on the dollar value of coverage or limits on the number of visits. Complementary and alternative medicine may be included in a defined contribution plan, such as an annual flexible spending account. Variation exists in insurance coverage between the states due to varying laws and regulations, therefore making sweeping statements about insurance coverage in the United States in challenging. One area of complementary and alternative medicine that is covered more broadly by insurance is chiropractic care. Chiropractic care is covered in full by Medicare, Medicaid and private insurance in many states.

As many people are unable to afford basic treatment options, an increasing proportion of Americans must resort to postponing or forgoing required medical treatment and are less likely to receive preventive services or consistent care for chronic conditions. These facts further demonstrate issues of access that are prevalent in health care and must be addressed in light of the moral and ethical duty to provide care, and moreover holistic care. The Affordable Care Act is an attempt for the government to address the uninsured. The act explicitly speaks to including complementary and
alternative medicine practitioners in a supportive role to primary care. As some patients access complementary and alternative medicine through the conventional medicine providers it is important to understand their role in care delivery as it relates to complementary and alternative medicine. In the trends described above continue complementary and alternative medicine will continue to make inroads into becoming more accepted into healthcare in the United States. According to Makowski, the consumer is likely to be the most influential party in the healthcare industry. As consumers continue to utilize complementary and alternative medicine, and others being the increase their utilization, the healthcare market will likely adjust to address the demand.
Chapter 7 – Conclusion

The practice of medicine has changed drastically over time due to increased knowledge and understanding. With the changes in the practice of medicine, health care in the United States has also changed over time. Advances in various fields have allowed for these changes. If the past is any indication of the future, health care will continue to change. The utilization of complementary and alternative medicine has grown and expanded as a part of the change in health care. The factors behind the growth of complementary and alternative medicine (lack of provider time for patients, dissatisfaction with conventional medicine, ineffective conventional medicine treatments, desire for wellness) are related to conventional medicine. In order to best understand patients practices regarding complementary and alternative medicine, it is important to understand both conventional medicine as a field as well as complementary and alternative medicine.

The rate of utilization of complementary and alternative, and more specifically the particular modalities, indicates that individuals perceive benefits from their strategy of choice, even in the absence of evidence. Whether individuals are pursuing complementary or alternative medicine for treatment, wellness or wellness and treatment, indicates the spectrum of benefits the complementary and alternative medicine can serve. Complementary and alternative medicine has demonstrated efficacy in multiple areas of health care such as chronic disease and mental health. Considering the prevalence of people in America with chronic disease, and the likelihood for more people to develop chronic diseases, there will be a pool of people who may always seek complementary and alternative medicine for these conditions. The increasing trend of complementary and
alternative medicine is an example of the transformation of health care in the United States, and is a demonstration of the importance of holistic concepts. Holistic care is important to health care, as health care continues to transform it is important for holistic concepts to be considered. In moving forward it is important to note that the trend of people with higher education and socioeconomic status are those who utilize complementary and alternative medicine therapies the most, due to issues of cost, access or knowledge. Existing research demonstrates these trends, but also highlights a gap in the research. There is a whole group of individuals who are not surveyed in the studies as they are not using complementary and alternative medicine due to cost and access. As research continues in the field, it is important to include all socioeconomic groups. Additionally research needs to take into account the perceptions of complementary and alternative medicine from both the patient and provider perspective.


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