

'A necessary evil that does not "really" cure disease': The domestication of biomedicine by Dutch holistic general practitioners

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Abstract

Against the background of studies about the domestication of complementary and alternative medicine into biomedical settings, this article studies how biomedicine is integrated into holistic settings. Data from 19 in-depth interviews with Dutch holistic general practitioners who combine complementary and alternative medicine with conventional treatments demonstrate that they do not believe that conventional biomedicine 'really' cures patients. They feel that it merely suppresses the physical symptoms of a disease, leaving the more fundamental and non-physical causes intact. As a consequence, they use conventional biomedicine for strictly practical and instrumental reasons. This is the case in life-threatening or acute situations, understood as non-physical causes of disease having been left untreated with complementary and alternative medicine for too long. More mundane reasons for its use are the need to take patients' demands for biomedical treatment seriously or to obey authoritative rules, regulations and protocols. The integration of biomedicine into complementary and alternative medicine, then, follows the same logic of domestication of complementary and alternative medicine into biomedicine: it is made subordinate to the prevailing model of health and illness and treated as a practical add-on that does not 'really' cure people.

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Introduction

Demand for and supply of complementary and alternative medicine (CAM)¹ have increased steadily in Western societies in the past decades (Ammon et al., 2012; May and Sirur, 1998; Van Dijk, 2006; Willis, 1994). Based on a sample of 1539 adults in 1991 and 2055 adults in 1997, Eisenberg et al. (1998) show that the use of alternative medicine in the United States increased by about 25 per cent in a period of 6 years. The prevalence of CAM use has remained more or less stable from 1997 to 2002 (Tindle et al., 2005). A study among the Dutch population shows that the use of alternative medicine from 1981 until 2002 has increased by approximately 58 per cent (Van Dijk, 2006: 20).² Thomas et al. (2001) suggest that the use of the CAM therapies acupuncture, chiropractic, homeopathy, hypnotherapy, medical herbalism and osteopathy by the adult population in England has increased from 8.5 to 10.6 per cent between 1993 and 1998. A study addressing the prevalence of CAM use in England suggests that lifetime and 12-month prevalence are 44 and 26 per cent, respectively (Hunt et al., 2010). In countries like the United States, some CAM groups, such as chiropractors, acupuncturists, and homeopaths, have won practice rights and managed to establish limited professions, with their 'own system of education, licensing, and inclusion in government-funded health insurance' (Winnick, 2005: 40).

CAM has meanwhile also appeared in medical curricula and biomedical practice settings (Keshet, 2013; Wiese et al., 2010). At many European Union (EU) universities, CAM is becoming available as part of undergraduate education (Ammon et al., 2012), and integrated clinics have appeared, which offer both conventional and alternative therapies (Parusnikova, 2002). A review of 19 international surveys found that 'large numbers of conventional physicians are either referring patients to or practising some of the most prominent and well-known forms of CAM' (Astin et al., 1998: 2309; see also Visser and Peters, 1990). A recent systematic review on CAM provision in Europe shows that approximately 305,000 CAM providers can be identified in Europe, of which approximately 160,000 are non-medical and around 145,000 are medical practitioners (Ammon et al., 2012). Moreover, CAM treatments appear to be increasingly integrated within hospital care (Ammon et al., 2012). There is also a growing interest in CAM among general practitioners (GPs; Fisher and Ward, 1994), who increasingly integrate complementary modalities in their surgeries (Adams, 2000; Ammon et al., 2012; Reilly, 1983). The provision of CAM in GP practices in the United Kingdom increased from 12.5 to 50 per cent between 1995 and 2001 (Ammon et al., 2012).

Acknowledging the conflicting paradigms on which biomedicine and CAM are based (e.g. Keshet et al., 2012; Shuval et al., 2012), much research has been done into the latter's integration into biomedical settings. The principal finding of these studies is that in these settings, CAM is typically used for practical and instrumental reasons and hence treated as a pragmatic add-on to the logic of biomedicine which remains largely

uncontested itself (e.g. Baer, 2008; Baer and Coulter, 2008; Fadlon, 2005; Winnick, 2005). A process that has thus far not been addressed is the reverse process, that is, how biomedicine is integrated into largely holistic medical practices. In this article, we study this by means of an analysis of the medical ideas and practices of holistic Dutch GPs who use biomedicine alongside CAM. To do so, we first discuss existing scholarly work about the combination of the two and then proceed with a discussion of our sample of holistic Dutch GPs and our methods of data collection and analysis. Subsequently, we present our findings. In the final section, we elaborate on their theoretical implications and provide some directions for future research.

Problems in integrating biomedicine and CAM

Most studies on the use of CAM by medical doctors are informed by an acknowledgement of the tensions between the premises underlying biomedicine and alternative forms of medicine (Bombardieri and Easthope, 2000: 480; Frank and Stollberg, 2004: 354; Hollenberg and Muzzin, 2010: 35; Keshet et al., 2012: 587; Mizrachi et al., 2005: 25; Parusnikova, 2002: 171; Shuval et al., 2012: 1317). On the one hand, biomedicine is based on a mind–body dualism, which assumes that diseases can be explained in terms of biological factors. Alternative therapies, on the other hand,

often maintain explanations of health and illness that are based on causal factors that differ from those of orthodox medicine (e.g., that ill-health is caused by an imbalance between opposing energy forces) and usually claim a holistic orientation as part of their paradigm of health knowledge. (Clavarino and Yates, 1995: 254; see also Mizrachi et al., 2005)

As a consequence, it has often been suggested that ‘there is no way that the paradigms can be compared to determine which one is more appropriate or useful’ (Shuval et al., 2012: 1319). In integrating the two modalities in medical practice, then, ‘physicians need to reconcile epistemological dilemmas and potential conflicts that might arise when they utilize both biomedicine and CAM in the course of regular clinical encounters’ (Shuval et al., 2012: 1318).

Studies of CAM integration into biomedical settings typically address this process at the institutional level, thereby looking at CAM groups’ professionalisation strategies and conventional medicine’s reaction to this. These studies commonly acknowledge biomedicine’s ubiquitous dominance in retaining control over the epistemological claims made and in preserving social-political status by subordinating and excluding alternative CAM groups (Cant, 2009).³ According to many of these studies, CAM is co-opted by biomedical settings for strictly instrumental or pragmatic reasons, for example, to meet patients’ demands, to maintain their own market share (Baer, 2008; Easthope, 2003; Parusnikova, 2002; Wiese et al., 2010) or to protect their monopoly on the practice of medicine (Adams et al., 2009; Parusnikova, 2002; Saks, 1994; Timmermans and Oh, 2010; Winnick, 2005, 2006). Zooming in on the epistemological aspect, many studies have demonstrated the validity of the so-called domestication thesis, which is ‘a process by which the tenets of CAM are transformed and rendered more culturally acceptable as well as less exotic and culturally challenging to biomedicine’ (Shuval et al., 2012: 1325).⁴ It is held that CAM

treatments will likely 'be absorbed into the biomedical paradigm and the practitioners abandoned', by 'recasting CAM in terms compatible with the biomedical paradigm' (Winnick, 2005: 56; see also Fadlon, 2005; Wiese et al., 2010). Saks (1995) shows, for instance, how biomedical organisations isolated acupuncture from its own theoretical premises and transformed it into a biomedical modality focused on pain therapy. This was understood as biomedically legitimate because the alleviation of pain could be explained scientifically as the 'release of endorphins' that came about as the result of the insertion of needles (Saks, 1995). In this case, the 'dominance of biomedical concepts remains unchallenged' (Frank, 2002: 798).

The epistemological authority of biomedicine has generally been demonstrated at the level of 'strategies of institutions', and yet there is a dearth of 'micro-level studies that have studied integration in practice' (Cant, 2009: 192). In case of 'recasting CAM' to something acceptable in biomedical terms, Frank and Stollberg (2004: 355) argue that medical doctors hybridise CAM ideas 'with Western medical thought' since they rely on a meta-theory of biomedical provenance in determining which medical system to use in which case. What it in fact implies is that CAM is made ideologically and theoretically subordinate to the biomedical model of healing and is used for other reasons than believing in its underlying premises. The pragmatic use of CAM because of its benefits for patients (Lewith, 2008), 'especially in areas where conventional medicine is weakest' (Parusnikova, 2002: 175; see also Budd and Sharma, 1994), does, hence, not at all mean that its holistic underpinnings are accepted but is rather motivated by 'its effectiveness, which is likened to the placebo effect' (Mizrachi et al., 2005: 26). Such a 'cautious approval' (Mizrachi et al., 2005) of CAM by medical doctors is deemed justified because they believe it can do no harm (e.g. May and Sirur, 1998) and has proven its effectiveness in practice (Willis, 1994; Shuval et al., 2012), although those concerned do not believe that it 'really' works, biomedically speaking. Indeed, Willis (1994) maintains that medical doctors who use CAM because 'it works', thereby referring to a non-biomedical form of legitimacy, cling to the biomedical model of health and illness. According to the domestication thesis, then, medical doctors who practise CAM alongside biomedicine hold on to the biomedical model, have a preference for cures and treatments based on the latter, and understand and use CAM as a mere pragmatic and instrumental add-on.

We are not aware of any studies about the combination of CAM and biomedicine in settings where the latter does not constitute the dominant and taken-for-granted model of health and healing. Acknowledging that holistic approaches to healing have always played a more substantial role in general practice than in most medical specialisations (Checkland et al., 2008; Easthope et al., 2000; Hasegawa et al., 2005), we study this by means of an analysis of the medical ideas and practices of holistic GPs who use biomedicine alongside CAM. More specifically, we study how holistic Dutch GPs combine CAM and biomedicine in their medical practices and the difficulties and obstacles they experience in doing so.

Data and methods

In order to obtain an understanding of how biomedicine and CAM are combined in practice, we studied 19 holistic GPs who rely on both in treating their patients. We randomly

sampled them from the address registers on the websites of various alternative medical associations.^{5,6} Although our 19 respondents make use of various types of CAM, these are all rooted in the notion that body, mind and spirit cannot and should not be separated from one another. More specifically, we interviewed 12 anthroposophists, 5 homeopaths, 1 acupuncturist and 1 natural healer. In all, 14 are male, and 5 are female.⁷

We used semi-structured interviews to gain insight in respondents' perspectives on health and illness, biomedicine and CAM, and the healing process, with special attention to the question of why and when they rely on either of the two in treating their patients. We also asked whether respondents experienced any pressures from the biomedical or alternative field in order to assess whether and – if so – what kind of struggles they experience. The interviews, varying between 30–90 minutes in duration, were conducted between May and August 2009 in different places in the Netherlands. They were all audio-tape recorded and transcribed.

We used thematic analysis (Braun and Clarke, 2006) to identify key themes relevant to our research question. The analysis began with a process of initial coding in which each individual interview was classified in general categories and subcategories. We coded the content of the whole transcripts, but paid special attention to codes which were relevant in terms of their 'keyness' to our research question. In the next step, we searched for broader and more meaningful themes by constantly comparing the codes within and between transcripts and sorting them into potential overarching themes (Braun and Clarke, 2006: 89). These tentative themes linked together different codes and themes. In the final phase of the data analysis, the themes were refined by going back to the coded extracts and by rereading the entire transcripts in order to ascertain whether the themes reflected the meanings found in them.

Description of the sample

Ten of our respondents came in touch with CAM during medical school, seven during their upbringing, and only two learned about alternative medicine after completing their medical studies. We can distinguish three main motivations our respondents have for using CAM and, hence, three different paths to holism.

For most of our respondents, the use of CAM in their family practice was quite a logical thing to do since they were either raised with some form of CAM and see it as their worldview or because it fits their holistic idea that 'a human being is more than what one can measure, weigh and count' (Dr 19). Some respondents felt attracted to the spiritual philosophies underlying some forms of CAM, which relates to their belief that 'there is more than we see around us', and for some with their belief 'that you don't live once, but return to earth' (Dr 11). Some respondents started using CAM because it provides them a different perspective on illness, which is not merely understood as a misfortune that strikes someone by coincidence, but as something closely related to someone's 'developmental path' (Dr 8). CAM is believed to address questions like 'why does one person get pneumonia, while another person does not?' (Dr 13) or 'why do I suffer from things?' (Dr 5), which is, according to our respondents, not addressed in the biomedical model of healing. Our respondents' adoption of CAM is, thus, partly driven by their search for the deeper causes of illness.

Some respondents also argue that, besides their interest in the 'broader perspective' on health and illness, they were motivated to use CAM because it helps people with complaints where conventional medicine is weak (Dr 16). One respondent argues he thought he could help people better with CAM because he could work on the deeper causes of diseases instead of focusing on the symptoms (Dr 7).

Others argue that they primarily started using CAM because of practical matters: because of the 'positive results' experienced in practice (Dr 6) or because one 'can do a lot, also more permanently, without having the annoying side effects of conventional medicine' (Dr 12). One doctor even argues that he was initially very sceptical about homeopathy, which was practised by a colleague of him. He, however, 'saw people getting better and feeling better, whereas they weren't entitled to this according to the books'. When asked why he used homeopathy, he says, 'when I see that something works, I want to try it, and then the theoretical background doesn't interest me much' (Dr 18). He even argues that he knows that a lot of placebo effect can be involved, and whispers, 'I actually do not care about that'. However, also these 'practically motivated' respondents resort to holistic explanations when asked how they think CAM works, such as working on 'energy levels' (Dr 6) or working on the emotional causes of complaints, 'because 99 per cent of diseases is determined emotionally' (Dr 12).

Most respondents thus started using CAM because they had an affinity with the underlying holistic principles from the outset. Some of them also mentioned they felt they were being able to help people better with CAM. Only three respondents started using CAM because of its effectiveness as experienced in practice. However, when asked how CAM works, these respondents also resort to holistic explanations.

Results

Putting CAM and biomedicine to practice

All our respondents adhere to holistic notions of health and healing and combine biomedicine and CAM in general practice. Since biomedicine and CAM are based on different notions of health and illness, the question arises how they combine the two and put them into practice, that is, on what grounds they decide to use one or the other.

CAM to work on 'the motor behind' people's physical problems. All GPs argue that human beings are more than their physical bodies. Although this idea that people 'are more' is expressed in different ways, these all refer to 'the intangible' or 'the immeasurable' – people's emotional households, their psyches, or energies – informing the notion that physical problems typically have mental, emotional, or other non-physical causes. All GPs in our study thus emphasise that the psyche or spirit is connected to the body, which informs a notion of illness as typically caused by a 'disturbance' of the whole person. Our respondents hold that CAM offers them a means to work on these deeper causes of physical problems. One respondent argues that if someone has an infection every so often, he thinks it is important 'to look at how it happens; what do you do in your life that makes you so ... well that's what we find exciting here'. Another respondent contends that one should focus on 'the motor behind' patients' physical problems:

You have a bladder infection, you have lower back pain, you have irritable bowels, you have a lot of problems. Then we try to trace the problem and work on it. If you suffer from a lot of pain, I give you a strong painkiller. But in the meanwhile I have to work on the motor behind the problem. (Dr 2)

Most GPs embed this idea that physical diseases are typically caused by psychological conditions in the more general conviction that a person's lifestyle influences his or her susceptibility to diseases. One respondent maintains, for instance, that 'seventy per cent of our cancer is related to our nutrition and lifestyle' (Dr 1). Hardly surprising, then, most GPs in our study feel that people should be put to work to improve and maintain their own health: 'it is your life, [...] you can do something about it' (Dr 9).

A total of 11 GPs share the assumption that illnesses have meaning for people's spiritual development:

You have to do with reincarnation and karma. It is not only this life you are living now; it goes further. You come from somewhere and you go somewhere. [...] If you follow this [line of thought] then you have chosen your parents, you have chosen the family you wanted to grow up in, and you can develop yourself with the help of the problems you encounter. You are engaged in a development your whole life. So then I try to help the patient in his development, because you get ill when something ceases within this development. (Dr 17)

This conception of illness relates to the notions that people are on earth to develop themselves and that diseases and other problems provide clues for spiritual growth: 'If everything goes well, then one develops not much. Diseases also belong to this development' (Dr 10). In this view, getting ill 'is no coincidence, but [...] has a signalling function; [...] it wants to tell you something. And the challenge for you is to find out what it [the signal] is' (Dr 18). As one respondent argues, 'if you break your leg, it has to be repaired. That's all fine. But then the question comes: and now what?' (Dr 3).

Because illness offers the possibility for personal growth, it is not necessarily seen as something negative:

For us [anthroposophists] not every illness is necessarily something that should have been suppressed earlier. Of course it is important to make illnesses manageable and get them under control, but also to look at, where possible, whether it offers a chance for development. It thus can be a possibility to grow in something, or to learn something you couldn't do before. It [illness] is thus not necessarily something negative, but it can also have a positive side. (Dr 14)

In short, our respondents hold that CAM responds to the deeper causes of illness and helps them to address and discuss the meaning of illness within the developmental paths of their patients. This way people can 'tackle the "why me?" issue by way of the realisation that disease has a purpose' (Heelas, 2012: 70).

CAM to promote health and prevent diseases. Our respondents commonly hold that alternative therapies are not in the first place aimed at eliminating disease but rather appeal 'to health to prevent diseases' (Dr 1). They argue that CAM treatments focus on people's lifestyle, immune system and (im)balance 'to strengthen the healthy side of people' (Dr 4).

Alternative medicines are thus seen as responding to people's immanent healing power by 'awakening something in one's self-healing capacity' (Dr 10), 'so one's body is solving [the problem(s)] itself' (Dr 12). In the same vein, it is preferred if 'someone overcomes a particular problem from his/her own restoring of balance, helped by his/her own natural context' (Dr 13), since then the body 'overcomes the illness itself' (Dr 18). In appealing to people's 'self-healing capacity', alternative treatments are seen as preventing diseases in the long term since one 'strengthens one's immune system' (Dr 11). Our respondents thus do not conceive of illness as something that happens suddenly, but as something that develops in time so that people can anticipate and prevent the disease from growing. According to one of them, a test exists 'which can indicate ten years in advance when someone will get cancer [...]. But it depends on your lifestyle' (Dr 2). He pleads for preventive scans or so-called 'blood crystallisation tests which can reveal [cancer] tendencies [...] on which one, then, could anticipate'.

In sum, all our respondents hold that CAM treatments help patients in restoring a balance in their body so as to prevent them from getting ill. Moreover, because CAM stimulates patients to actively contribute to a healthy lifestyle, it is held to promote health in the long run.

Conventional treatments: 'a necessary evil'. Our respondents have mixed feelings about conventional medication. Generally speaking, they are grateful for biomedicine's technological advancements in preserving lives through drugs and surgery. They also ascertain that they make good use of conventional drugs if needed. Most of them are not against biomedicine, since combined with CAM it offers them a broad array of medical treatments. However, they do think that conventional medication has its downsides and are therefore reluctant to use it:

A conventional drug is often compelling. I mean in the sense that they of course work really hard. But then one can wonder what a patient himself or herself learns from it [the treatment]. (Dr 11)

It is considered preferable and much better for one's health when people learn from their disease and adjust their lifestyle, something which conventional drugs discourage. In all, 13 physicians are dissatisfied with conventional drugs because the latter tend to cause other maladies or diseases so that 'one should always be wary of side-effects and one actually knows that one is playing a double game' (Dr 5). It is even maintained that 'people have the tendency to get better, despite the doctor' (Dr 18). The commonly held assumption, underscored by all our respondents, is that conventional medicines are not able to 'really' heal people. One respondent is particularly outspoken about this:

One cannot recover with the help of a dead drug. [...] One can give an antibiotic in case of a bacterial infection, [but] then one gives something against life. Anti-bio, the word says it all: one gives something against the bacteria. In general the infection and inflammation go away immediately. But it could also be that the bacteria go away, while the inflammation remains. [In cases like that] conventional medicine can do nothing but giving more antibiotics. As a consequence, the immune system weakens and other diseases emerge. (Dr 2)

The respondents who are less outspoken claim that conventional drugs merely suppress the symptoms of a disease, without really taking it away: they don't 'really work on healing' (Dr 12) and 'do actually never heal: you have to use them for always and forever' (Dr 10). Another respondent explains that 'we can give you a hundred pills, but if you don't change, then it doesn't heal' (Dr 9), and yet another, noting that chemical drugs make the symptoms go away, asks herself, 'does it heal you? Has the relationship between body, soul and mind improved? Very often not' (Dr 4).

Our respondents are thus reluctant to use conventional medication because of its negative side effects and because it only suppresses the symptoms of a disease, without really curing it. Why, then, do our respondents still use biomedicine in their practice? All our respondents argue that they resort to conventional treatments when they are confronted with severe or life-threatening cases because in circumstances like these conventional treatments have their merits: they 'work' in the sense that they prevent patients from dying:

If [...] the patient is so sick, (s)he cannot drink anymore, then (s)he will die [...]. You'll refer him [to a specialist]. [...] It is not my job to let people die responsibly, but to keep them alive. (Dr 3)

Other respondents similarly refer to acute situations such as cardiac arrests, stating that in an age 'in which we don't want people to die, which is [...] right, I think, you should keep using them [conventional medicines]' (Dr 13), that conventional treatments make for the fact that 'nowadays we no longer die of things our parents in the sixties would die from' (Dr 9) and that anti-HIV pills may have severe side effects, 'but at least they [the patients] stay alive' (Dr 10).

Another reason for some GPs to use conventional medication is that it could prevent radical, negative life changes. One respondent, for example, is glad that there are antidepressants:

But if somebody really has a severe depression, (s)he would have ended up in a mental institution if it had been in the fifties. Then a mother with a postnatal depression would be in a mental institution for years. That is really terrible: a child has no mother anymore, the father has to do it on his own [...]. Well, then you may be grateful that we have antidepressants nowadays. (Dr 9)

One GP says that 'if somebody drowns in his complaints, [...] or is so depressed and has suicidal thoughts', he has no objections to giving an antidepressant since after that he 'can work with more energy on his real problem' (Dr 14).

The GPs thus deem the use of conventional treatments necessary in severe and life-threatening cases, when staying alive is the primary aim. In these cases, it is not about what one prefers but about what is absolutely necessary.⁸ The compelling effects of conventional treatments enable GPs to 'extinguish a fire' (Dr 1), as one respondent expresses it. Another explains that he would rather use treatments that stimulate the body to prevent one from getting cancer, but 'at this moment we have nothing better to remove the tumours, and to fight cancer ... With sometimes horrible methods' (Dr 18). Although conventional treatments are not understood as making people healthy in the long run,

they are thus seen as necessary in cases of emergency: 'well, cynically speaking I could say that conventional medication can be interpreted as a necessary evil' (Dr 5).

Our respondents, in short, have mixed feelings about biomedical treatments. On the one hand, they acknowledge the latter's downsides in generating side effects and in not taking away the motor behind the problems. On the other hand, however, they acknowledge that biomedical drugs and therapies are sometimes necessary to prevent people from dying or from ending up in life-threatening situations.

GPs' rationale for choosing between CAM and biomedicine in practice. Our respondents' explanations of their use of biomedicine and CAM show that they rely on a developmental theory about disease and about the 'hardness' of the necessary therapy or treatment. They hold that if disease is in an advanced state, alternative treatments cannot do anything to cure it. One respondent explains that he is less inclined to use homeopathy when diseases are grounded 'more and more in the body' (Dr 7) and hence more persistent: 'To give just one example: gallstones. Stone, you are not going to take that away with granules' (Dr 7). This understanding is informed by GPs' holistic notions of health and illness: when physical diseases emerge, there is already something wrong at the non-physical level so that physical problems are understood as basically the 'advanced states' of diseases, which therefore require more compelling conventional medical treatments. As such, severe or life-threatening physical diseases are seen as 'out of control' (Dr 6). They are seen as no longer curable with alternative methods but as requiring stronger and more compelling conventional methods, although the latter are not seen as making people 'really' healthy. Most of our respondents, therefore, see conventional medicine as an indispensable part of their medical practice: 'as yet we still need conventional medicine, because people are often still very ill, such as heart attacks for instance' (Dr 11).

In sum, our respondents do not experience any tensions in combining CAM and biomedicine since the former works for prevention and maintaining health by working on the 'deeper causes' of illness and the latter for combating really severe and 'advanced' conditions. They hence understand illness as a continuum, with the initial stages treatable with more gentle CAM treatments and the more advanced ones being 'out of control' and therefore necessitating more compelling conventional treatments. Whereas our respondents think conventional medicine does not 'really' cure, it is nonetheless deemed *necessary* to combat severe and acute conditions.

Day-to-day struggles in practising CAM

Whereas the severity and acuteness of patients' conditions may force our respondents to pragmatically apply biomedical drugs, treatments and therapies, there are also more mundane practical and instrumental reasons why they sometimes feel compelled to do so.⁹

Patient demands: 'Who am I to say: you may not?' A first more mundane motive for using conventional treatments is *patient demand*. All respondents argue that patients need to be given the freedom to choose their own treatments, be they conventional or alternative. Constrained by patients' wishes and desires, then, GPs choose the best available

treatment. Consequently, GPs sometimes have to use treatments they would rather not use in the case at hand:

But if somebody [...] wants an antibiotic, and I try to explain its disadvantage and that there might be alternatives, but (s)he still insists ... Well, yes, who am I to say 'You may not'? (Dr 14)

Indeed, many GPs point out that they often use conventional treatments because many patients want treatments that make their disease go away as quickly as possible. In cases like this, they use conventional medicine simply because it 'works' to satisfy patients' wishes, but not because they personally feel it is best for them.

Counteracted by the government. A second mundane practical motive for relying on biomedicine relates to government regulations with respect to alternative drugs. Many of our respondents explain that the Dutch government is counteracting the practice of CAM by prohibiting the sale of non-registered alternative medicines. For this reason, many alternative medicines need to be purchased in Germany, where they are legal. This is, however, impractical and sometimes informs decisions to rely on conventional ones instead:

Many medicines are not easy to obtain, and the pharmacy is not allowed to have them in stock. Then they must be ordered and that takes another three days. And yes, people do not have the patience to wait for that. And then I am forced to give something conventional, while I'd rather not do that, and often the patient doesn't want it either. (Dr 15)

Another respondent maintains that the government is misinformed and misled by powerful pharmaceutical lobbies and asks attention for the role and influence of health insurance companies, too:

The chemical companies have made it happen that all those laymen of the ministry of healthcare are informed in such a way, that they think that only a chemical drug has effects. So homeopathic and anthroposophic medicines are barely being reimbursed. And when somebody here says (s) he cannot pay it [...] Then all I can do is give a chemical drug. (Dr 2)

Some of our GPs thus feel literally forced to rely on conventional medicine every now and then because government and insurance companies make it difficult for them to prescribe alternative medicines by hampering their availability and failing to reimburse them. In this case, too, conventional medicine is used from a practical point of view: the GPs feel they *have to* resort to conventional treatments, although the latter are in their eyes not the preferable ones.

Binding protocols. Thirdly, our respondents point out that, due to binding protocols, they sometimes feel forced to rely on biomedicine where they would personally prefer an alternative treatment. More specifically, they point at the protocols of the 'Dutch GP Society' (NHG) in this context, also called the 'NHG-guidelines'. One respondent for instance mentions that these standards are bound up with 'a flood of bureaucracy' (Dr 4).

Some feel restricted in exercising their autonomy, because the protocols prescribe what GPs should do in certain cases, thereby limiting the available options. One respondent argues that those protocols make it sometimes hard to deviate from the prescribed conventional treatment:

There are of course also standards and protocols which prescribe: if it is over 6.5 then you should do this, and over 8 you should do that, and if it is over 10 then you should do that. That leaves little space for a different vision, which is of course sometimes complicated. It doesn't always leave space for doing something in a different way, and not using those anti-pills. (Dr 9)

Binding protocols are thus experienced as working in favour of conventional treatments, leaving no space to choose for other treatments. This sometimes leads to situations in which our respondents feel forced to use conventional treatments, whereas they would rather use a CAM treatment. In these cases, our holistic GPs are constrained to use conventional treatments because they otherwise run the risk of being sued.

Conclusion and discussion

Our analysis has shown that holistic GPs practising both CAM and biomedicine understand both modalities as healing on different levels, with conventional treatments primarily used as a 'rough remedy' deemed necessary to combat the 'advanced states' of diseases and as such incapable of achieving a state of optimal health in which 'overall imbalance' is healed. Complementary methods, to the contrary, are deemed to respond to the 'whole person' and therefore contribute to a healthier person. Whereas previous studies have demonstrated that biomedical professions adopt CAM for strictly pragmatic, practical or instrumental reasons (e.g. Baer, 2008; Baer and Coulter, 2008; Parusnikova, 2002; Willis, 1994; Wiese et al., 2010), our analysis points out that holistic GPs' use of biomedical treatments is motivated by the same type of practical considerations. They do not use conventional medicine because they believe that it 'really' cures their patients, but because in certain conditions they have no other options. This is not only the case in life-threatening or acute situations but also when their patients insist on a biomedical treatment or when regulations or protocols imposed by the government, medical insurance companies or professional associations require them to do so. Our respondents, then, explain their use of conventional medicine entirely in terms of necessity and practical limitations encountered in day-to-day practice.

The domestication thesis, which accounts for CAM integration into biomedical settings thus holds for biomedical integration in CAM settings, too. Holistic GPs domesticate biomedicine into their holistic healing practices instead of the other way around: here, it is biomedicine that is treated as a strictly practical tool that remains theoretically and ideologically subordinate to the model of holistic healing.

While our holistic GPs domesticate biomedicine into CAM, it is clear that they experience overpowering macro processes that work in favour of biomedicine. These obstacles increase only further as a consequence of the shift towards evidence-based medicine (EBM), which is difficult to reconcile with CAM's emphasis on clinical experience rather than double-blind experimental evidence (e.g. Adams, 2000). To get a fuller

understanding of the forces at play in the field of CAM integration, then, future research should not only address responses of biomedical professional bodies to CAM adoption but also individual providers' practices and struggles.

Furthermore, there is a need for research aimed at a contextualised understanding of developments in the relationship between CAM and biomedicine. This study is limited in its particular sample of Dutch holistic GPs. Future research should compare changes in biomedical settings that vary in their initial adherence to either CAM or biomedicine. Unlike the holistic GPs discussed in this article, for instance, hospital settings tend to be dominated by biomedicine, with CAM practitioners merely tolerated as 'islands of holism within a sea of dualism' (Keshet et al., 2012: 598). Moreover, developments in the integration of CAM could vary considerably across countries (e.g. Baer, 2006), also depending on national legislation and regulation regarding the practice and reimbursement of CAM, the power of the medical profession and pharmaceutical companies and the power and influence of patient groups advocating CAM. In the Netherlands, there are no government-administered regulations and laws concerning the practice of CAM, but the Dutch medical association does prescribe rules of conduct limiting the use of CAM. Alternative therapies are only covered by private insurance companies. We can imagine that the practice of CAM by medical doctors might look entirely different in countries where the practice of CAM is regulated by the government and where alternative treatments are covered by the statutory health insurance. Indeed, medical professions will have to deal with the increasing popularity of CAM in one way or another since CAM modalities seem as yet to persist and thrive within Western countries.

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Notes

1. The terms Complementary and Alternative Medicine (CAM) and alternative medicine are used interchangeably in this study to denote those healing practices which are generally not approved by the medical profession and not included in the curriculum of medical schools. In this article, the use of the term alternative is *not* meant to denote the idea that it should replace or is incompatible with biomedicine.
2. In the Netherlands, there are no government-administered regulations and laws concerning the practice of CAM. The provision of healthcare services is regulated by the Dutch act 'Wet op de beroepen in de individuele gezondheidszorg' also known as BIG, which allows alternative practitioners to practice their profession, except for some acts reserved to medically trained physicians. The rules of conduct prescribed by the Dutch medical association KNMG prohibit physicians to use alternative therapies when a therapy is available which belongs to the generally accepted professional standards. Alternative medicine is not covered by the statutory health insurance in the Netherlands, but many alternative therapies are covered by private insurance companies.
3. We want to emphasise that we acknowledge that this dominance of biomedicine is not a one-way process of biomedicine responding to the growing 'threat' of alternative medicine. Indeed, also CAM groups aimed at professionalising and gaining acceptance, have moved

towards biomedicine in relying on biomedical knowledge to prove CAM's effectiveness and in moving away from CAM's theoretical premises (e.g. Cant, 2009).

4. Whereas the dominant thesis is that biomedicine, indeed, co-opts CAM groups and therapies and retains its own model of health and healing, there is also some evidence for biomedicine moving into the direction of CAM. In such a case, 'CAM provides biomedical physicians with a more holistic approach to treating the patient' (Shuval et al., 2012: 1325).
5. The websites of the 'Nederlandse Vereniging van Antroposofische Zorgaanbieders' (NVAZ), 'Artsenvereniging voor homeopathie' (VHAN), 'Nederlandse Artsen Acupunctuur Vereniging' (NAAV) and 'Artsenvereniging voor Biologische en Natuurlijke Geneeskunde' (ABNG-2000).
6. Ethical approval is not required for this type of study in the Netherlands.
7. The authors acknowledge that these modalities have different underlying philosophies and their own ways of explaining and treating illnesses. This article, however, does not focus on the differences between these modalities but on how GPs who all have a holistic view on health and illness integrate biomedicine within their holistic practice.
8. A few GPs mention they occasionally use alternative treatments in acute cases because patients demand it, while they would rather use more compelling, conventional treatments that are deemed safer in the cases at hand. In these cases, our respondents try to persuade their patients to having a conventional treatment. When patients still insist on an alternative treatment, some of our respondents argue, GPs let them sign a form indicating that they turn aside their GPs' advice.
9. We want to emphasise that this section focuses on the reasons our respondents have for using conventional medicine rather than on actual prescription patterns. We also asked whether our respondents could indicate what percentage of their prescriptions is 'conventional' and what percentage is 'alternative'. This yielded different answers; some indicated it is 50/50, some indicated they prescribe more alternative medicines, but the majority indicated conventional medicines are prescribed more often (most of them suggest 60/40). Some respondents mention that the distribution was not reflecting their ideal practice, due to changed regulations to the detriment of CAM provision, to specialists' large number of prescriptions for conventional medicines which our respondents just have to follow up and to patients who only want to be treated conventionally or who never indicated they would like to be treated alternatively.

References

- Adams J (2000) General practitioners, complementary therapies and evidence-based medicine: The defence of clinical autonomy. *Complementary Therapies in Medicine* 8(4): 248–252.
- Adams J, Hollenberg D, Lui C, et al. (2009) Contextualizing integration: A critical social science approach to integrative health care. *Journal of Manipulative and Physiological Therapeutics* 32(9): 792–798.
- Ammon K, Von Frei-Erb M, Cardini F, et al. (2012) Complementary and alternative medicine provision in Europe: First results approaching reality in an unclear field of practices. *Forschende Komplementärmedizin* 19(2): 37–43.
- Astin JA, Marie A, Pelletier KR, et al. (1998) A review of the incorporation of complementary and alternative medicine by mainstream physicians. *Archives of Internal Medicine* 158(21): 2303–2310.
- Baer HA (2006) The drive for legitimation in Australian naturopathy: Successes and dilemmas. *Social Science & Medicine* 63(7): 1771–1783.
- Baer HA (2008) The emergence of integrative medicine in Australia: The growing interest of biomedicine and nursing in complementary medicine in a southern developed society. *Medical Anthropology Quarterly* 22(1): 52–66.

- Baer HA and Coulter I (2008) Introduction – Taking stock of integrative medicine: Broadening biomedicine or co-optation of complementary and alternative medicine? *Health Sociology Review* 17(4): 331–341.
- Bombardieri D and Easthope G (2000) Convergence between orthodox and alternative medicine: A theoretical elaboration and empirical test. *Health* 4(4): 479–494.
- Braun V and Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2): 77–101.
- Budd S and Sharma U (1994) Introduction. In: Budd S and Sharma U (eds) *The Healing Bond: The Patient-Practitioner Relationship and Therapeutic Responsibility*. London; New York: Routledge, pp. 1–20.
- Cant S (2009) Mainstream marginality: ‘Non-orthodox’ medicine in an ‘orthodox’ health service. In: Gabe J and Calnan M (eds) *The New Sociology of the Health Service*. London; New York: Routledge, pp. 177–200.
- Checkland K, Harrison S, McDonald R, et al. (2008) Biomedicine, holism and general medical practice: Responses to the 2004 General Practitioner contract. *Sociology of Health & Illness* 30(5): 788–803.
- Clavarino A and Yates P (1995) Fear, faith or rational choice: Understanding the use of alternative therapies. In: Lupton G and Najman J (eds) *Sociology of Health and Illness: Australian Readings*. 2nd ed. Melbourne, VIC, Australia: Macmillan, pp. 252–275.
- Easthope G (2003) Alternative, complementary or integrative? *Complementary Therapies in Medicine* 11(1): 2–3.
- Easthope G, Tranter B and Gill G (2000) General practitioners’ attitudes toward complementary therapies. *Social Science & Medicine* 51(10): 1555–1561.
- Eisenberg DM, Davis RB, Ettner SL, et al. (1998) Trends in alternative medicine use in the United States, 1990–1997: Results of a follow-up national survey. *Journal of the American Medical Association* 280(18): 1569–1575.
- Fadlon J (2005) *Negotiating the Holistic Turn: The Domestication of Alternative Medicine*. Albany, NY: State University of New York Press.
- Fisher P and Ward A (1994) Complementary medicine in Europe. *British Medical Journal* 309(6947): 107–111.
- Frank R (2002) Integrating homeopathy and biomedicine: Medical practice and knowledge production among German homeopathic physicians. *Sociology of Health & Illness* 24(6): 796–819.
- Frank R and Stollberg G (2004) Medical acupuncture in Germany: Patterns of consumerism among physicians and patients. *Sociology of Health and Illness* 26(3): 351–372.
- Hasegawa H, Reilly D, Mercer SW, et al. (2005) Holism in primary care: The views of Scotland’s general practitioners. *Primary Health Care Research and Development* 6(4): 320–328.
- Heelas P (2012) ‘New Age’ spirituality as ‘tradition’ of healthcare. In: Cobb M, Puchalski C and Rumbold B (eds) *Spirituality in Healthcare*. Oxford: Oxford University Press, pp. 69–76.
- Hollenberg D and Muzzin L (2010) Epistemological challenges to integrative medicine: An anti-colonial perspective on the combination of complementary/alternative medicine with biomedicine. *Health Sociology Review* 19(1): 34–56.
- Hunt KJ, Coelho HF, Wider B, et al. (2010) Complementary and alternative medicine use in England: Results from a national survey. *The International Journal of Clinical Practice* 64(11): 1496–1502.
- Keshet Y (2013) Dual embedded agency: Physicians implement integrative medicine in health-care related organizations. *Health* 17(6): 605–621.
- Keshet Y, Ben-Arye E and Schiff E (2012) Can holism be practiced in a biomedical setting? A qualitative study of the integration of complementary medicine to a surgical department. *Health* 16(6): 585–601.

- Lewith GT (2008) The cultural context of CAM. *The Journal of Alternative and Complementary Medicine* 14(10): 1179–1180.
- May C and Sirur D (1998) Art, science and placebo: Incorporating homeopathy in general practice. *Sociology of Health and Illness* 20(2): 168–190.
- Mizrachi N, Shuval JT and Gross S (2005) Boundary at work: Alternative medicine in biomedical settings. *Sociology of Health and Illness* 27(1): 20–43.
- Parusnikova Z (2002) Integrative medicine: Partnership or control? *Studies in History and Philosophy of Biological and Biomedical Sciences* 33(1): 169–186.
- Reilly DT (1983) Young doctors' views on alternative medicine. *British Medical Journal* 287(6388): 337–339.
- Saks M (1994) The alternatives to medicine. In: Gabe J, Kelleher D and Williams G (eds) *Challenging Medicine*. London: Routledge, pp. 84–103.
- Saks M (1995) The changing response of the medical profession to alternative medicine in Britain: A case of self-interest or altruism. In: Johnson T, Larkin G and Saks M (eds) *The Health Professions and the State in Europe*. London: Routledge, pp. 59–65.
- Shuval JT, Gross R, Ashkenazi Y, et al. (2012) Integrating CAM and biomedicine in primary care settings: Physicians' perspectives on boundaries and boundary work. *Qualitative Health Research* 22(10): 1317–1329.
- Thomas KJ, Nicholl JP and Coleman P (2001) Use and expenditure on complementary medicine in England: A population based survey. *Complementary Therapies in Medicine* 9(1): 2–11.
- Timmermans S and Oh H (2010) The continued social transformation of the medical profession. *Journal of Health and Social Behavior* 51(1): S94–S106.
- Tindle HA, Davis RB, Phillips RS, et al. (2005) Trends in use of complementary and alternative medicine by US adults: 1997–2002. *Alternative Therapies in Health and Medicine* 11(1): 42–49.
- Van Dijk P (2006) Omvang alternatieve geneeswijzen in Nederland. In: Van Wijk R and Van Nieuwenhuijze O (eds) *TIG Jaarboek 21/22, 2005/2006*. Amsterdam: Supplement BV, pp. 13–22.
- Visser GJ and Peters L (1990) Alternative medicine and general practitioners in the Netherlands: Towards acceptance and integration. *Family Practice* 7(3): 227–232.
- Wiese M, Oster C and Pincombe J (2010) Understanding the emerging relationship between complementary medicine and mainstream health care: A review of the literature. *Health* 14(3): 326–342.
- Willis E (1994) Complementary healers. In: Willis E (ed.) *Illness and Social Relations: Issues in the Sociology of Health Care*. Sydney, NSW, Australia: Allen & Unwin, pp. 54–74.
- Winnick TA (2005) From quackery to 'complementary' medicine: The American medical profession confronts alternative therapies. *Social Problems* 52(1): 38–61.
- Winnick TA (2006) Medical doctors and complementary and alternative medicine: The context of holistic practice. *Health* 10(2): 149–173.

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