Chapter 2

Western and Traditional Medicine: a comparison of paradigms and working methods

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Introduction

In the West half the population uses non-conventional medicines (complementary and alternative medicine, CAM; also referred to as Traditional Medicine, TM) annually (Bodeker & Kronenberg, 2002), almost always in combination with Western Medicine (WM) (Astin, 1998). For instance in the Netherlands CAM is used by 42% of psychiatric outpatients (Hoenders et al., 2006a). Most of them favour integration of CAM and WM (Hoenders et al., 2006a). In the East, traditional medicines like Chinese and Tibetan medicine and Ayurveda are increasingly being researched with Western research methods (like the RCT; randomized clinical trial) often with remarkable results. Of course, these medicines have already proved their value in thousands of years. But now in this information era with increasing exchange between East and West and an emphasis on scientific research, there seem to be great opportunities for collaboration, exchange and even integration of WM and TM; the different medicines of the world.

But although the practical integration of western medicine (WM) and complementary and alternative medicine is growing (Hoenders et al., 2008), their paradigms and therapeutic methods often differ greatly. At first sight they even appear impossible to reconcile. Is theoretical and therapeutic integration of WM and CAM really an illusion or is the presumed gap mainly related to our points of view? We did a literature search on this issue and this is what we found (Hoenders et al., 2006b).

Comparison of CAM and Western Medicine

Many authors compared the Western biomedical paradigm with alternative paradigms (McFarlane, 1996; Goldstein, 2003; Kaptchuk & Eisenberg, 1998). Table 1 shows five factors that in our opinion characterize the differences most clearly, with references to the original authors.

These distinctions are in most cases not categorical but dimensional, for example, the ‘procedures’ aspect ‘technology versus natural sources’. A great deal of current WM medications is directly derived from herbs and plant extracts, such as procaine and digitalis. This obscures the boundary between ‘natural’ and ‘technical’.

The same counts for the ‘expert’ issue. It is clear that during surgical intervention the patient is under anaesthesia and the doctor is the expert. However, afterwards the patient himself has to work actively on rehabilitation. The patient’s contribution varies from minimal to a great deal considering the circumstances.

With regard to the ‘therapist-patient relationship’, mainstream psychotherapy currently strongly recognizes the importance of non-specific factors (Duncan & Miller, 2006).
**Table 1: General differences between CAM and WM**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Western Medicine</th>
<th>CAM / TM</th>
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<tbody>
<tr>
<td><strong>Perspective</strong></td>
<td>Reductionism⁷</td>
<td>Holism</td>
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<tr>
<td></td>
<td>Pathogenesis (focusing on factors that cause disease)</td>
<td>Salutogenesis (focusing on health, well-being, and one’s self-healing capacity)⁹</td>
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<tr>
<td><strong>Paradigm</strong></td>
<td>Mechanism⁷</td>
<td>Vitalism⁹</td>
</tr>
<tr>
<td></td>
<td>Giving antidote (allopathy)</td>
<td>Stimulating healing response (homeopathy)⁵</td>
</tr>
<tr>
<td><strong>Procedure</strong></td>
<td>Therapist is expert and responsible</td>
<td>Patient is expert and responsible⁹</td>
</tr>
<tr>
<td></td>
<td>Therapeutic relationship is minor detail⁷</td>
<td>Therapeutic relationship is central⁸</td>
</tr>
<tr>
<td></td>
<td>Technology</td>
<td>Natural sources⁹</td>
</tr>
<tr>
<td><strong>Research method</strong></td>
<td>'Outer science'¹⁰ / 'evidence'¹⁰</td>
<td>'Inner science'¹¹ / 'experience'⁹</td>
</tr>
<tr>
<td></td>
<td>RCT, efficacy¹⁰</td>
<td>N of 1, effectiveness¹²</td>
</tr>
<tr>
<td><strong>Organisation</strong></td>
<td>Legitimate, official¹³</td>
<td>Unofficial¹⁴</td>
</tr>
<tr>
<td></td>
<td>Training¹⁴</td>
<td>'Calling'¹⁵</td>
</tr>
<tr>
<td></td>
<td>Costly</td>
<td>Cheap¹⁶</td>
</tr>
</tbody>
</table>

⁷ Engel, 1980; Van Der Steen, 1991  
⁸ Goldstein, 2003; Cassidy, 2001; Weil, 2000  
⁹ Jonas, 2002  
¹⁰ Goldstein, 2003; Kaptchuk & Eisenberg, 1998; Micozzi, 2001; Gulmen, 2004  
¹¹ Vickers & Zollman, 1999  
¹² Weil, 1996; Gangchen Rinpoche, 1997  
¹³ Snyderman & Weil, 2002  
¹⁴ Astin, 1998  
¹⁵ Kaptchuk & Eisenberg, 1998  
¹⁶ Sackett et al., 2000  
¹⁷ Wilber, 2000; Bensing, 2000; Happle, 1998; McFarlane, 1996  
¹⁸ Ho & Van Der Steen, 2005; Kaptchuk, 2001  
¹⁹ Barrett et al., 2000  
²⁰ Happle, 1998  
²¹ Bruce, 2002  
²² Sarnat & Winterstein, 2004; Boon et al., 2004
Regarding research, in Western medicine it is largely based on positivism, reductionism, objectivism and determinism. This is sometimes called ‘outer science’. It strives for standardization and generalization. In furnishing scientific proof, the RCT is the golden standard. Alternative therapies are particularly based on subjective experience, intuition and belief. The assumption is that the truth is found by way of personal experience (McFarlane, 1996). This is sometimes called ‘inner science’ or ‘first-person science’ (Wilber, 2000). This approach seems particularly suitable for observations or ‘single-case’ studies (n = 1). In research terms, it is related to the difference between efficacy (the ideal outcome in controlled circumstances) and effectiveness (the clinical outcome in natural circumstances). According to Bensing (2000), ‘outer’ and ‘inner science’ are two different worlds. Some say ‘inner science’ is by definition irrational and irreconcilable with rational science (Happle, 1998). Conversely, the criticism of RCTs is that they artificially reflect a complex clinical practice and that the importance of the individual patient becomes devaluated by this (Tataryn & Verhoef, 2005). Moreover, the ‘RCT as golden standard’ is, to our opinion, culture-bound and is implemented less outside of Western culture. After all, for instance various Eastern spiritual philosophies, consider the inner experience as the ultimate basis for attaining knowledge about reality. Assumptions are tested according to other (inner) research methods (McFarlane, 1996).

Despite these differences, it is clear that in the last decade Eastern philosophies have found more acceptance in the Western world and in psychiatry, for example, mindfulness and other Buddhist techniques in the (third generation of) behaviour therapy (Brewin, 2006). Additionally, the unassailable status of the RCT is more frequently put into question, and research methods suitable for ‘inner science’ are proposed more often (Ho & Van Der Steen, 2005; Kaptchuk, 2001). So, also where it concerns research methods, the differences found are not as absolute as they initially seemed to be. The same gradual distinctions seem to be valid for all other factors and aspects. Therefore, theoretical and therapeutic integration of WM and CAM seems relatively easy. But is it?

There seems to be an exception. The contrast between ‘mechanism’ (often accompanied by reductionism) and ‘vitalism’ (often accompanied by holism) is categorical and has been one of the greatest controversies in philosophy. It still leads to heated discussions between WM and CAM. This absolute contrast is of a meta-theoretical nature and therefore cannot be solved through standard scientific logic (Hein, 1971). Supporters of each paradigm and perspective cannot be convinced by scientific evidence to the contrary because their points of view concern an existential premise, a conviction regarding the question of ‘why’ things are as they are (Coulter & Willis, 2004).

However, looking deeper, this controversy seems also relative. For example, a mechanical, work-related frame of mind does not rule out religion and spirituality in private life. Furthermore, a vitalistic philosophy as the leading therapeutic principle can occasionally imply a mechanical working method.
Conclusion

Besides practical integration practised by patients already for a long time, the theoretical and therapeutic integration of WM and CAM is also possible. The findings of our literature search argue for using the biopsychosocial model as originally proposed by Engel (1980; 1992) to facilitate this process. This model fits well because it maintains a middle ground between the biomedical approach and the holistic-vitalistic approach and because its basis is in biological systems theory. This theory attempts to surpass (the opposition between) mechanism and vitalism, partly by nuancing both (Hein, 1972). And it is precisely this nuancing that seems important in our post-modern, multicultural society.

In our opinion we should support integration of WM and CAM in a professional, critical manner and with an open mind so that we can arrive at a complete, efficient, effective integrated healthcare system in which everyone, regardless of his or her culture, race, philosophy of life or need, can receive the help he or she needs.
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References:


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Part II: Implementation