REVIEW ARTICLE

How Holistic is Complementary and Alternative Medicine (CAM)? Examining Self-Responsibilization in CAM and Biomedicine in a Neoliberal Age

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Abstract

This review paper adds to recent social science interrogation of common boundaries between CAM (complementary and alternative medicine) and biomedicine, by examining an unquestioned dichotomy often ascribed to them: holism vs. individualism. Drawing from social scientific literature review, this paper draws attention to the individualistic focus of CAM by situating contemporary CAM developments within a neoliberal climate that emphasizes individual responsibility for health care. Focusing on the individualistic features of CAM helps rethink commonly held assumptions regarding the holistic features of CAM, which tend to gain the most attention in popular and scholarly representations of CAM as distinct from biomedicine. As well, the individualistic features of CAM shed light on the significant role of CAM in health care as a form of individual consumptive choice rather than as a collective responsibility on the part of the state to complement national health care systems.

Key words: Complementary and Alternative Medicine, Biomedicine, Individual Responsibility, Neoliberal Governance

Introduction:

The holistic features of complementary and alternative medical practices (CAM) such as holism, vitalism, naturalism, humanism and spiritualism tend to gain the most attention in popular and scholarly representations that emphasize CAM's distinction from biomedicine's dualism, reductionism, materialism, scientism, and individualism (Coulter, 2004; Eskinazi, 1998; Hare, 1993; Kelner & Wellman, 1997). However, CAM's relatively individualistic focus has received less attention – an issue that this review paper endeavours to further investigate. Specifically, this paper argues that contemporary CAM use in diverse regions occurs within broader social developments that impart individual responsibility for

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health care. As such, the importance of CAM in national health care delivery is strongly motivated by individual initiatives rather than by a collective social responsibility to enhance mainstream health care systems.

Undeniably, CAM is increasingly shaped by neoliberal strategies of governance within transnational global flows in which human experiences have become significantly hybridized through intense negotiations and exchanges of knowledge, services and products. Neoliberalism as a cultural, political and economic ideology has been a dominant global feature in the past 30 years, emphasizing economic deregulation, free trade, privatization and individualism. Within the context of global cultural flows, CAM products and services parallel other commodities that are consistent with neoliberal government and biomedical initiatives to impart individual responsibility and consumptive choice to self-regulating citizens. In order to understand how CAM is constitutive rather than resistant to a neoliberal context, I will show through social science literature review how *self-responsibilization* permeates CAM, biomedicine and neoliberal governments in the ways they emphasize the rhetoric of personal choice to achieve optimal health.

CAM in the Age of Neoliberal Governance

A deeper examination of local and global health policies reveals increasing emphasis on individuals to assume greater responsibility for their own health care to counter diminishing public resources (Fries, 2008; Iedema & Veljanova, 2013; Wanless, 2004). For example, The World Health Organization (2016) has renewed its prior commitment to integrate CAM in primary health care initiatives especially in remote or rural areas, citing cost/benefit analyses. Our Canadian government has also drawn a new role for itself as an advocate in favour of individual responsibility for health care (Gilmour, 2001). In this respect, CAM would support and advance this new health care approach whereby the government could tolerate CAM without specifically endorsing it. This position is convenient for the government since it places responsibility on individuals to take care of their own health, dovetailing with government agendas to diminish the role of the state in the provision of important social services. Through the regulations of natural health products, and some CAM practices like naturopathy, chiropractic, acupuncture and Traditional Chinese Medicine without extending public health coverage, the approach of the Canadian government is one that emphasizes ‘inherent safety’ and freedom of consumer choice (Qu, 2004). Thus, individual responsibility has become a key government strategy to promote the use of CAM, as part of the rhetoric of consumer choice.

Indeed, Canadians spent an estimated $8.8 billion on CAM in the latter half of 2015 and first half of 2016. This was an increase from the estimated $8.0 billion spent in 2005/06 and the estimated $6.3 billion spent in 1996/97. Of the $8.8 billion expensed in 2016, more than $6.5 billion was paid to providers of CAM, while another $12.3 billion covered for herbs, vitamins, special diet programs, books, classes, and equipment (Esmail, 2017).

In this era of shrinking public resources, increasing unemployment, mobility, and threats of terrorism, neoliberalism conflates “individualism and liberation,” along with

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"consumption and activism" through its consumer driven logic (Butler, 2013:46). As Butler argues, the opportunity to participate in open, free global networks marks oneself as a good citizen subject through appropriate consumption. Neoliberal forms of governance have enabled "the development of discourses that emphasize consumer citizenship, personal responsibility, and individual empowerment" (Butler, 2013:41). Undoubtedly, these discourses help explain why CAM use in Western societies appeals primarily to higher income and educated consumers, since they possess the symbolic and material capital to self-direct expertise from diverse networks without having to consult professionals, becoming experts themselves (See Childerhose & MacDonald, 2013 for a discussion of expert consumers in the use of biomedical devices).

Within this neoliberal climate, wellness is seen as the result of good choices made by autonomous and efficacious citizens, capable of social transformation and civic participation. More importantly, appropriate health management and the consumption of wellness lifestyles are ways in which citizens can allegedly avert risks (Lavrence & Lozanski, 2014: 80). As a result, the promotion of healthy bodies is no longer the exclusive goal of the state, because it can now assume that good citizens desire to be healthy and are actively working to fulfil this aim (Rose, 1999). CAM use as a form of self-care becomes the responsibility of the citizen to achieve health and wellness. In this way, CAM as an important element of *self-responsibilization* does not need to be governed through legal injunction such as state regulation[i] but through a language of personal choice. Also, putting the onus on individual choice to endorse CAM, detracts collective responsibility from the state to provide diverse treatment options within the national health care system.

Self-Responsibilization towards Health: A Common Feature of CAM and Biomedicine

In effect, popular and academic representations of CAM focus on its holistic perspective that facilitates a connection between body, mind and spirit. The ideological motivations underlying CAM use have been extensively discussed in social scientific literature in which CAM practices are distinguished from biomedicine in binary oppositions: tradition vs. science, holism vs. dualism; vitalism vs. reductionism; humanism vs. machine metaphor; naturalism vs. body as an object of control; spiritualism vs. materialism (Coulter, 2004; Eskinazi, 1998; Hare, 1993; Kelner and Wellman, 1997; Fries, 2013; Quah, 2003). Recently, such binary oppositions have been problematized in light of extensive cross-fertilization between CAM and biomedicine over time and space (Givati, 2015; Fries, 2013; Ning, 2013; Zhan, 2014), thus uncovering greater overlap between them than commonly assumed.

Indeed, there is an emerging literature (Barry, 2006; Brosnan, 2016; Gale, 2011; 2014; Ziguras, 2004; Zhan, 2009; 2014), which questions narrow explanations about individuals' ideological and/or pragmatic decisions to undertake CAM treatments. Although bio-scientific standards remain the most acceptable form of evidence for evaluating treatment outcomes, extensive social science research shows that many individuals in diverse settings use CAM outside of "rational" frameworks. Many use CAM practices irrespective of demonstrated scientific evidence bases (Broom & Tovey,

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2008; Chacko, 2003; Connor, 2004; Fadlon, 2004; Little et al., 2007; MacArtney & Wallberg, 2014). They often continue seeing CAM practitioners despite limited treatment outcomes or even after the original symptoms have subsided (Baarts & Pedersen, 2009; Thorpe, 2008). Their decisions to pursue CAM options often follow others' advice, rather than arising solely from informed personal choices, especially as they encounter end of life issues or conventionally untreatable conditions (Iedema & Veljanova, 2013). And contrary to popular assumptions, many resort to CAM not necessarily because of its ideological underpinnings like holism, vitalism, naturalism, humanism and spiritualism (Öhlén et al., 2006; Shippee et al., 2012; Thorpe, 2008; Quah, 2008) but due to "pragmatic acculturation" (Quah, 2008). That is to say, CAM users often adopt a pragmatic approach to health management that places value upon well-being rather than ideological principles (Thorpe, 2008: 416). Central to the understanding of "pragmatic acculturation" is the existence of cross-fertilization in any society whereby CAM systems, diverse healers and patients borrow from each other's ideas, ways of thinking and doing to solve particular problems (Quah, 2008). Even if many use CAM as a form of self-care to deal with chronic issues like HIV/AIDS, which may require daily management such as self-monitoring of symptoms and side effects, their self-care occurs alongside, rather than in opposition to biomedicine (Pawluch et al., 2000; Dew et al., 2008; Thorpe, 2008).

Recently, several scholars recognize that CAM practices tend to focus on the individual person as responsible or even blamed for their health behaviours, while broader social determinants of health may be ignored (Givati, 2015; Ning, 2013; Sered & Agigian, 2008). These scholarly approaches rethink common presentations of CAM use as driven by enhanced agency of individuals with higher symbolic and material capital who favour more natural and holistic interventions, against the reductionist, synthetic and technical aspects of mainstream biomedicine (Eskinazi, 1998; Fries, 2013; Hare, 1993; Kelner & Welman, 1997; 2000).

Previously, some authors had identified individual responsibility as a key 'alternative' ideology for many Western consumers to endorse CAM. In their view, CAM consumers actively choose the health care option that best suits their needs and interests, and are not confined to their conventional health care system (Kelner & Welman, 1997; Pawluch et al., 2000; Tataryn & Verhoef, 2001). These scholars note that individual responsibility is strongly influenced by social factors such as one's income and educational levels as well as the severity of certain health conditions. In particular, many HIV/AIDS patients have felt discriminated against biomedical professionals given initial speculation that HIV/AIDS was related to homosexual lifestyles. As such, the stigma surrounding HIV/AIDS in addition to perceived, limited biomedical outcomes to address this condition has prompted many individuals to seek CAM therapies, alternatively to, or concurrently with biomedicine (Evans, 1999; Pawluch et al., 2000; Songwathana & Manderson, 2000; Thorpe, 2008; Torri, 2012). While these individual actions denote individual agency in seeking more appropriate alternatives to meet specific health needs, individual responsibility is not an 'alternative' ideology per se. I have argued that Euro-North American ideals and cultural expectations of health are significantly tied to an emphasis on individual responsibility and blame

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for one's health (Ning, 2013). Social scientific literature provides several accounts of the "healthy self" in mainstream Western societies (Crawford, 1994; Kleinman, 1988; Lavrence & Lozanski, 2014; Lupton, 1999; Rose, 1999; Sontag, 1978), which illustrates individualistic orientations for ensuring one's health. As well, popular self-help literature such as that by Deepak Chopra and Andrew Weir, promote individual health and well-being based upon individual actions such as maintaining appropriate diet, exercise, mindfulness, and seeking spiritual comfort through meditation.

Indeed, self-help and do-it-yourself (DIY) healing are becoming increasingly pervasive aspects of how people manage their health and sickness everywhere. Global networks, free and open technologies allow contemporary individuals to negotiate and exchange their everyday care experiences (Iedema & Veljanova, 2013; Thorpe, 2008; Ziguras, 2004). Fuller (2010) conceptualizes these exchanges of knowledge and treatment experiences as "protoscience", which challenges authoritative scientific expertise, creating the opportunity for alternative forms of expertise and experience such as the use of CAM. Although CAM use exemplifies a form of self-care, I believe it does not simply originate from individuals' enhanced personal agency to move away from impersonalized, scientific-based biomedicine, nor does it reflect individuals' greater voice and choice in health care. Rather, it must be situated within the current globalized neoliberal climate in which widespread economic downturns have shifted collective responsibility for the provision of important social services away from the state.

Evidently, individual responsibility as a feature of *both* conventional health promotion ideology and CAM has already been discussed in social scientific literature (Lee-Treeweek, 2001; McClean, 2005; Ning, 2013). However, individualism has been the least identified as a hallmark of CAM. Rather, many would argue that CAM is holistic, focusing on wellness rather than disease, being connected with the notion that the body will naturally heal itself, and that the practitioner facilitates the body to achieve this by considering each individual's unique constitution and their interaction with broader environments (Barnes et al., 2004; Park, 2002).

CAM's focus on wellness rather than disease is not so different from the biomedical emphasis on individual responsibility, in that biomedicine is more *individualized* than much of the rhetoric around it. As Foucault (1973; 1980) has discussed, partly as a product of the machine metaphor and the quest for mastery, the biomedical model conceptualizes the body as the proper object of control by emphasizing the responsibility of the individual to exercise this control in order to maintain or restore health. The machine metaphor views the body as a complex biochemical machine, and disease as the malfunctioning of some mechanical component. I believe this machine metaphor encourages the physician to *individualize* treatment by 'repairing' one part in isolation from the rest, justifying as a medical procedure to replace non-working parts by organ transplants, pacemakers or artificial joints.

The idea of the body as an object of control is intertwined with other mainstream normative values, resulting in the biomedical and social emphases on such standardized body disciplines as appropriate diets, exercise programs, routines of hygiene and even sexual activity. These body disciplines ex-

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emplify what Foucault (1980) calls 'technologies of the self', whereby pro-active, self-regulating individuals undertake desirable means to achieve self-enhancement and self-improvement. However, the body as an object of control is not exclusive to biomedicine but is also apparent in other healing systems. In fact, CAM modalities prescribe similar body disciplines, as well as suggest that every body is individual – that 'one is the best judge for one self' (Evans, 1999:44) or that one must have positive thinking, controlling one's mind and avoiding negative thoughts to assist the body in healing itself (Ning, forthcoming). Thus, CAM's focus on wellness rather than disease is not so different from the biomedical emphasis on individual responsibility whereby CAM interventions are not only for maintaining health or preventing disease, but also for engaging each individual as an active and conscious participant in maintaining his or her own health (Tataryn & Verhoef, 2001: 95). That is to say, putting the onus on personal choice is an interesting homology between biomedical and CAM discourses of individual responsibility for health care. While the discourse of individual responsibility in biomedicine appears to focus on individual lifestyle choices such as appropriate diet, exercise, patterns of sexual activity and the degree of engagement with legal/illegal substances, a similar discourse in CAM extends to deeper personal meanings by accounting for the unique circumstances of each individual including individual perceptions of the body as an experiencing subject rather than as a natural and biological object (Barry, 2006; Gale, 2014; Givati ,2015, Ning, 2013). Thus, individual responsibility for one's health and health care options raises interesting research questions and conversations about the *individualized* nature in both biomedicine and CAM in ways that extend common rhetoric of striking differences between these modalities of care. Concomitantly, individual responsibility for health care uncovers ongoing challenges of CAM practices to achieve true integration within biomedically-dominant health care systems as neoliberal agendas detract responsibility to provide important social services away from the state to individual pockets.

Conclusion

This review paper has argued that contemporary CAM developments embody *self-responsibilization* of individuals in their use of CAM. Drawing upon social scientific literature, I contended that individuals in the current globalized neoliberal climate, have become self-regulating subjects through CAM as "technologies of the self" (Foucault 1980), whereby they take it upon themselves to ensure they function as healthy subjects for the state through the desirable rhetoric of personal choice. In this way, my paper rethinks a commonly held binary that posits CAM use within a holism/individualism dichotomy: *either* as an 'alternative' consistent with a holistic ideology that distinguishes from biomedical reductionism *or* as a consumer-driven movement arising from individuals' enhanced agency to pursue more meaningful strategies to achieve health and wellness outside of the confines of bio-scientific standards. In contrast, by exploring the individualistic features underlying CAM within the current neoliberal climate, I drew attention to an unexamined area in popular and academic representations of CAM that tend to focus on its holistic tenets in opposition to biomedicine rather than its individualistic underpinnings that much like biomedicine, impart individual responsibility

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for health care. In turn, the latter fits into the current neoliberal rhetoric of personal choice that extends the value of CAM in health care delivery as an individual rather than as a collective endeavour.

NOTES

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[i] Most CAM modalities remain unregulated in Canada, operating outside of the national health care system, and only some extended benefit plans cover them.

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