

The Spectrum of Therapeutic Influences and Integrative Health Care: Classifying Health Care Practices by Mode of Therapeutic Action

CURTIS H. JONES, Ph.D.

ABSTRACT

The growing popularity of complementary and alternative medicine (CAM) and integrative medicine (IM) highlight the need for a clinically relevant system for classifying health care practices. All systems, modalities, and techniques of health care (conventional, complementary, alternative, and traditional) can be organized in categories of “primary mode of therapeutic action.” This results in six categories: biochemical; biomechanical; mind–body; energy; psychological (symbolic); and nonlocal. In each category, there are subdivisions. Organizing health care by primary mode of therapeutic action has numerous benefits: (1) conventional and CAM practitioners, and the public, can readily see some of the general similarities and differences among practices; (2) health care educators gain a common foundation and shared language for explaining CAM and IM; (3) professionals and the public, wishing to combine dissimilar practices, gain a common framework for evaluating the meaning of integration; and (4) the crossover problem can be understood as a natural occurrence in health care, not a confusing intellectual dilemma. The National Center for Complementary and Alternative Medicine (NCCAM) system of categories for CAM is briefly critiqued.

INTRODUCTION

The intellectual progression of humanity can be interpreted as a cycle, one portion of which is amassing understanding of detail, while the other portion involves understanding the generalizations evident among the details. These generalizations lead to comprehension of the broader relationships hidden in the world of the details.¹

Imagine a society in which all color design is done in blue, only blue; houses, clothing, automobiles—everything in various shades of blue. Someone arrives from a far-off land and introduces red; then another foreigner introduces yellow. Soon, people are combining blue, red, and yellow in their house furnishings and clothing. Some of the new color combinations are appealing, and some are not.

When enough new colors are introduced, it becomes apparent there is a *spectrum* of color. Once the entire range of

possibilities within the spectrum is appreciated, many creative possibilities arise—hue, intensity, and shading; everything begins to fall together once the complete diversity in color is seen. A similar change must have occurred in the world of chemistry with the construction of the periodic table of elements.

The field of integrative medicine (IM) is in a state similar to that illustrated by the above examples. In contemporary health care, there are seemingly innumerable systems, modalities, and techniques. Discovering how, and why, any selection of health care practices should be combined remains a formidable challenge. Nonetheless, many practitioners are engaged in what we now call “integrative health care,” and efforts continue to classify health care practices.

The need for an understanding of CAM that places its practices in clear relation to one another and to conventional medicine is well documented. In the literature, we find: the

North American College of Botanical Medicine,* Albuquerque, NM.

*Ceased operations in September 2004.

“urgent need of definition and analysis,” from the European Commission² “a wider cultural perspective is needed . . . it will be crucial to develop a language for communication”³; there is “absence of shared principles”⁴; “[h]ow should physicians and CAM clinicians be educated to facilitate integration?”⁵; in medical schools “there is considerable heterogeneity in content, format, and requirements among CAM courses”⁵; and, finally, “there is a fair amount of discussion of the possibilities, perils, and promises of integration” with 15 articles cited.⁶

This article contains a proposal for classifying the practices of health care—a health care taxonomy. It is offered as a beginning to clarifying the “spectrum” of health care.

BOOKS ON CAM—ATTEMPTS TO ORDER THE GREAT DIVERSITY

The rise of CAM has broadened the choices for health care providers and consumers. This array of potentially beneficial therapies is catalogued in such works as *Alternative Medicine: The Definitive Guide*⁷; *Alternative Healthcare, A Comprehensive Guide to Therapies and Remedies*⁸; *New Choices in Natural Healing: Over 1,800 of the Best Self-Help Remedies from the World of Alternative Medicine*⁹; and *Complementary and Alternative Medicine*,¹⁰ organized by conditions treated and population groups. The first three books list 43, 32, and 17 CAM practices, respectively. In the Gottlieb book, there are “1,800 remedies” under 17 chapter headings. When consumers attempt to choose a CAM treatment path, we should not be surprised if confusion and indecision arise.

Such texts usually present alphabetical lists of practices or categories, such as “Eastern Therapies, Manipulative Therapies, Natural Therapies, Active Therapies, and Therapies Involving External Powers” (from the Bradford book). This lack of agreed upon organizing principles indicates the need for a well-defined and clinically relevant categorization of health care practices.

PRIMARY MODES OF THERAPEUTIC ACTION CATEGORIES INDICATE THE NATURAL SPECTRUM OF THERAPEUTIC INFLUENCE

The six primary modes of therapeutic action (PMTA) in Table 1 create a catalogue of the ways in which therapeutic effects can be initiated in the health care exchange. These are the influences on the patient/client that support processes of health. The six categories arise from the nature of human being—from the material to the spiritual (nonlocal). Therefore, these categories are fundamentally “human-centered,” not therapy-centered, resulting in a classification that reflects

the multifaceted nature of patients and creating a foundation from which CAM and IM can be discussed.

In Table 1, each practice is placed in the category of its primary mode of therapeutic action, avoiding the confusion of listing practices in every category in which they are possibly therapeutic. For example, massage is placed in the biomechanical category, though it can have therapeutic body–mind effects.

The goal here is to clarify the potential *content* of IM (the “colors” that create the IM “painting”), not the *processes* of IM (the ways in which the colors might be applied to create a personalized health care pathway), discussed in depth elsewhere.^{11,12}

The terms “practice” and “therapy” are used throughout as collective terms to cover the more specific terms, “system,” “modality,” and “technique.” Only the generally accepted major systems of health care are listed as “systems” in Table 1.

MODE OF THERAPEUTIC ACTION AS A METHOD OF CLASSIFICATION

It is assumed that all health care practitioners acknowledge some form of “mode of therapeutic action” (MTA). Therefore, using this as the basis for classification should make sense. Practitioners, treating more than self-limiting conditions, know that for their patients to improve *something has to happen*. This “something happening” comes in many forms. It is these I am calling therapeutic actions or influences. In conventional health care, these actions are usually quantifiable—medicines are prescribed, exercises suggested, physical interventions conducted, or information is exchanged, such as lifestyle suggestions.

Therapeutic actions can also occur in qualitative, or “subjective,” forms through energetic, mind–body, psychological, or prayerful means. Thus, “mode of therapeutic action” is a general term for any of the variety of means by which a therapeutic process is initiated. Practitioners of qualitative forms of PMTA may be more comfortable with “therapeutic influence,” in place of “therapeutic action.” These terms are used interchangeably here.

Table 1, in which the lists of practices are clearly not exhaustive, contains six modes of therapeutic action, with subdivisions, defined below.

Biochemical

A biochemical therapy is any therapy in which influence occurs through chemical means at the molecular, cellular, or genetic levels. That is, employing chemical actions to induce or support healthy functioning. Of course, natural human involvement with biochemicals occurs in the processes of living—breathing, eating, and touching the world. Therapeutic uses include: pharmaceuticals, Western herbal med-

TABLE 1. PERIODIC TABLE OF HEALTHCARE SYSTEMS AND PRACTICES: BASED ON MODE OF THERAPEUTIC ACTION

<i>Biochemical</i>	<i>Biomechanical</i>	<i>Mind-Body</i>	<i>Energy</i>	<i>Psychological</i>	<i>Non-Local</i>
<p>SYNTHETIC PRODUCTS Pharmaceuticals Some Dietary Supplements Some Vitamins</p> <p>NATURAL PRODUCTS Some Dietary Supplements and Vitamins Biological Medicine Ortho-Molecular Med. West. Herbal Med. Nutrition Colonics Ozone Therapy Gerson Therapy</p> <p>INJECTION Cell Therapy Chelation Therapy Neural Therapy Reconstructive Therapy Oxygen Therapy Prolotherapy</p> <p>INGESTION Enzyme Therapy Internal Cleansing Products</p> <p>SYSTEMS Allopathic Medicine Biological Medicine Herbal Medicine Functional Medicine Naturopathy*</p>	<p>INVASIVE METHODS Surgery Dentistry</p> <p>NON-INVASIVE/MANIPULATION Applied Kinesiology Chiropractic Medicine Cranial Sacral Therapy Feldenkrais Massage Occupational Therapy Osteopathy Rolfing Reflexology Trager Therapy</p> <p>PERSONAL ACTIVITY Exercise Hatha Yoga</p> <p>PHYSICAL/PSYCHOLOGICAL Alexander Technique Biodynamic Therapy Hellerwork Metamorphic Technique Pancha Karma (Ayur.) Pilates</p> <p>SYSTEMS Allopathic Medicine Chiropractic Med. Naturopathy* Naprathic Medicine Osteopathy</p>	<p>MIND-BODY Autogenic Training Behavioral Medicine Biofeedback Training Guided Imagery Holographic-Meditation Placebo Psychoneuro-immunology Quantum Healing Rebirthing Visualization</p> <p>BODY-MIND Aromatherapy Emotional Kinesiology Flower Remedies</p> <p>Art Therapies (Dance, Pottery)</p>	<p>BIO-ENERGY Acupuncture (CTM) Acupressure (CTM) Healing Touch Neuro Modulation Tech. Reiki Polarity Therapy Tai Chi Qi Gong</p> <p>NON-HUMAN FIELD Chinese Herbs (CTM) Cymatics Homeopathy Radionics</p> <p>EMITED ENERGY Acutonics Color Therapy Diathermy Laser Therapy Light Therapy Magnets Radiation Sound Therapy Ultra Sound</p> <p>CONDUCTION & CONVECTION Hydrotherapy Hypohermia Sauna Warm/Cold Objects</p> <p>SYSTEMS Ayurvedic Medicine Chinese Trad. Med. Energy Medicine Homeopathy</p>	<p>INDIVIDUAL Counseling Grief Work Hypnotherapy Neurolinguistic Programming Psychotherapy Art Therapies (Drawing, Painting, Drama, Music) Ritual</p> <p>GROUP Support Groups (AA, Narcotics Anonymous) Family Therapy Ritual</p> <p>SYSTEMS Psychotherapy Systems (Freudian, Jungian, Humanistic, Buddhist, etc.)</p>	<p>RELIGIOUS Distance Healing Faith Practices Prayer Christian Science</p> <p>EXTRA-RELIGIOUS Distance Healing Positive Intention Practices Prayer Animistic Practices (Shamanism-soul retrieval, etc.)</p> <p>SYSTEMS Religious Healing Traditions</p>

© 2005 All rights reserved. Curtis H. Jones, Ph.D.

Ayur. = Ayurvedic Medicine. CTM = Chinese Traditional Medicine. *Naturopaths employ a variety of MTA, including Energy.

icine, nutritional therapy, dietary supplements, internal cleansing products (liver, blood, lymph cleansing), external applications (creams, salves), colonics, biological medicine, aromatherapy, orthomolecular medicine, and others too numerous to list.

Biochemical practices have been subdivided into the following groups: synthetic, natural/organic, ingestion, and injection. The first two divisions indicate qualitative chemical differences, while the final two indicate delivery mechanisms. There are numerous other ways to subdivide this category: prescription and over-the-counter products; licensed and unlicensed practices; and folk and professional methods, among others. These four divisions have been selected for their relevance to clinical work and patient education. Clearly, natural and synthetic products can both be injected and ingested, which indicates I am pursuing educational utility, not exclusive divisions among the four subdivisions in this category.

Biomechanical

These are therapies in which a physical therapeutic influence occurs at the level of tissue structure and larger. These are therapies using large-scale physical intervention or manipulation to induce or support healthy functioning. Biomechanical influences occur naturally in all bodily movement and in controlled (and uncontrolled) “bumping into” others and the physical world. Therapeutic applications of biomechanics include: surgery; massage; physical and occupational therapy, exercise (weight training, running, aerobics), chiropractic medicine, osteopathic medicine, CranioSacral therapy, Rolfing, Hellerwork, Pilates, and reflexology.

Biomechanical practices have been subdivided to indicate the manner of delivery of practices: invasive (the surface of the body is broken); noninvasive/manipulation; personal activity; and physical/psychological. The subcategory physical/psychological is included for those therapies in which a psychological intervention is used along with noninvasive physical practices, such as the Alexander Technique and Pilates.

Mind–body

These are ways to initiate therapeutic processes that arise from intentional alteration or modification of intellectual and/or emotional states and processes in order to influence physiological states and processes through such structures as the psycho-neuro-endocrine pathways. Mind–body events are also naturally part of being alive; we live them; they are “us.” Therapeutic practices include: behavioral medicine; psychoneuroimmunology (PNI); meditation; visualization techniques; biofeedback training; autogenic training; biodynamic therapy; some art therapies; and the Alexander Technique.

Mind–body techniques can be divided into two subcategories: mind–body and body–mind, depending on the “di-

rection” of the therapeutic influence. This indicates the mind–body continuum can be affected from either “side,” or “pole.” Recent developments in this field indicate that the term mind–body, with its implication of two separate entities acting upon one another, may be a misnomer.^{13,14} Possibly, these should be called “personal continuum therapies,” but I will leave renaming the field to practitioners. Discussion below on the crossover problem returns to this issue of the personal continuum (holism).

It should be noted that there are *solo* (autodidactic) techniques, with which self-treatment is possible; and *assisted* (mediated) techniques, requiring a practitioner. Examples of autodidactic techniques are meditation, visualization, and art therapies; while examples of assisted techniques include biofeedback training, biodynamic therapy, PNI, and hypnotherapy. Some methods require assistance in the learning stage and then can be managed individually, such as biofeedback and art therapies. This distinction is not included in Table I.

Energy

Energy therapies are those using an energy source or vital force to initiate therapeutic processes. Natural human involvement with “energy” seems to occur in all of our interactions with other individuals and the world. Therapeutic uses of energy fall into four subcategories.

Bioenergy (human-field energy). These are practices in which the therapeutic influence results from interaction with the patient’s energy field, and include acupuncture, acupressure, neuromodulation technique, Healing Touch, Reiki, and Polarity Therapy. Many of these use an exchange between the practitioner’s energy field and the patient’s energy field, in which the personal intentions of the practitioner and patient play central roles.

It must be noted that there are fundamental differences between the conceptual foundations of Eastern and Western systems of medicine (as well as within Western health care, e.g., homeopathy) involving reductionist and holistic paradigms of care.¹⁵ These differences give rise to great variations among practitioners’ perspectives of health, illness, and healing processes and illustrate another way to classify health care practices. For further discussion, see Holbrook,¹⁶ Kaptchuk and Eisenberg,⁴ and Jarrett.¹⁷

Nonhuman field energy. These are practices in which an energetic influence arises from nonhuman organic or inorganic energy fields, “signatures,” or vibrations. Examples include homeopathy, the Bach Flower Remedies, radionics, cymatics, and Chinese herbal therapy.

Emitted energy sources. These are therapies arising from atomic, electromagnetic, and other emission sources. Examples include radiation, light therapy, acutonics, diathermy, magnets, and ultrasound treatments.

Conduction and convection energy. Examples of such practices are: hot or cold baths; hydrotherapy; and use of warm/cold objects and surroundings (compresses, saunas).

Psychologic (symbolic)

These are ways of initiating therapeutic processes, using the symbolic references (meanings) of words, movements, images, sounds, and music, to induce constructive change in a person's intellectual and/or emotional processes. Psychological influences occur naturally in relation with oneself, family, and in all social settings.

In this category are psychotherapy, counseling, grief work, group therapy, neurolinguistic programming, some art therapies, *mudras* (symbolic movements), mantras (symbolic chants), and support groups such as Alcoholics Anonymous. Therapies have been divided into individual and group approaches in Table I.

The psychologic/symbolic category is included to indicate that purely symbolic means (related entirely to "meaning") can be used to induce therapeutic change by altering purely symbolic (psychological) aspects of an individual. Of course, physical changes often result from these treatments, but the therapeutic activity and the initial therapeutic influence is in the *symbolic* (meaning) realm, which is mental and/or emotional. This category might also be named "symbolism" or "meaning" therapies, as symbols and meanings are the realm of the mind and emotions.

The psychologic/symbolic mode of therapeutic action is, to a large degree, dependent upon personal *intention*. The study of intention and subjectivity in healing is a captivating and growing field.¹⁸⁻²²

Nonlocal

These are therapeutic practices arising solely from transcendent personal or group intention focused on an individual or group, usually in the context of Deity, religious experience, or humanistic principles.²³ Nonlocal events seem to occur only in transcendent human experiences. There is no scientifically understood mode of action for nonlocal therapeutic interventions. Examples include prayer, distance healing, Christian Science healing, all faith healing practices, Transcendental Meditation™, and some shamanistic practices. Again, intention is central.

It must be noted that nonlocal therapeutic influences occur in both religious settings and extrareligious settings. In the latter, nonlocal influence occurs outside of organized religion and may be called "secular-spiritual."

TYPES OF IM: INTRA-CATEGORY AND INTER-CATEGORY IM

If practitioners confine their IM practice to a single category of therapeutic action, we have "*intra-category*" inte-

gration. For example, an M.D. using Western herbal remedies is working exclusively within the biochemical category, whereas an M.D. trained in acupuncture is practicing in two areas of therapeutic influence (biochemical and bioenergy), which is "*inter-category*" integration.

This distinction indicates a basic level of complexity in integrative health care. Moving beyond the category of therapeutic action in which one is primarily trained is a more complex undertaking because a practitioner is moving into a new area of therapeutic influence and will be conducting interventions from dual or multiple sets of assumptions regarding operational principles. Many practitioners are now practicing inter-category IM and much analysis of its effectiveness remains to be done. Classification by PMTA makes it possible to see clearly when this type of complexity arises in combining therapies.

ADDRESSING PRACTICE AND PARADIGM

Using PMTA as the basis for classification addresses both paradigm and practice. The six categories of mode of therapeutic action are not only descriptions of the ways by which patients are influenced in health care; they fall into four paradigms that underlie health care. These four paradigms indicate ways of interpreting the world: the biochemical and biomechanical categories are *materialistic*, while the energy category is *energetic*, in which some practices arise from an understanding of qualitative energetic balances, imbalances, and patterns—physical and otherwise. The mind–body and symbolic/psychological categories arise from *multilevel interactionism*,²⁴ while the nonlocal category is *spiritualistic*. For understanding the differences among health care practices, greater educational utility is achieved by speaking of modes of therapeutic action rather than paradigms. This is for practical reasons, assuming practitioners and consumers are primarily concerned with different types of health care practices, not the conceptual differences among paradigms.

Certainly, many CAM practitioners working within the biomechanical category might object to their practice being labeled "materialistic." These objections are well founded and addressed later in this article in the discussion on the crossover problem.

These four paradigms are similar to those offered by Tataryn, "body–body, body–energy, body–mind, and body–spirit."²⁵ Classifying health care practices by mode of therapeutic action, as opposed to paradigm, creates additional distinctions that can be helpful to practitioners and consumers alike. For example, in the materialistic paradigm (Tataryn's body–body), there is a clinically relevant distinction between biochemical and biomechanical therapies; in the energy paradigm (Tataryn's body–energy), there are four distinctions regarding types of energy; and in the multilevel interactionism paradigm (Tataryn's body–mind), there is the "directional" distinction (body → mind and

mind → body). Finally, there is the additional distinction of the PMTA category of “psychological,” indicating mind → mind therapies.

Although the similarities with the four paradigms noted by Tataryn are evident and using paradigms *is* a valid way to categorize health care practices, categorizing by PMTA creates more clinically relevant information for practitioners and consumers. It creates an overall picture of health care from which all parties can see more specific differences among practices, as each category and most subdivisions indicate a specific type of therapeutic influence. Also, practitioners using Table 1 have an overview of the six fundamental ways of being involved therapeutically with patients, which is unavailable if we categorize by paradigm alone.

EDUCATIONAL AND CLINICAL APPLICATIONS OF PMTA CLASSIFICATION

Educational applications

A “periodic table of health care” (see Table 1) can be helpful to practitioners as an overview, especially those who are new to CAM and whose patients may be using a range of such practices. Also, practitioners will more readily understand the possibilities of integrating modalities when they understand the MTA of the practices integrated. Also, the public, driving the expansion of CAM, deserves an accurate system for ordering and understanding all health care practices.

Finally, IM and CAM programs in medical schools can use this classification to familiarize students with the world of alternative health care. This would facilitate efficient learning and a sense of order in introductory CAM courses. Table 1 can be used to facilitate general understanding of the “Big Tent” of therapeutic influences in health care. The need for this has been widely discussed.^{5,11,26}

Clinical applications

Recent developments in medical humanities include discussion of Optimal Healing Environments (OHE), in which seven aspects supportive of healing are depicted (Healing Spaces, Awareness and Intention, Personal Wholeness, Healing Relationships, Healthy Lifestyles, Collaborative Medicine, and Healing Places).²⁷ Each of these aspects functions to induce healing through one or more of the six MTA. This is another way of saying that the goal of an OHE is to address the entire spectrum of human needs that appear in health care and are met through the six modes of therapeutic action/influence. Understanding the six MTA should help in the creation of OHE.

Also, classifying by PMTA is another step toward removing ourselves from “us versus them” perspectives. Every practitioner is applying an MTA that, I assume, is found to

be suitable and effective. Clarity regarding this “Big Picture” of health care—the six therapeutic influences—might help all practitioners understand that the future lies in “appropriate health care,” discovering which practices from within the complete spectrum of therapeutic influence might be used effectively for each patient.

Additional clinical applications appear in patient education and in design of treatment protocol. Full disclosure to patients of treatment options includes an overview of appropriate CAM therapies, for which Table 1 can be used as an educational tool. Clinical protocol design might be facilitated by having treatment options placed in PMTA categories. Patients and practitioners interested in exploring additional therapies have an overview of their options. It would be beneficial to consult a chart in which therapies that have been explored are noted, leaving the remaining categories and therapies as treatment options.

THE NATIONAL CENTER FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE SYSTEM OF CATEGORIZING CAM

The National Center for Complementary and Alternative Medicine (NCCAM) at The National Institutes of Health (NIH) classifies CAM in five categories²⁸:

1. Alternative medical systems (homeopathy, Ayurveda, naturopathic medicine, Chinese medicine)
2. Mind–body interventions (cognitive–behavioral therapy, patient support groups, prayer, mental healing, meditation, art and dance therapy)
3. Biologically based therapies (dietary supplements, herbal products, shark cartilage)
4. Manipulative and body-based methods (chiropractic, osteopathy, massage)
5. Energy therapies (two types—biofield therapies [Reiki, *qigong*, Therapeutic Touch] and bioelectromagnetic-based therapies (unconventional use of electromagnetic fields)).

When the NCCAM system of categorizing health care practices first appeared some years ago, it was at the time a constructive step towards categorizing CAM in a way that offered a coherent overview of a vast field. However, the NCCAM categorization is handicapped by overlapping categories (alternative medical systems with energy therapies and body-based methods), and failure to address the distinctions between mind–body, psychological, and nonlocal (spiritual) therapies. The overlapping of categories arises primarily from including the category of alternative medical systems, while the other categories indicate modes of therapeutic action.

OTHER CATEGORIZATIONS OF HEALTH CARE

Following development of the NCCAM categorization, numerous authors have, from a variety of perspectives, been developing additional taxonomic systems. In *Varieties of Healing: A Taxonomy of Unconventional Healing Practices*,⁴ the classification is from a sociologic perspective. It is also possible to categorize health care practices according to basic assumptions regarding health and disease.²⁵ CAM has been defined from the frame of reference of the patient, an “operational” definition.²⁹ Finally, some authors offer interesting refinements of the NCCAM categories: The Mayo Foundation for Education and Research³⁰ and Health Goods.³¹ Limitations of space do not permit comments on these numerous classifications.

THE CROSSOVER PROBLEM: HOW ARE WE TO CATEGORIZE THERAPIES EFFECTIVE IN MULTIPLE MODES OF THERAPEUTIC ACTION?

Clinical and conceptual issues are intertwined in endeavors to classify health care practices. One of these intersections relates to therapies that are effective by more than one MTA. For example, massage is clearly a biomechanical therapy, yet energy work can occur during a massage and may have salutary effects upon patients’ mental and emotional states, a body → mind influence.

This illustrates that when dealing with individuals, as is always the case in health care, multiple therapeutic influences may be inevitable, owing to the fact that each person is a unique and inherently unified body-mind-spirit-emotions-energy field. Our personal holism makes multiple effects nearly inevitable (and often advantageous).

Insightful practitioners are aware that their patients cannot be surgically deconstructed into “a body *with* a mind that *has* emotions *and* a spirit *within* an energy field.” We are, by nature, woven of all that makes us human. Thus, the crossover problem is a dilemma only if we ignore the fact that all therapeutic influences occur in the whole person. Considering this, it is unrealistic to expect any practice to be confined to a single therapeutic effect.

It may be intellectually inconvenient that “it is all One” within each of us (practitioners and patients alike). In spite of this, we need a classification system to organize our understanding of the multiplicity of health care practices. Finally, for those among us searching for the ultimate Common Denominator that will unite all health care practices, I suggest it is right here—the indivisible person.

CONCLUSIONS

The continual expansion of IM and CAM, driven by public demand, strengthens the need for a classification system that is user-friendly—it needs to be accurate and simple enough for consumers to use and refined enough for practitioners of IM. As well, needs in health care education have to be met. If we continue to lack a shared understanding of CAM and conventional medicine *within* the spectrum of health care, we will continue to have difficulties establishing a foundation for perfecting IM. A classification system based upon primary mode of therapeutic action attempts to portray the “Big Tent” of therapeutic actions within which all practitioners are working. What is currently needed is sufficient input from all concerned, and, should we create an expanded Periodic Table of Health Care, we will have achieved something both useful and remarkable.

REFERENCES

1. Whitehead AN. *Science and the Modern World*. Basingstoke Hampshire, England: Macmillan, 1925.
2. Reilly D. Comments on complementary and alternative medicine in Europe. *J Altern Complement Med* 2001;7:S23–S31.
3. Jobst KA. Toward Integrative Healthcare: Practical and Philosophical Issues at the Heart of Integration of Biomedical, Complementary, and Alternative Medicine. *J Altern Complement Med* 1998;2:123–126.
4. Kaptchuk TJ, Eisenberg DM. Varieties of healing: A taxonomy of unconventional healing practices. *Ann Intern Med* 2001;3:196–204.
5. Giordano J, Boatwright D, Stapleton S, Huff L. Blending the boundaries: Steps toward an integration of complementary and alternative medicine into mainstream practice. *J Altern Complement Med* 2002;6:897–906.
6. Barrett B. Alternative, complementary, and conventional medicine: Is integration upon us? *J Altern Complement Med* 2003;3:417–427.
7. Goldberg B Group (eds.). *Alternative Medicine: The Definitive Guide*. Washington, DC: Future Medicine, 1993.
8. Bradford N (ed). *Alternative Healthcare: A Comprehensive Guide to Therapies and Remedies*. San Diego, CA: Thunder Bay, 1997.
9. Gottlieb B (ed.). *New Choices in Natural Healing*. Emmaus, PA: Rodale, 1995.
10. Spencer JW, Jacobs JJ. *Complementary and Alternative Medicine—An Evidence-Based Approach*. New York: Elsevier (Mosby), 2004.
11. Weil A. The significance of integrative medicine for the future of medical education. *Am J Med* 2000;108:441–443.
12. Boon H, Verhoef M, O’Hara D, Findlay B, Majid, N. Integrative healthcare: Arriving at a working definition. *Altern Ther Health Med* 2004;5:48–56.
13. Pert C. *Molecules of Emotion: Why You Feel the Way You Do*. New York: Scribner, 1997.

14. Martin PR. *The Healing Mind: The Vital Links Between Brain and Behavior, Immunity, and Disease*. New York: Dunne Books, 1998.
15. Cassidy CM. Unraveling the ball of string: Reality, paradigms, and the study of alternative medicine. *Adv J Mind-Body Health* 1994;10:1.
16. Holbrook B. *The Stone Monkey: An Alternative Chinese-Scientific Reality*. New York: William Morrow, 1981.
17. Jarrett LS. *Nourishing Destiny: The Inner Tradition of Chinese Medicine*. Stockbridge, MA: Spirit Path Press, 2000.
18. Greenwood MT. *The Unbroken Field: The Power of Intention in Healing*. Victoria, BC, Canada: Paradox, 2004.
19. Grof S, Bennett HZ. *The Holotropic Mind*. San Francisco, CA: Harper Collins, 1992.
20. Jahn RG, Dunne BJ. *Margins of Reality: The Role of Consciousness in the Physical World*. New York: Harcourt Brace Jovanovich, 1987.
21. Jonas W, Crawford C. *Healing Intention and Energy Medicine*. New York: Churchill Livingstone, 2002.
22. Rhead J. The deeper significance of complementary and alternative medicine. *J Altern Compl Med* 2003;9:455–457.
23. Dossey L. *Healing Words*. San Francisco, CA: Harper Collins, 1993:84–87.
24. Ford M (ed.). *A Process Theory of Medicine: Interdisciplinary Essays*. Lewiston, NY: Edwin Mellon Press, 1987.
25. Tataryn JD. Paradigms of health and disease: A framework for classifying and understanding complementary and alternative medicine. *J Altern Compl Med* 2002;6:877–892.
26. Berman BM. Complementary medicine and medical education. *BMJ* 2001;322:121–122.
27. Samueli Institute. Online document at: www.sib.org/ohe.htm Accessed October 15, 2004.
28. National Institutes of Health. Health information: Understanding alternative and complementary medicine. National Center for Complementary and Alternative Medicine. Online document at: www.nccam.nih.gov Accessed October 10, 2004.
29. Caspi O, Sechrest L, H.C. Pitluk, Marshall CL, Bell IR, Nichter M. On the definition of complementary, alternative, and integrative medicine: Societal mega-stereotypes versus patients' perspectives. *Altern Ther Health Med*. 2003;6:58–62.
30. Mayo Clinic. Healthy living, CAM: What is it? Mayo Clinic. Online document at: www.mayoclinic.com Accessed October 10, 1994.
31. Health Goods. Health, education, alternative therapies, classification of alternative therapies. Health Goods. Online document at: www.healthgoods.com Accessed October 10, 1994.

Address reprint requests to:
Curtis H. Jones, Ph.D.
 128 State Route 399
 Espanola, NM 87532

E-mail: chj@mail.com