INTEGRATIVE MEDICINE’S RHETORICAL REPRESENTATION OF COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM)

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A Thesis

Submitted to the Graduate College of Bowling Green State University in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

May 2005

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ABSTRACT

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This thesis explores the rhetoric of integrative medicine, especially as to how integrative medicine represents Complementary and Alternative Medicine (CAM). The objective of this research was to reveal physician’s sub-conscious and/or conscious perceptions of CAM as evidenced by their rhetoric. An enthymematic analysis (based on Aristotle’s definition of enthymeme) informed by the semiotics of Saussure was used to analyze selected texts, three of which are represented in this paper. Various forms of rough rhetorical treatment were uncovered, including blatant and subtle use of disparaging language against CAM, name-switching, mystifying rhetoric, and unfair contrasts. It was concluded that this rough rhetorical treatment was possible due to a widespread enthymeme that exists concerning CAM: because allopathy is the dominant form of health therapy and because it is more often tested, anything else is automatically second best; thus, CAM is inferior to allopathy. The existence of this enthymeme is evidenced by the aforementioned rough rhetorical treatment.
ACKNOWLEDGEMENTS

The writing of this thesis could not have been adequately and completely finished without the help first, of my thesis advisor, Dr. Andrew Mara. The time, effort, guidance, and especially the true interest in my topic that he showed throughout the research and writing of this thesis are deeply appreciated. Also, I would like to acknowledge my second advisor, Dr. Jude Edminster. The interest she showed as well was inspiring and encouraging. Finally, I’d like to acknowledge my husband, David Woolf, for his tactful critiques of my writing and for his willingness to listen and respond thoughtfully to my ideas concerning this thesis.
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PREFACE

This thesis was undertaken in order to reveal the biases that exist in our culture concerning Complementary and Alternative Medicine. At this point in time, integrative medicine is still emerging and developing as a field or practice of medicine. While I have chosen to look at the rhetoric within integrative medicine it is only because I see the influence that this kind of practice can have on the reputation and/or outcome of CAM within this nation. As every rhetorician understands the impact language can have on a culture, I too am aware of its influence and know that how we talk about CAM, and especially, how the leaders in the health industry—those we respect and look to for medical advice—talk about CAM, can shape our society’s perception of it. This perception then, can establish whether or not CAM will be widely accepted or only used as an alternative. It is my hope that we will not limit ourselves to only one strain of medical care—that we will invite, or at least explore the possibilities that exist everywhere, so that we can benefit in every way possible. And this begins, I believe, with language.
I. INTRODUCTION

Complementary and alternative medicines (CAM) as defined by the National Center for Complementary and Alternative Medicine, is a “group of diverse medical and health care systems, practices and products that are not presently considered to be part of conventional medicine” (NCCAM “Get the Facts”). Earlier CAM practices have been around for centuries, and have been used by most cultures. When people think of CAM, they might think of herbal therapies, chiropractic methods or acupuncture, but actually, CAM therapies consist of a plethora of methods and each of these methods can also be broken down into various categories. CAM has been used in this country long before allopathic medicine (otherwise known as “conventional” medicine) ever was. However, in more recent years it has come to the attention of allopathic practitioners that CAM’s popularity has risen dramatically.

David Eisenberg’s benchmark survey on CAM’s popularity showed that 42.1% of the population used at least one alternative therapy in 1997 (1569). More daunting to allopathic practitioners might be the amount of money spent on complementary and alternative professional medical services in 1997: 21.2 billion dollars. This is in contrast to the out-of-pocket physician expenses of 29.3 billion dollars in the same year (Eisenberg 1571-73). Since that survey was published in 1998, allopathic practitioners have realized the need to familiarize themselves with CAM. Various articles have been written discussing issues involved with CAM from ethical practices, efficacy of various herbs, methods, etc., to how to treat people who have disclosed that they are using a CAM method.

It is a common notion that medical doctors practicing allopathic medicine (the conceptual framework of healing that is driven by suppression of symptoms using pharmaceuticals and other invasive procedures) are in general not sympathetic to the types of therapies found outside of this
(i.e. CAM). The allopathic view of health and the body is one that has been referred to as the “machinist” view—one that values the Cartesian duality of the mind—body. However, according to Constance Park,

With the recent explosion of interest in the association between illness and stress and with recent advances in mind—brain—body research, the Cartesian mind—body duality is losing its grip on medical thinking. It is not surprising that there is increasing interest in CAM therapies based on conceptual frameworks that posit connections between the mind and the body, thus enabling the mind to affect bodily health and vice versa. (Park 1570)

Along with this new research in mind—brain—body associations within the medical profession, the public demand for knowledge of and treatment by CAM has grown, and allopathic practitioners must comply with this demand. One place this compliance has already taken effect is within medical schools. Park reports that “an increasing majority of American medical schools offer . . . required courses or electives in [CAM]” (Park 1568). Perhaps the largest efforts involving CAM, however, have come from those advocates of integrative medicine.

Many believe that integrative medicine is simply combining, or integrating, CAM with allopathic medicine. Dr. Andrew Weil, often referred to as the father of integrative medicine, and the founder of the first integrative medicine clinic and academic program for integrative medicine suggests that it is more than that. He defines integrative medicine as restoring “the focus of medicine on health and healing and emphasize[ing] the centrality of the patient-physician relationship. In addition to providing [the best] conventional care, integrative medicine focuses on preventive maintenance of health by paying attention to all relative components of lifestyle” and uses CAM methods when they are better than allopathic methods (Snyderman & Weil 396).
Weil also suggests that in this framework of thinking, “physicians need to be teachers of health and healthy living” and that a major need is to “develop more rigorous definitions and standards in integrative medicine, ‘to help bring more order and clarity’ to the field [of CAM]” (reported in NCCAM “Report: ‘Can Alternative Medicine’”).

With a vision like this, it seems that advocates of integrative medicine would see the potential that lies in CAM. And apparently they do, as it is their goal to “advocate sound clinical research to test the efficacy of CAM strategies” and not to simply leave them behind in their quest for medicine (Snyderman and Weil 397). Although this seems to indicate a growing respect for CAM, the literature available on CAM in peer-reviewed, scientific and allopathic journals does not reflect an overarching acceptance among physicians and medical scientists of this “alternative” form of medicine. Furthermore, I have found that their rhetoric does not reflect an overall true appreciation of the potential of CAM. Instead, there appears to be an underlying enthymeme\(^1\) in favor of allopathy that automatically results in a negative rhetorical interpretation of CAM. It is my belief that before a change can be made in the stature and/or reputation of CAM (which would inadvertently affect the amount and type of investigation into it), the language we use to describe CAM must change.

**The Rhetoric of CAM**

There are many words and phrases that have been used across various communities, places and time to describe CAM. While some are more specific, defining a particular type of medicine, therapy, or how these therapies fit into the framework of healing, some are used interchangeably, or incorrectly. For instance, there has been one discussion among medical scientists and practitioners concerning the use of “alternative” or “complementary.” The term

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\(^1\) My description of the enthymeme alluded to here appears on page sixteen in this text.
complementary was first coined in Britain to suggest that herbals were to be used to complement, or “enhance” the natural healing functions of the body (Trachtenberg 1566-67). However, when the term crossed the seas to the United States, Americans transformed its meaning: “complementary” in the United States means that herbals are a complement to pharmaceuticals—the monoglossic² form of healing therapy in the United States (Trachtenberg 1566). It is no surprise that the term’s meaning shifted once it hit western shores; it is surprising, however, the power that shift in meaning continues to have on popular thought. Unfortunately, the ramifications that exist because of this shift include an image of CAM as not just second place to allopathy, but as a helpmate that can only be used in conjunction with allopathy.

The second part of this discussion involves the meaning of “alternative.” Again, this word elicits ideas in American minds of CAM as an “alternate” to allopathic methods, once again making CAM second place to them. Trachtenberg notes that health practices that come from outside of the Western biomedical setting are considered “alternative,” and for this reason (at least in part), the United States is resistant to these “alternative” therapies. Some physicians cite their resistance to alternative therapies based on the lack of scientific evidence proving their efficacy and safety. However, Trachtenberg points out that,

Therapies, like surgery, psychotherapy, and the early antibiotics came from within our own Western biomedical tradition and predated the advent of evidence-based medicine. Some have since been confirmed by rigorous methodology, but many have not. Likewise, new technologies such as intrapartum fetal monitoring may emerge from within our own biomedical culture and become widespread, despite an absence of rigorous data on benefits² (1566).

² Monoglossic, a term coined by M.M. Bakhtin refers to the hegemonic structure wielding the power and influence in a culture within a certain sphere. In this case, the sphere is medicine.
Trachtenberg seems to suggest, then, that the lack of scientific data is not the conclusive factor for resistance to CAM. Considering this, it seems likely that deeming these potentially valuable therapies as “alternative” will further stigmatize them in our society, and the medical community. When people hear the word “alternative,” they might automatically define that word with its opposition—“conventional medicine.” Scholars in semiotics speak of an alignment that arises between these paired signifiers. According to Kaja Silverman, “a cultural code is a conceptual system which is organized around key oppositions and equations, in which a term like “woman” is defined in opposition to a term like “man,” and in which each term is aligned with a cluster of symbolic attributes” (qutd. in Chandler 106). Unfortunately these binary oppositions become dichotomous, and are broken down to a basic idea that one is good and one is bad. Daniel Chandler, in his book, *Semiotics: The Basics* confirms this idea when he cites Leach: “Apparently fundamental oppositions such as *male-female* and *left-right* become transformed into the ‘prototype symbols of the good and the bad, the permitted and the forbidden’” (106). Although the alternative-conventional opposition may not be fundamental, it is natural to identify something in order to understand it better by reducing it to a basic fundamental, such as the *good-bad* or the *male-female* binary.

It is evident that something needs to be done to change this. As a technical communicator, I appreciate the power of rhetoric and believe that how we speak about things will be how we see things. Therefore, it is important that the medical community at large begins speaking about these CAM therapies as “drugs,” or “phyto-chemicals” or “herbal medicines.” Also, if, in the scientific literature they would treat CAM with the same respect that they treat allopathy, rather than as a folk remedy with little potency, then a shift would occur. Not only would doctors be more willing to introduce more CAM treatments to the American public, but
CAM would begin to take on a new image: one that reflects the value that they can have for our health.

Studies in Medical Rhetoric: Discovering the Controlling Influence

Considering that this topic requires me to look at the rhetoric within the scientific/medical literature, it is important to look at the research that has been done concerning medical rhetoric. Because science is a discipline that has been considered “factual,” and objective, until recently, not much attention has been paid to the language that scientists, including medical scientists, use in a given text. But, as scholars of rhetoric understand, all language is rhetorical. According to Aristotle, rhetoric is “the faculty of observing in any given case the available means of persuasion” (“Aristotle’s Rhetoric”). In fact rhetoric is unlike any other art in that it has the “power of observing the means of persuasion on almost any subject presented us” (“Aristotle’s Rhetoric,” my italics). According to the postmodern understanding of science as “uncertain knowledge,” then, one of these subjects would include science. In agreement with this notion, Richard D. Johnson-Sheehan states that, “words like invention, style, ethos, topoi, narrative, and genre that are mainstays in any good-faith discussion of rhetoric can now be used to explain scientific discourse” (“What is Rhetoric of Science?”).

Judy Segal, in her article “Strategies of Influence in Medical Authorship,” uses these “mainstays” to set up a model for analyzing medical rhetoric. Specifically, she takes Aristotle’s categories of rhetorical means— invention, arrangement, and style—and demonstrates how the medical community applies rhetoric within medical journals to persuade the audience. Although medical texts might create the appearance of “neutrality” they employ rhetoric. In fact, it is this use of “neutrality” which “is part of the rhetoric of science” (Segal 525). Aristotle’s rhetorical means help us to look beyond and through this appearance of neutrality and see the rhetorical
constructions. In doing this, we are able to see the influence that medical practitioners and scientists have on our medical ideologies.

This medical influence is also discussed in “Risk Talk: Rhetorical Strategies in Consultations on Hormone Replacement Therapy” (Hoffman, et al.). In discussing hormone replacement therapy with their patients, “doctors’ rhetorical strategies . . . seem[ed] to be designed to induce reassurance and confidence in patients, thereby possibly increasing compliance (Hoffman, et al. 153). Although this study was done on hormone replacement therapy, the idea that doctors use rhetoric to increase compliance also applies to herbal medicines. In my own observations, I have found that doctors have a negative opinion of CAM. Although at the time I might not have noticed the use of rhetoric in my discussions with my doctor, in retrospect I am convinced he did use rhetoric. This is because there were times I left the doctor’s office feeling as though I had been belittled for using any type of CAM practice. I also remember more than once that upon arriving home, I consulted my reference books to verify whether or not I was using something inappropriately.³ Obviously, in that case, the doctor had used his influence to increase compliance—in this case, compliance to not use herbal medicines. Although it did not ultimately change my attitude about CAM, if people who were not well-read on the subject asked their doctor about it, I imagine that this type of response would often deter them from pursuing it any further. This is how the reputation is carried on. Unfortunately, it is passed on this way not only from physician to patient, but also from medical scientist to physician, from physician to physician, and from patient to patient.

³ I would like to note the importance of doing thorough research and consulting a licensed practitioner before taking any herbal product. I am an informed consumer of herbal products, and even with that information, I am aware of the lack of regulation on these products. I do not by any means intend for this paper to promote the uninformed use of any type of alternative treatment. On the contrary, regulation of these products is my ultimate aim, so that misuse is reduced to a minimum.
This cycling of ideologies about CAM is another way that it does not gain acceptance in the mainstream. Dale Sullivan, in his article, “Keeping the Rhetoric Orthodox: Forum Control in Science,” would categorize this cycling under the term “forum control,” specifically, the type of forum control that is found within peer review or simple denial of forum (125). This forum control can be seen as the rhetoric that the public does not see. In other words, it is persuasion that goes on before a document is printed or even begun. For instance, peer review, a type of forum control, would likely be when scientists learn to talk about their subject (Sullivan 127). If a scientist were to be slightly off the conventional ideas about CAM in his/her discussion of them, his/her peer might correct them, and give them another “more appropriate way” to discuss that topic. They might also direct them to attach their topic to another more accepted topic in some way (Sullivan 128). Although Sullivan showed the negative side of this method, Margaret Hamilton sees this as a positive when one is trying to establish a sympathetic audience for a new or less accepted idea. Margaret Hamilton used Chaim Perelman’s method of rhetorical analysis to look at the medical rhetoric in Promoting Health, the Institute of Medicine’s report, and she believes it is important to base the new topic’s arguments within “premises acceptable to its audience” (127). Considering CAM treatments are not yet entirely accepted within medical communities, I expect that this type of rhetoric is used within the texts I analyzed The awareness of this, and its influences on my thesis will be discussed in my methodology.

Studies in Scientific/Medical Rhetoric: The Mystification of CAM

Because allopathic methods (pharmaceuticals, surgeries, invasive procedures) are the monoglossic form of treatment in the United States, medical scientists who realize the potential in CAM therapies might still use (without realizing it) the monoglossic language that is biased against them. This could have something to do in part with the fact that it is seen as a foreign
practice. Because CAM is composed, in part, with methods and medicines (herbals) initiated with the Chinese they can take on a foreign status. Also, “many different schools of herbalists have operated from a romantic perspective that the healing power of herbal treatment derives from a spiritual-holistic base, that some ritual process is crucial to the healing, and that some special esoteric knowledge or communion with nature is at the source of wellness” (Tyler 93). This spiritual component, for many people, makes herbal products and other medical treatments within Chinese medicine seem elusive; that if they are not spiritual, then a CAM practice would not work for them. This furthers the foreign image of CAM. The problem with this foreign image is that it can cause problems when writers try to communicate about it. For instance, Marianthe Karinikas explains that one of the problems with communicating acupuncture to an audience is the fact that “traditional Chinese medical theory tends to be either devalued or over-valued—both extremes mystify rather than elucidate an understanding of acupuncture” (70). We can take Karanikas’ observation and apply it to other forms of CAM as well. It seems that people do either value or de-value CAM practices, and this, added to the already existing spiritual aspect (regardless if that spiritual aspect is warranted or not) can show up in the literature that discusses them.

This mystification that is applied to CAM is a hindrance “preventing large-scale incorporation of herbal medicines into scientific, mainstream medical practice” (Tyler 93). And not only herbal medicines, but CAM in general. It seems that if a foreign practice is mystified in some way, it is absent of credibility, despite the evidence indicating that the practice works.

Furthermore, medical practitioners and scientists appear to be resistant to any kind of evidence

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4 The relation of CAM to China is warranted. Much of our knowledge of treatments like acupuncture, Tai Chi and the medicinal qualities of herbs comes from China, and in fact, herbs are a major component of Traditional Chinese Medicine, the conceptual framework of healing in China.
other than scientific quantitative empirical studies. Bernice Hausman describes this type of resistance in her article “Rational Management: Medical Authority and Ideological Conflict in Ruth Lawrence’s *Breastfeeding: A Guide for the Medical Profession.*” In looking at the rhetoric concerning breastfeeding, she found that it was the doctors’ “experience” that was valued more. Hausman noted that “experience seem[ed] to be the territory of the physician—this would be experience in the management of nursing mothers. Any experience of women in this matter seems doubly discounted” (274). In other words, physicians did not value the experience of mothers, despite the fact that mothers have the most direct experience in breastfeeding. Perhaps this has something to do with the mystification that still surrounds reproduction and breastfeeding. Medical practitioners could not place the experience of mother’s above their own simply because it was not experience that was informed by science. It was experience informed by motherhood⁵, and thereby it was mystical. In the same way, physicians and medical scientists do not give enough value to the thousands of years of practice that the Chinese have done in the area of herbal medicines, acupuncture, and a variety of other CAM practices. Because Chinese medicine has a mystical, foreign image, it discredits the results it receives.

**Conclusion to Introduction**

As can be seen, scientists have an influence in determining how physicians will understand a certain health topic. At the same time, physicians take what they have learned from scientists and pass it on to influence the public. As the public receives this information and integrates it with the mystification of CAM, an unfair image of this form of therapy is formed.

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⁵ Also note that the motherhood experience is a specifically female experience, as opposed to the “masculine science” experience. Again, this reveals the male/female= good/bad binary in this situation.
The goal of this project, in part, is to begin to de-mystify CAM by changing the way scientists and medical practitioners talk about them. While this might seem unreachable to some, I believe it is practical. Although CAM is not the accepted form of healing in the United States, as shown in this research, it is growing to be more accepted, and there seems to be a solid base of scientists and physicians out there who are open to using them, or at least educating themselves in this area. It is this group of people and the already existing Doctors of Naturopathy (and other practitioners of natural healing) that I would like to target.
II. METHODOLOGY

In my review of the literature on medical/scientific rhetoric, I had not seen any close analysis of the medical rhetoric involved in the writing of scholarly texts on CAM. Thus, it was interesting to see the types of rhetorical strategies that were used by those who speak of CAM within integrative medicine. Typically, the doctors and researchers within integrative medicine are those who come from a discourse community that does not support CAM (the allopathic discourse community). Consequently, it seemed logical that their acquired rhetoric would reflect those ideologies despite their conscious intentions of promoting CAM. Because these people should have a certain level of respect for CAM, I expected that their speech would reveal the extent to which the biases against CAM have seeped into our sub-consciousnesses.

In order to uncover these biases, I performed an enthymematic analysis informed by Aristotelian rhetoric, in particular, his explanation of enthymeme. Aristotle defines an enthymeme in this way: “when it is shown that, certain propositions being true, a further and quite distinct proposition must also be true in consequence, whether invariably or usually, this is called . . . enthymeme in rhetoric” (“Aristotle’s Rhetoric”). I understood that in order for the rough rhetorical treatment (see section below) to occur, there must have been an underlying assumption—one that insisted upon the “inferiority” of CAM. Thus, Aristotle’s definition of enthymeme became the basis for my thesis and the basis upon which I performed my analysis. Finally, to expand on and illuminate the evidence for the intertextual enthymeme, I used the semiotics of Saussure and Jakobson.

I started with a total of twelve texts: ten texts written by scholars within the emerging field of integrative medicine, who would be sympathetic towards CAM; and two texts written by those who wrote about CAM outside the field of integrative medicine and before CAM gained
widespread attention; I then selected three representative texts, two from the former group, and one from the latter. The analysis from outside the field of integrative medicine served as a model by which to compare the analyses of those written within integrative medicine. These findings were then reported in my thesis.

It was my presupposition that those articles written outside the field of integrative medicine and before CAM gained widespread attention would contain rough rhetorical treatment against CAM. Those written within the field of integrative medicine would have a higher standard in their attitude toward CAM in that the rhetorical treatment would be less abrasive and more supportive of the attributes of CAM. However, in order to position myself within this research, I would like to reveal that I believed before beginning that there is a bias in the literature of integrative medicine. I was aware that these preconceived ideas could affect the outcome of this study. However, the influence these preconceived ideas could have were limited to an inconsequential minimum by the forum control noted by Dale Sullivan. Of the ten articles I looked at that represent the voice of integrative medicine, I chose articles from medical journals that have a well-established reputation for supporting discoveries for CAM. Furthermore, the forerunners of integrative medicine wrote many of these articles. Both of these criteria aided in making the influence of my own presuppositions inconsequential, because it can be assumed that forum control took place before the articles were ever published.

Terminology for Results

The following is a list of terms or phrases and their definitions or standards that I used to describe rough rhetorical treatment.
Mystifying CAM—Name Switching: If CAM remains nameless, it does not have a true standing or identity. It also leaves the readers and speakers of CAM confused about what to call it; therefore, their feelings about it include confusion.

Mystifying CAM—Feminizing Language: Using words that are typically “feminine” when speaking about or describing CAM. This is in direct contrast to the “masculine” terms used to describe conventional medicine.

Disparaging Terminology/Phrasology: Any words or phrases that otherwise denigrate CAM.

Applying Hypocritical Standards to CAM: These are standards that are absolute—“not all are safe.” These are standards that not even conventional medicine can stand up to.

Unfair Comparisons: Comparing CAM to conventional medicine, and in doing so, they show only the good side of conventional medicine, whereas they show the worst side of CAM.

Villainizing/Danger Terms: Using words to evoke in the reader fear of danger concerning CAM.
III. RESULTS AND DISCUSSION

Introduction to the Analyses

In the course of this investigation, I read and analyzed twelve articles; one article dealt with CAM generically and the other eleven dealt with CAM in the context of integrative medicine. The following three sections are analyses of three articles involving CAM and/or integrative medicine. The first is an analyses of “Physicians and Healers—Unwitting Partners in Health Care” by Raymond Murray, MD and Arthur Rubel, PhD; the second is “The Tower of Babel” by Opher Caspi, MD et al.; the third is “Integrative Medicine: Bringing Medicine Back to Its Roots” by Ralph Snyderman, MD and Andrew T. Weil, MD. These articles represent a few of the types of observations I made during my analysis of eleven articles on integrative medicine. My overall observation was that allopathic practitioners write about CAM in a way that suggests that CAM is second best to allopathy. Their rhetoric also suggests that this is an inherent, irreversible and true quality of CAM. Whether this type of treatment is subconscious or purposeful, they do this using the rough rhetorical treatment that I listed and defined above.

A Representative Sample of Early CAM Rhetoric

“Physicians and Healers—Unwitting Partners in Health Care” by Raymond Murray, MD, and Arthur Rubel, PhD is a text published in January 1992 concerning complimentary and alternative medicine (CAM). This article was published at least three years before the institutionalized establishment of “integrative medicine;” however, Murray and Rubel’s purpose in this article is to educate other allopathic doctors on issues of CAM, and to advise them in how to communicate with patients who use CAM. Although this is not the complete goal of proponents of integrative medicine, as the father of integrative medicine, Dr. Andrew Weil, defines it, it is, at least, part of that goal. Considering also that this article was written in the
budding stages of interest in CAM, we might look at it as one of the precursors to integrative medicine.

Regardless if we look at it as a precursor to integrative medicine, it is a representative sample of the rhetoric of CAM. And, because integrative medicine communicates, in part, with the rhetoric of CAM, I am certain it is necessary to analyze it. It is also important to analyze it because it was written in January of 1992—more than five years before Eisenberg’s monumental survey on the popularity of CAM, and more than three years before Dr. Andrew Weil’s national efforts to promote a program for integrative medicine. Both of these movements have exponentially increased interest and heightened the popularity of CAM among allopathic practitioners in the past decade. Since then, article writers have increasingly given more favor to CAM in their rhetorical treatment of it. Consequently, more recent articles may not exhibit as many subtle evidences of rhetorically rough treatment of CAM, and they certainly may not exhibit the blatant rough rhetorical treatment as those articles written before Eisenberg and Weil’s efforts concerning CAM. Because this article was written before those movements, it contains many subtle instances of rough rhetorical treatment as well as many visible instances of the same. Because many were visible in this article, I will draw from it as a model, by which I will be able to point these same types out in other articles (later in the thesis) where they occur embedded within the rhetoric.

The Intertextual Enthymeme

The first thing I would like to focus on is an enthymeme upon which this text, and most others discussing CAM, is based. Aristotle defines an enthymeme: “when it is shown that, certain propositions being true, a further and quite distinct proposition must also be true in consequence, whether invariably or usually, this is called . . . enthymeme in rhetoric”
(“Aristotle’s Rhetoric”). In other words, if the rhetorician believes that the reader believes point “a,” then he can be reasonably sure that the reader will believe point “b” which is based on the belief in point “a.” The enthymeme this author uses is that allopathic medicine and its methods are the norm, and they are the field that has been scientifically proven; thus, allopathic medicine is the best form of medicine. While it is true that allopathic medicine is the dominant form of health control in the United States at this time, this does not mean that it is the best form of health control (if a best even exists); nor does it mean that it is the standard upon which all others must be based. CAM is much too young within the scientific research community to disqualify it. In fact, recent evidence already suggests that we should not disqualify it. Because it cannot be disqualified, the enthymeme that this text uses sets CAM at an unfair disadvantage—one that non-hesitantly favors allopathy.

Murray and Rubel use the basic enthymeme that allopathic medicine is the best or the standard (and that all readers will accept this) throughout their article. They do not voice this assumption—rather it is an underlying assumption that is apparent throughout the whole text, and it is infused in other texts as well. In this way, it seems best categorized as an intertextual enthymeme. Intertextuality is “a semiotic notion” described by Julia Kristeva as existing in “two axes: a horizontal axis connecting the author and reader of a text, and a vertical axis, which connects the text to other texts (Chandler 195). In the analyses discussed in this thesis, I will be most concerned with the vertical axis.

Disparaging Language in “Physicians and Healers”

This intertextual enthymeme is most evident in the section entitled “Dealing With Patients Who Use Alternative Medicine.” It is already in action in this subheading with the reference to the term “dealing.” By using this term, the authors have relied on the assumption
that allopathy is the best (or if I may go so far as to say only in this case) way to go, and that the reader will agree with this. Thus, the authors can reasonably assume that other doctors will feel that they must “deal” with patients who use CAM. However, this terminology puts CAM at a disadvantage—it is, in effect, a disparaging use of language. We “deal” with an unruly child; we “deal” with disgruntled customers; we “deal” with a negative situation. How then, can a doctor suggest that one who uses CAM must be dealt with? He can suggest this simply by playing off the intertextual enthymeme that allopathic medicine is the best way to go. In fact, at the time this article was published, this enthymeme must have been fully accepted among allopathic practitioners, or the editors at The New England Journal of Medicine would never have allowed this to be published this way. It is obvious that accepting this enthymeme, however, does not place the two forms of health care on the same playing field—something that needs to be done if CAM is going to receive the scientific treatment that it needs and deserves.

This intertextual enthymeme is used to allow for the use of other disparaging terms as well. In the case of this article written in 1992, the disparaging terms are much more blatant than those post-Eisenberg texts. In this particular article, the authors refer to the “hodgepodge of beliefs and treatments” within CAM (Murray and Rubel 61). The use of this term “hodgepodge” to describe the variety of beliefs and treatments is derogatory. Hodgepodge is generally a term used in popular rhetoric; even in that context it is considered slang. It is not a term one would generally use to describe something for which they have even the remotest amount of respect. For instance, it can reasonably be suggested that an allopathic doctor or a pharmacist would not describe the variety of pharmaceutical treatments for depression as a “hodgepodge?” They would instead probably refer to “the variety of treatments,” and even consider this variety a benefit because it allows for the different variables that occur with each patient.
Second, the authors use this term to describe the various beliefs within CAM. In essence, they are suggesting that the beliefs within CAM have no central ideology under which they can be categorized or understood. For a moment, let us suppose that this is true. Knowing this is true, the authors suggest that “alternative practices” represent a hodgepodge of beliefs. If this is a derogatory way to describe CAM, then the authors must assume that this hodgepodge of beliefs is a negative thing. But who has the problem? CAM practitioners, because they don’t all assume one belief? Or allopathic practitioners because they don’t understand CAM, and in their attempt to understand it, they try to group it under one umbrella, and categorize it—and then turn around and say that, collected underneath one umbrella, it is a hodgepodge of beliefs. By doing this, these authors are subscribing to the intertextual enthymeme—that the allopathic way is the best way to do things—the only way. Because allopathy has been categorized and grouped, they assume that CAM should also be able to be categorized and grouped—and if it can not be grouped, then it is bad. But in fact, some allopathic practitioners even see this “grouping” action as a negative thing, and argue that even allopathic medicine “is not a single coherent theory but rather a mixture of statements about practical skills and pieces of theory drawn from biology, psychology, and elsewhere” (Kristiansen and Mooney 5). Yet somehow, those who support allopathy over CAM want to be able to fit CAM into a box. Perhaps, then, if they can contain it in that box, they believe it will be much easier to control it.

Villainization of CAM in “Physicians and Healers”

Another way we see this intertextual enthymeme at work is in the way authors of CAM texts tend to villainize CAM and those who use or practice CAM. In this article, Murray and Rubel are no exception when they write of the variety of beliefs and treatments within CAM, they say that CAM therapies “derive from a wide variety of sources . . . [such as] health-
and-wellness groups exploiting the growing rebellion against technology and the perceived impersonalization of medical care” (61). The use of the terms “exploiting,” and “growing rebellion,” all paint a picture of an evil villain. For instance, to suggest that someone is exploiting something is to suggest that they are wrongfully taking advantage of it. We exploit someone who is weaker than us, either physically, mentally, emotionally, economically, politically etc., or we exploit a bad situation. In other words, these health-and-wellness groups are taking advantage of a growing rebellion against technology and the perceived impersonalization of medical care. Or perhaps, they are taking advantage of the growing rebellion; in which case, they are taking advantage of a bad situation. This then paints a picture of people in a riot taking advantage of business owners who have fled (and an absent or preoccupied police force) and looting out the businesses—in other words, they are making a bad situation worse. Second, this sentence infers that those who are “against” technology and the impersonalization of medical care are “rebellious.” Not only that, it infers that their feelings are not validated because they are mistaken: there is not an impersonalization of medical care, these people only “perceive” it that way. We can see in this last point how this is informed by the intertextual enthymeme. Because allopathy is the norm, and therefore, the best mode of health, it would be “the other” who mistook it—not that there might be any truth to the allegation that medical care is becoming impersonal.

Name-Switching in “Physicians and Healers”

Another type of rough rhetorical treatment that we encounter in this article is name switching. Name switching is one form of tainted rhetoric that is common within medical literature discussing CAM. Name switching is when the author refers to CAM as one thing, then throughout the article, refers to it as something else. Oftentimes the author tends to call it by the
name that best serves to belittle CAM in that particular rhetorical situation. It is not surprising that this would be a rhetorical treatment that I would point out, because it was only in the late 1990’s that CAM began to be called (for the most part, anyway) “CAM” among most medical practitioners. This happened when the NCCAM tagged it as CAM, and then defined the term for the medical community. It is important to note, however, that it was the NCCAM itself which may have lead the way for this name switching. In a period of less than ten years, the institution funded by the government to research CAM formally changed its name three times. Since they are an established leader in the field of CAM, it is not surprising that others would follow suit, and have a difficult time sticking to one name. Despite this history, CAM has officially been dubbed “CAM” now for over five years. Before this, medical writers often referred to it as “alternative,” “unconventional,” “complementary,” “natural,” “New-Age,” or “holistic,” among other names, and this has, in a way, reinforced the intertextual enthymeme.

Murray and Rubel’s article is no exception to that rule. In fact, the first sub-title refers to CAM’s lack of a name, and then the body text commences to find a name for it. In telling the reader the various names that CAM was known by, the authors also say why those names are not suitable. Finally, they say that, “‘alternative medicine’ seems to be the most widely used term and one that is reasonably unambiguous;” thus, the authors settle on this name. First, it is important to point out that Murray and Rubel called the term “unambiguous,” but defined it as “a heterogeneous set of practices that are offered as an alternative to conventional medicine for the preservation of health and the diagnosis and treatment of health-related problems” (61). It seems contradictory that a term they tag as “unambiguous” is then, moments later, defined. Furthermore, the definition that is supplied, if it is not ambiguous, is at least a broad definition that could be interpreted many ways. For instance, “a heterogenous set of practices” does not
suggest to the reader what specific practices may be included; “that are offered” is passive, and does not allude to who offers these practices; “health related problems” also does not specifically suggest what kind of health related problems that are being treated or diagnosed. Though I do not suggest that the writer could in a few words or less define the issues I have addressed, I would suggest that perhaps the true issue of ambiguity here, lies in the fact that allopathic practitioners attempt to group all of these therapies into one umbrella (and expect them all to be covered).

Furthermore, the definition they give it does not make it any less ambiguous than it already is. Basically, what we can derive from this definition is that it’s an “alternative,” to allopathic medicine that is “offered” for health. That it is an alternative is already understood in the title, and one would assume that it is at least “offered” for health. Because this definition does not enlighten the reader with any new knowledge, this definition then, mainly serves to emphasize the perception that it is an “alternative” to allopathic medicine. Consequently, it makes one wonder why the authors chose this name above all others, besides their statement that it “seems to be the most widely used term.” While it may be the most widely used term, it is not the best term. By tagging it as “alternative medicine,” these allopathic practitioners have set it as second place to allopathic medicine. Thus, this article does not just belittle CAM in certain rhetorical situations, but throughout the text, each time the authors use this name, it does this.

However, we see this belittling in certain rhetorical situations as well, as the authors involve themselves in name switching. They refer to CAM in various ways including terms such as “unorthodox,” “unconventional,” “nonconventional,” “healing practices,” and of course, “alternative medicine.” As stated before, name switching often involves using a name that serves to belittle it. This article is no different. For instance, the first time we see a major name
switch, Murray and Rubel say “unconventional medical practices have long been popular in the United States, but were especially so in the latter part of the 19th century and during the 1920s” (62). This sentence is pointing out a positive of CAM—that it has been popular. This could be threatening to doctors who practice allopathy; however, the authors downplay its importance by calling it “unconventional medical practices.”

First, this term unconventional, in its use of the “-un” and in contrast to its paired word, tags it as a marked term. In semiotic theory, Russian linguist and semiotician Roman Jakobson calls this “markedness” (Chandler 111). Daniel Chandler, in explanation of Jakobson’s observation of markedness, suggests that these types of markers can “generate negative connotations and that the “unmarked term is primary, being given precedence and priority, while the marked term is treated as secondary” (Chandler 111). Chandler also states that “the marked form is foregrounded—presented as ‘different’; it is ‘out of the ordinary’—an extraordinary deviational ‘special case’ which is something other than the standard or a default form of the unmarked term. Unmarked—marked may thus be read as norm—deviation” (112). With this semiotic understanding, then, “unconventional” medicine is in stark contrast to “conventional” medicine. This is a blatant reminder that it is not conventional—not the norm, and therefore it is different, and it influences us to perceive it as second best to allopathic medicine.

Another example of name switching in this article occurs when Murray and Rubel say “occasionally, the pharmacopeias of healers turn out to be helpful, and some unorthodox remedies have indeed been found to be effective in controlled clinical trials” (63). Again, this sentence is pointing out a positive fact of CAM. As the example above, however, it downplays this positive by switching its name to a more negative one. The term “unorthodox remedies” implies many things. First, “unorthodox” is, again, a marked word. It is marked against the term
orthodox—a term most often used to refer to religions. Webster’s New World Dictionary defines it as “conforming to the usual beliefs or established doctrines, as in religion, politics,” and further defines it in relation to Christian and Jewish religions. This term, then, is closely linked to God in its connotative meaning. We can assume that since the alternative form is described as unorthodox, the un-alternative form (or allopathy) is described as orthodox—thus, it is linked to God. Because it is linked to God, it is, in essence, supreme. On the other hand, since alternative is described as “un-orthodox” it is linked to not-God (or Satan, or darkness or evilness in some religions), and therefore it is ultimately perceived as the defeated foe, the not-supreme, the second best.

During the time this article was written, CAM had not yet officially received a name; therefore, this fact would give reason to this name switching. However, the very act of this name switching added to the elusiveness of CAM—without a real name, no real identity could be ascribed to it; thus, no real value could be added to it. If no real value were added to it, then it would continue to be looked at as an “outsider,” or second-best to allopathic medicine. Also, if CAM itself were elusive, then its benefits were elusive—or at least they appeared to be. This, too, caused CAM to be less likely to be taken seriously. Thus, it was good for CAM when the National Center for Complementary and Alternative Medicine dubbed it as CAM and maintained that identification tag.

Deconstructing the “Tower of Babel”

A recent article on integrative medicine, “The Tower of Babel: Communication and Medicine,” written by a group of doctors at the University of Arizona College of Medicine, Program in Integrative Medicine, the first program started in integrative medicine in 1996, suggests that, yes, integration is possible (Caspi, et al 3193). However, they cite one major
problem: language barriers between CAM and allopathic practitioners. Caspi, et al suggest that allopathic practitioners do not understand the basic concepts of CAM, nor do CAM practitioners understand the basic concepts of allopathy and that “in such a climate, communication between both schools of thought is almost impossible. Is this not a modern form of the Tower of Babel?” (Caspi, et al 3194). If the medical education paradigm would shift to include the language of CAM, Caspi, et al believe this would remedy the problem (3194).

In my analysis of this article, I found that perhaps their language barriers are far larger than they expect. Because allopathic medicine is the hegemonic form of medical treatment in this nation, they run the risk of assimilating CAM into their framework of healing, rather than integrating it. I do not suggest that this would be a purposeful act—in fact, I believe the advocates of integrative medicine truly wish to make a change for the better concerning the practice of medicine, and their inclusion of CAM in this new framework of healing is a step in the right direction. However, as the hegemony, allopathy’s perceived superiority has saturated the medical community and society in general. More importantly, its perceived superiority, especially when in contrast to CAM, has tainted the rhetoric of those speaking about CAM. My fear is that, with this tainted rhetorical treatment of CAM, Dr. Elliot Dacher’s assertion will be realized—that it will “not be possible to integrate alternative and conventional systems of care without ending up with much of the same, an expanded therapeutic tool kit for the practitioner” (175). In so much as language determines an institution, then, assimilation, rather than integration, will occur with the continued tainted rhetorical treatment that I have found. While it is expedient that the two domains speak the same language, as Opher, et al point out, it is vital that they tread lightly in their rhetorical treatment of CAM in order to avoid assimilation and promote integration.
Name-Switching in “Tower of Babel”

There were four forms of “tainted” rhetoric that I found in the article “The Tower of Babel: Communication and Medicine.” Name switching is one form of tainted rhetoric that is common within medical literature discussing CAM. Name switching is when the author refers to CAM as one thing, then throughout the article, refers to it as something else. Before its name was institutionalized by the NCCAM, it was obvious that this name switching added to the elusiveness of CAM—without a real name, no real identity could be ascribed to it; thus, no real value could be added to it. If CAM itself were elusive, then its benefits were elusive—or at least they appeared to be.

However, CAM has a name now. Since this name has been applied to it, its reputation has grown (for the better); physicians and scientists alike have taken notice to it. While it has been its growing popularity that has caused these people to take notice, its new name has given it a sort of “handle”—something by which medical practitioners can grab hold of it, turn it around and begin to inspect it. By giving it a name, it developed an identity; it was no longer elusive. By giving it a name, it gathered all of those healing systems underneath one umbrella, so that all of them could come together and be united as one. Because this name has done so much for it, it is important at this stage in its growth to consistently call it by its name—CAM. Although allopathic practitioners generally call it CAM, as evidenced in “The Tower of Babel,” they still revert to other names as well. A digression of this sort only serves to hold it back from discovering its potential (whether that potential be out on its own, or integrated within allopathic practice). Also, as will be shown, this name switching is evidence of the intertextual enthymeme and simultaneously reinforces the intertextual enthymeme.
In the very first paragraph of “The Tower of Babel,” we see this name switching occurring. While in the first sentence, Caspi, et al refer to it as “complementary and alternative medicine (CAM),” four sentences later they switch: “it remains unclear (1) whether a true integration of conventional and unconventional therapies is even possible” (3193, my emphasis). First, the name they decide to use is one that segregates it as “the other.” The “un” added to “conventional” puts it in stark contrast to “conventional,” as pointed out earlier in this text. Because unconventional is a marked word, it is assumed to be “the other.” Thus, in this instance of name switching, not only does it detract from its identity as “CAM,” but it also produces in it a sense of “otherness.” Second, because it is a marked word, and is in stark contrast to its “conventional” counterpart, it is also seen as the opposite of its counterpart. This is particularly harmful considering the context of this name switching. The goal of integrative medicine advocates is to integrate CAM into allopathic medicine. But, because this author has used these two words next to each other in a sentence that questions whether or not they can be integrated, he has highlighted the fact that they are opposites, and therefore, he has indirectly inferred that they cannot be integrated.

Perhaps the consistent use of “unconventional” within these texts is evidence of a subconscious fear that can be revealed by semiotics. According to Jonathan Culler, a leading semiotician, the marked term is produced as an “effect” of the unmarked term—in this instance, “unconventional” medicine is produced as an effect of “conventional” medicine (Chandler 111). However, we know from medical history that this is not historically true; CAM was in existence long before allopathic medicine ever came to be. If we follow this semiotic logic, then, allopathy should have been the one named “unconventional.” And actually, this is in part true. The term allopathy is actually one that is not normally used to identify the type of medicine that is widely
practiced in North America. Perhaps if we look at the Greek root of allopathy it will begin to explain why it has lost popularity. Allopathy is derived from “allos” which means “other” in Greek, and the term allopathy was first expressed around 1850 when the founder of Homeopathy, Hahnemann, dubbed all “other” forms of therapy “allopathy” (Skinner 18). However, allopathic medicine gained in popularity and in economy quick enough that it was able to escape this tag. Somewhere along the way, the health pendulum swung in the other direction causing CAM to be referred to as “unconventional,” and with that marked term, it has developed a sense of “otherness.” The fear of allopathic practitioners, then, whether conscious, subconscious, or even passed down from other physicians, may be that their own “otherness” will be revealed. To compensate, they consistently refer to CAM as “unconventional.” Thus, this use of “unconventional” continues to seal the intertextual enthymeme described in this text.

The Mystification of CAM in “Tower of Babel”

This sense of “otherness,” then, brings us to the next “tainted” rhetorical treatment common within discourse on CAM—the mystification of CAM: the rhetorical treatment ascribed to it which implies that treatments within CAM are mystical or magical at a rudimentary level. Applying descriptive words or phrases to it like “unusual” and “unexplained,” heightens the perception that it is elusive (a quality that it already has, in part, from being unnamed so long). This elusiveness, then, creates for it a sort of mystical sense. What is interesting about this is the fact that if CAM seems mystical to us, it is only because we do not understand it. If a longstanding therapy has worked for centuries, such as is the case with treatments within Chinese Medicine, then there is some reason for it—whether or not we are intellectually, technologically or otherwise capable of understanding it. Simply because we have not found that reason, or perhaps because there is not even a test developed that could explain it, it does not
mean that the therapy is magical at the rudimentary level. Rather, the fault lies with us, and our inability to understand everything there is to know about the human body.

In “The Tower of Babel,” Opher et al suggest that bridging the language gap between CAM and allopathy will help to create a successful integration of the two. With this in mind, Caspi, et al cite the “widespread use of jargon that is peculiar to particular CAM practices” as an “impediment to constructive dialogue” (3194, my emphasis). In this sentence, the use of the word “peculiar” creates that mystical sense that CAM needs to diverge from. While this word can mean “unique,” it also can mean “out of the ordinary; queer; odd; strange” ("Peculiar" 995). Because it has this additional meaning, the use of this word also connotates that CAM is “strange.” The first part of the sentence also adds to this mystical sense in its use of the word “jargon.” According to Webster’s, the first meaning is “incoherent speech; gibberish” (723); although the word may also mean “the specialized vocabulary and idioms of those in the same work, profession” it also indicates that it is a “somewhat derogatory term, often implying unintelligibility” (723). This definition stirs up images of incantations that might be said around a witch’s black pot as she stirs her magical potion. Obviously, this is definitely a descriptive word that CAM advocates would want to avoid as it, too, connotates a mystical sense. Because CAM is so young in the allopathic world, and has for so long held this reputation of mystery, it is important to use words that have no mystical connotation to them. As long as CAM is perceived as being mystical, it will never establish the reputation it needs to be accepted among practitioners of allopathic medicine. Without that reputation, it will not discover its potential benefits. In this instance, perhaps it could have been suggested to write “widespread use of language that is specific to particular CAM practices.”
Disparagement in “Tower of Babel”

But the words in this sentence do more than simply apply a mystical sense to CAM—they also suggest a lack of respect for the language of CAM, a language that the article says allopathic practitioners should learn. In this sentence, it is particularly harmful because this sentence suggests that it is CAM’s language that is to be blamed for the “impediment to constructive dialogue” (Caspi, et al 3194). Most rational people would not blame one ethnic group for impeding constructive dialogue—it would simply be understood as a language gap. This type of “blaming” is reminiscent of the days before the Civil Rights movement, when people would look down upon immigrants who could not read or write English and ascribe to them ignorance.

This kind of disparagement is the third form of tainted rhetorical treatment I would like to point out. I do not suggest that this disparagement is purposeful. I do suggest, however, that whether it is purposeful or not, it will affect the reputation of CAM. While the disparagement in this sentence is more abrupt than in others, and this abrupt kind is becoming less common in the medical literature discussing CAM, simply because other disparagement is less noticeable does not mean that it is less harmful. Thus it is important to take notice of both kinds, and avoid them in our written discourse on CAM. It will be a more difficult task to do so in our spoken discourse, but as we make a conscious effort to expel them from our written discourse, it will come easier to expel them from our verbal discourse.

One example of subtle disparagement in the article “The Tower of Babel,” occurs in the conclusion when Caspi, et al note that “a real breakthrough in CAM as a legitimate form of therapy can only occur when the 2 schools of thought learn a common language in which to communicate” (3195). My concern is with the phrase “CAM as a legitimate form of therapy”
because this discounts that it is currently a legitimate form of therapy. The question is, then, what is legitimate, what standards define legitimacy and who gets to decide what those standards are? With that question aside, though, there is still the notion in this sentence that CAM is not legitimate. Whether doctors agree or disagree on this is no matter—if CAM’s legitimacy is still to be decided, at the very least, we should speak of it with the confidence that it will be proved to be legitimate or that there is already some legitimacy to it (if there were not, why would we bother to study it?). In other words, it might have been good to say “a real breakthrough in CAM being perceived as a legitimate form of therapy can only occur when . . .” With this new phrasing, it allows the reader to realize that legitimacy is, at least to a degree, subjective. It also allows the reader to realize that it is not about whether or not CAM is legitimate—it is more about how we perceive it. Although this disparagement may be embedded in the rhetoric, this only reveals the depth to which allopathic medicine ideologies have permeated our ideas of medicine. Consequently, it is also evidence of the intertextual enthymeme.

*Unfair Contrasts in “Tower of Babel”*

Finally, there was at least one other form of tainted rhetoric which I would like to point out in this article: unfair contrasts. Unfair contrasts are the most illustrative of the intertextual enthymeme. Unfair contrasts are when the writer has spoken about both entities in the same context, and, has shown allopathy in the best light possible, but shown CAM in a negative light. For instance, in “The Tower of Babel,” Caspi, et al speak of the gap between the two forms of therapy by stating, “the present relative scarcity of thorough exposure of allopathic medical students to the diversity of CAM therapies and their fundamental concepts and of students of CAM to allopathy and its related sciences is far from ideal” (3193). The unfair contrast is seen when they speak of the “fundamental concepts” of CAM and the “related sciences” of allopathy.
In other words, CAM has only concepts and a concept is often referred to as an idea. It also seems that in contrast to the “related sciences” of allopathy that CAM’s “concepts” are disjointed—here and there—whereas a science is a unified subject of study. It is a “hard” topic—one set in stone (which should not be the case).

This same type of unfair contrast occurs on the second page when the authors state, “we must admit that the majority of us know very little about the basic ideas of CAM. Likewise, what do CAM providers really know about applied molecular biology?” (Caspi, et al 3194). The unfair contrast occurs here in that they essentially suggest that allopathic practitioners only need to learn the “basic ideas of CAM.” Yet the CAM providers need to understand an entire science. Not only is this an unfair contrast, but it is also disparaging to CAM in that it infers that it is a simplistic science, when in fact, this is a very complex field of study. These types of unfair contrasts will only continue to hurt the reputation of CAM and hold it back from discovering its true potential.

Analysis of “Integrative Medicine: Bringing Medicine Back to Its Roots”

In the article “Integrative Medicine: Bringing Medicine Back to Its Roots,” Ralph Snyderman and Andrew Weil recognize and state that there is a “rapidly widening gap” between “what many conventional health care providers deliver and what the public wants and needs” (395). These authors believe that reform is necessary for the present American health care system and that integrative medicine is, in part, the answer to that reform. In their estimation, integrative medicine is an approach that emphasizes the patient-physician relationship and pays attention to the spiritual, and emotional state of the patient. Also, it understands the fundamentals of CAM therapies and applies them when they improve upon conventional medicine. Although these authors seem to have a respect for CAM, evidence within the text
suggests that they are informed by the intertextual enthymeme of which other physicians are also informed: that since allopathic medicine is the most widely used (and tested) in the United States, it is also the best; since it is “the best” then all other forms of medicine are inferior. Unfortunately, because they are informed by this enthymeme, CAM receives rough rhetorical treatment by these authors.

**Disparagement in “Integrative Medicine”**

Of the types of rough rhetorical treatment that is found in physician’s literature on CAM, the first I would like to point to in this article is subtle disparagement. As suggested earlier, subtle disparagement is terms, phrases or suggestions used that belittle, put down or in some way harm the reputation of CAM. It is subtle; thus, it is less noticeable than blatant name-calling found in earlier texts. However, simply because it is less noticeable, it does not mean that it is less harmful. This subtle disparagement is first found in the authors’ definition of integrative medicine. They state, “integrative medicine is not synonymous with complementary and alternative medicine (CAM). It has a far larger meaning and mission in that it calls for restoration of the focus of medicine on health and healing and emphasizes the centrality of the patient-physician relationship” (Snyderman and Weil 396). Obviously, they are promoting their medicine as “better” than CAM when they suggest that integrative medicine has a “far larger meaning and mission.” Essentially, these words “puff up” integrative medicine while they downplay CAM.

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6 These authors, although seemingly supporting of CAM, are still biased for allopathic medicine—at least sub-consciously. One must remember that they were trained in allopathic schools and taught allopathic ways—not to mention that they grew up in a country where allopathy is (and was) favored. The intertextual enthymeme is one that has been ingrained in them, whether they knew it or not. If they truly wish to be “healers,” they must free themselves of this enthymeme. One way to do that is to pay attention to their language.
Looking closely at what that meaning and mission is, we can see that in reality, the meaning and mission is not “far larger” than CAM’s. The first mission suggested by these authors is that it calls for “restoration of the focus of medicine on health and healing.” Admittedly, CAM does not call for the restoration of the focus of medicine on health and healing. However, CAM does not need to. It is widely known that CAM’s focus is and always has been on health and healing—they do not need to call for a restoration since they never demolished that focus in the first place. In fact, CAM’s practitioners have often been referred to as “healers” (Murray and Rubel 61). In actuality, this makes CAM’s mission and meaning “far larger” in that it is obviously a standard that CAM has consistently stood by. What is it, then, within this phrase that makes integrative medicine have a far larger meaning and/or mission than CAM? The only other part of this phrase to look at is the author’s definition of medicine. If they do not include CAM within their definition of medicine, then certainly CAM cannot take a part in “the restoration of the focus of medicine on health and healing,” and integrative medicine would, then, have a far larger meaning and mission than CAM. If the latter is the case, then this is evidence of subtle disparagement in that they are suggesting that CAM is not a form of “medicine.” If the former is the case, then they are disregarding the fact that CAM has always had a focus on health and healing. Both of these instances are evidence that the authors’ are informed by the intertextual enthymeme in that they either do not regard CAM as medicine, or that they do not regard CAM’s mission at all (which suggests that they do not feel it is necessary, which, in turn, suggests that they see it as inferior).

The second way that the authors suggest that integrative medicine has a “far larger meaning and mission” than CAM is that it “emphasizes the centrality of the patient-physician relationship.” Again, this does not prove that integrative medicine has a “far larger meaning and
mission” than CAM because CAM practitioners have always emphasized the importance of the patient-physician relationships. Again, the authors’ have apparently disregarded this fact. In fact, it seems that it is only by disregarding the basic tenets of CAM that they have been able to make the statement in question. By disregarding CAM’s tenets in this way, they have subtly disparaged CAM; they do not overtly claim that CAM is not important enough to be considered within this statement, but they subtly suggest this.

Disparagement can also be found in the way that the authors promote their own form of medicine above that of CAM. By doing this, they apply to it a false impression of superiority. For instance, Snyderman and Weil conclude by giving several ways that allopathic medicine can “build on its fundamental platform of science and at the same time reposition itself to create a health care system that more broadly focuses on the well-being of patients” (397). One of the points of advice is to “use the best in scientifically based medical therapies whenever appropriate but provide compassion, pay close attention to our patient’s spiritual and emotional needs, and suggest appropriate complementary and alternative approaches when they improve conventional medicine” (Snyderman and Weil 397). This advice suggests that allopathic medicine will be first choice for these healthcare providers. While it is good that they will include CAM in their practice, the order that it was presented suggests that it will not be a first choice. Second, they give allopathic medicine the upper hand when they state that they will “use the best in scientifically based medical therapies,” but they will only “suggest appropriate complementary and alternative approaches.”

There is a contrast here between the choice of the words “use” to describe their actions toward allopathy, and “suggest” to describe their actions toward CAM. While I understand that physicians might be hesitant to “use” a CAM method that is not scientifically proven, for those
methods that are scientifically based, certainly they could “use” them, rather than just “suggest” them. A doctor might protest and say that they can not push these methods on their patients—even if they have been proven—thus, the current language is correct. However, the power of influence that a doctor has is unmatched. She only has to bring the treatment up as a possible therapy and it will more than likely be accepted by the patient. Thus, by stating that doctors should “suggest” CAM rather than “use” CAM, the authors have inferred that it is not really as good as some might claim it to be. This then, is evidence that they are being influenced by the intertextual enthymeme: because allopathy is the most widely used in the United States, it is also the best—it should be “used,” while anything else is merely “suggested.”

There is a second contrast in the adjectives they chose to describe allopathic and CAM methods that ascribes to it an a-medical image. First, they have described allopathic methods as “scientifically based medical therapies” while at the same time they have described CAM as “appropriate complementary and alternative approaches.” The contrast between “scientifically based” versus “appropriate” methods is a strong one, and one that gives allopathic medicine the upper hand in the eyes of other allopathic practitioners and/or anyone who unrealistically values scientifically based medicine over all other methods. Again, there are scientifically based CAM methods, and this point should not be ignored in the literature. The second contrast here is the use of the terms “medical therapies” to describe allopathic methods and “approaches” to describe CAM methods. An “approach,” according to Webster’s, is “a means of attaining a goal or purpose” ("Approach" 67). In juxtaposition to “medical therapies” the term is a-medical; in other words, it has no medical meaning inherent in it as both of the words within “medical therapies”

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7 Scientifically based medicine, also known as Evidence-Based Medicine (EBM), although defined as integrating “the best research evidence with clinical expertise and patient values,” has been critiqued as not valuing clinical expertise or patient values (Kristiansen and Mooney 5-6).
do. By using this word, the authors have stripped CAM of its medical association; thereby reducing it to nothing more than an “approach.” This shows that the authors have been informed by the intertextual enthymeme. In the rhetoric within this passage, they have discounted the medical qualities of CAM and suggested that only allopathy should have the medical association.

*The Mystification of CAM in “Integrative Medicine”*

Another form of rough rhetorical treatment within this article that I would like to discuss is the mystification of CAM. Briefly, authors mystify CAM when they use words, phrases or ideas that create an impression that CAM is mystical, mysterious, innately difficult to understand, among other things. This mystification of CAM causes a negative image of CAM in that its therapies are in some ways magical, or have no explanation to them. For those people who do not believe in magic, or who are convinced by science (most doctors, I’d venture to state), this could cause them to dismiss CAM, and claim it ineffective without giving it the close attention it deserves. As the authors discuss the necessity of including CAM in the new design of healthcare that they propose, they state that patients would “jump at the chance” to talk with an allopathic-trained doctor who was also open to CAM’s foundations for healing. They state that these people want “competent help in navigating the confusing maze of therapeutic options that are available today, especially in those cases in which conventional approaches are relatively ineffective or harmful” (Snyderman and Weil 396, my emphasis).

This phrase that CAM is a confusing maze is one that creates a mystical impression of CAM. According to Webster’s, the word “maze” comes from the Middle English word *masen*, which means to confuse, or to puzzle (838). Certainly, there are still some remnants of this meaning in the sense that these authors used this word. They, obviously, refer to the noun form of maze—“a confusing, intricate network of winding pathways” (838). Growing up, we
learn that a maze is a puzzle with a path that leads to the end of the trail, and many paths that lead to dead ends. Thus, to suggest that CAM is a “maze” suggests that there are starts and stops; there are roads that lead somewhere, but there are also dead-ends. If a maze is something that one is inside, it seems endless and the confusion is intensified because they can see nothing but the spot around which they stand. Certainly, a person standing inside of a maze would be mystified by it. But the authors refer to this maze as a “confusing maze.” Considering that a maze is defined as “a confusing . . . network of pathways,” and that our understanding of a maze from childhood is that it is a confusing puzzle, these authors have emphasized the fact that it is confusing. Hence, they have mystified CAM in this way.
IV. CONCLUSION

Although CAM’s reputation is growing, and allopathic practitioners are beginning to see its potential for healing, its reputation is still not strong, especially among allopathic practitioners. Because of this, it is important to be sensitive to the ways in which reputations are established. I have pointed out four in the analysis of the article within this section: name switching, mystifying, disparaging terms and/or phrases and unfair contrasts. While it may seem in some cases that I was splitting hairs, I was not. What lies in the subtleties of our speech often reveals what is embedded deeply in our minds whether we know it consciously or not. What lies in the subtleties of our speech often reveals the extent to which a particular hegemony has saturated our ideologies. Unless we consciously make an attempt to change our speech concerning CAM, true change will not occur.

Future Research

This study focused on the rhetoric within the exclusive community of physicians and their mentors because their ideas tend to trickle down into society, affecting the attitudes and beliefs of the typical citizen. However, there is a need for further study on this topic. For instance, it would be beneficial to look at physicians’ rhetoric on CAM as it is discussed with their patients in the doctor’s office, to ascertain whether the underlying biases differed from those found in text, or to what extent the doctor’s advice was taken. At the same time, it would be interesting to see the representation of CAM within the layman’s rhetoric. Would that rhetoric mirror those in the medical profession, or would there be fewer underlying biases? While it would certainly be more costly, it would also be beneficial to trace through the cultural circuit the influence that the integrative medical field has on society, especially as it pertains to CAM. It would be interesting to see the response to CAM within a community where an
integrative medical clinic had been established, and to compare that to a community where no integrative health care clinic existed. Certainly, the outcome of any of these types of studies would be evidenced in the rhetoric first.
WORKS CONSULTED


