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HACIA NUEVOS MODELOS DE ATENCIÓN EN SALUD: LA INTEGRACIÓN DE LAS MEDICINAS NO CONVENCIONALES

Towards new models of health care: the integration of non-conventional medicines

Cristina Guadalupe Carrillo Sánchez[1]**:** Universidad Autónoma de San Luis Potosí. México.
a309413@alumnos.uaslp.mx

Leonardo Ernesto Márquez Mireles: Autónoma de San Luis Potosí. México.
leonardoemm@uaslp.mx

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Resumen

Existe una demanda de una diversidad de sistemas y modelos terapéuticos que se muestran subordinados ante el modelo médico hegemónico, como eje rector de la eficacia y seguridad. En la mayoría de los discursos internacionales e investigaciones se plantea una disputa entre dos sistemas: el biomédico o convencional y las denominadas medicinas no convencionales. Este artículo tiene como objetivo discutir los términos relacionados con las denominadas medicinas no convencionales y las implicaciones de establecer las prácticas biomédicas como mecanismo de validación en la articulación de las medicinas no convencionales en el sistema de salud. Para dicho propósito, el estudio se basa de fuentes documentales. Se consultaron metabuscadores y buscadores genéricos como Google Scholar para la exploración de artículos originales y de revisión elaborados en el periodo 2002 y 2020 en español, inglés y portugués. En primer lugar, se describe la incorporación de las medicinas no convencionales en los discursos de la OMS y la OPS como actores relevantes que alinean las políticas nacionales sobre las medicinas no convencionales; en segundo lugar, se presenta una discusión sobre las principales diferencias en el uso de los términos relacionados con las medicinas no convencionales: alternativa, complementaria e integrativa y,

[1] **Cristina Guadalupe Carrillo Sánchez**: Universidad Autónoma de San Luis Potosí. Maestra en Sociología de la Salud. Estudiante de Doctorado en Estudios Latinoamericanos en Territorio, Sociedad y Cultura.

finalmente, se exponen las implicaciones de establecer los criterios metodológicos de la biomedicina como elemento de validación de las medicinas no convencionales.

Palabras clave:

Terapias Complementarias, Medicina Integrativa, Integración de Sistemas, Pluralismo Médico.

Abstract

There is a demand for a diversity of therapeutic systems and models that are shown to be subordinate to the hegemonic medical model, as the guiding axis of efficacy and safety. In most international discourses and research, a dispute arises between two systems: the biomedical or conventional and the so-called non-conventional medicines. This article aims to discuss the terms related to the so-called non-conventional medicines and the implications of establishing biomedical practices as a validation mechanism in the articulation of non-conventional medicines in the health system. For this purpose, the study is based on documentary sources. Metasearch engines and generic search engines such as Google Scholar were consulted for the exploration of original and review articles prepared in the period 2002 and 2020 in Spanish, English and Portuguese. In the first place, the incorporation of non-conventional medicines in the discourses of the WHO and PAHO as relevant actors that align national policies on non-conventional medicines is described; secondly, a discussion is presented on the main differences in the use of terms related to non-conventional medicines: alternative, complementary, and integrative and, finally, the implications of establishing the methodological criteria of biomedicine as a validation element are exposed. of non-conventional medicines.

Keywords:

Complementary Therapies, Integrative Medicine, Systems Integration, Medical Pluralism.

1. INTRODUCTION

This article is based on the need to recognise that in all societies there are different ways of understanding and experiencing the health-illness-care process, and with it, different forms of prevention, diagnosis, treatment and rehabilitation that offer technical as well as social and subjective solutions (Haro, 2000; Kleinman, 1978; Perdiguero-gil, 2006).

While this medical, care or therapeutic pluralism is dominated by so-called conventional medicine (CM), which throughout the document is defined as biomedicine, considering it as one of the main producers of ideology and hegemony (Menéndez, 2015) that conceptualises biological or psychobiological anomalies as the main cause of illness and undermines its social and cultural causality (Martínez, 2011); it cannot be denied that other medical systems and models are recurrent and may impact on access to health care, whether due to cultural, economic, geographic or ideological factors. The latter, if, like Andersen and Davidson, access is thought of as the actual use of health services and all that facilitates or impedes their use in relation to the contextual characteristics of both the health system and the community, individual characteristics such as education, occupation, ethnicity, interactions and social relations; perceived needs of the user, health beliefs manifested in attitudes, values and people's health-illness knowledge, lifestyles and behaviours towards self-care and adherence to treatment, and health outcomes based on the user's perception of health status (Andersen & Davidson, 2007).

By taking into account the right to health in all its forms, including culturally appropriate care that encompasses local, national and global contexts and knowledge transactions, as well as the role of the state in protecting the population from potential health risks, the recognition of a diversity of notions of health, illness, diagnosis and treatment becomes a necessary mechanism (Stuttaford et al., 2014).

In 2019, the World Health Organization (WHO) published an update of its global report on traditional and complementary medicine (TCM), reporting that acupuncture is the most common therapeutic practice being present in 113 Member States, followed by the use of herbal medicines in 110 countries and indigenous traditional medicine practices used in 109 countries. In addition, 100 Member States reported the use of homeopathy and traditional Chinese medicine (TCM), 82 countries reported the use of Unani medicine and more than 100 countries reported the use of naturopathy, chiropractic, osteopathy and Ayurvedic medicine, in that order (WHO, 2019).

In relation to T&CM practitioners, it was reported that only 78 Member States enacted some form of regulation on who practises these practices. In addition, it was reported that the most frequently regulated practitioners were indigenous TM practitioners, with regulation in 36 countries, followed by physicians providing acupuncture and chiropractic services, who are regulated in 30 and 26 countries, respectively. While WHO data indicate that there is undeniable demand for therapeutic forms and models that differ from those offered by the formal health system, it is essential to understand how these therapeutic models are recognised and the progress made in articulating them in national health programmes (WHO, 2019).

Therefore, the aim of this article is to discuss the terms related to the so-called non-conventional medicines (NTCMs) and the implications of establishing biomedical practices as a validation mechanism in the articulation of NTCMs in the health system. Based on the literature review, firstly, the incorporation of NQMs in the discourses of the WHO and the Pan American Health Organization (PAHO) as actors aligning national policies on NQMs is described; secondly, a discussion is presented on the main differences in the use and interpretation of the terms related to NQMs: alternative, complementary and integrative; and finally, the implications of establishing the methodological criteria of biomedicine as an element of validation of NQMs are examined.

2. METHODOLOGY

This study was developed from secondary sources. In the first instance, we consulted various WHO and PAHO documents as international organisations that have proposed the integration of other models of care as part of health systems. Secondly, meta-search engines (PubMed, the Virtual Health Library [VHL], specifically the database managed by the Traditional, Complementary and Integrative Medicine Network of the Americas [Red MTCI], and generic search engines such as Google Scholar) were consulted to explore original and review articles produced in the period 2002-2020 in Spanish, English and Portuguese. This, considering the first WHO strategy on TM (2002). However, after reviewing the texts, we searched for the references of the articles that were considered to be relevant background to the research found.

The search was conducted using the following descriptors: non-conventional medicines, alternative medicine, complementary medicine, alternative and complementary medicine, and integrative medicine; and their corresponding English translations. We identified 769 articles on complementary and alternative medicine (CAM) and 379 articles on integrative medicine. The selection of articles was made by reading the abstracts, choosing those that discussed the terminology of CAM and IM, their characteristics and their relationship with biomedicine. Thus, 37 references were integrated, mainly editorials, letters to the editor, debates, essays and literature reviews, and clinical studies, meta-analyses and empirical analyses on the efficacy of NQFs were excluded.

The works referred to in the conceptual delimitation and debate on the relationship between biomedicine and other alternative, complementary and integrative medical models are listed in Table 1.

Table 1.
Articles analysed on the conceptual delimitation of so-called non-conventional medicines

Author(s)	Year	Country	Language
Eisenberg	1993	United States	English
Menéndez	1994	Mexico	Spanish
Angell y Kassirer	1998	United States	English
Fontanarosa y Lundberg	1998	United States	English
Rosch	1998	United States	English

Zollman y Vickers	1999	England	English
Ernst	2000	England	English
Kaptchuk y Eisenberg	2001	United States	English
Tonelli y Callahan	2001	United States	English
Ernst	2002	England	English
Barret *et al.*	2003	United States	English
Duarte	2003	Mexico	Spanish
Menéndez	2003	Mexico	Spanish
Tovey, Easthope y Adams	2003	England & Australia	English
Borrell I Carrió	2005	Spain	Spanish
Barry	2006	England	English
Caminal, Rodríguez y Molina	2006	Spain	Spanish
Cernadas	2006	Argentina	Spanish
Coulter y Willis	2007	United States & Australia	English
Alfonso, Albarracín, Caminal y Rodríguez	2008	Spain	Spanish
Maizes, Rakel y Niemiec	2009	United States	English
Keshet	2009	Israel	English
Hollenberg y Muzzin	2010	Canada	English
Otani y Barros	2011	Brazil	Portuguese
Templeman y Robinson	2011	Australia	English
Wieland, Manheimer y Berman	2011	Estados Unidos	English

Dalcanale Tesser y Carvalho De Sousa	2012	Brasil	Portugués
Istúriz, Acevedo y Jiménez	2012	Cuba	Español
Ning	2012	Canadá	Inglés
Schveitzer, Esper, y Paes da Silva	2012	Brasil	Portugués
Rojas, Silva, Sansó y Alonso	2013	Cuba	Español
Gale	2014	Inglaterra	Inglés
Ng, Boon, Thompson y Whitehead	2016	Canadá	Inglés
Cant	2017	Inglaterra	Inglés
Crocker *et al.*	2017	Estados Unidos	Inglés
Pegado	2019	Portugal	Portugués
Nunesa y Louvisonb	2020	Brasil	Inglés

Source: *Own elaboration.*

3. INTERNATIONAL DISCOURSES ON OTHER MEDICAL MODELS AND SYSTEMS

The consideration of models and forms of care other than biomedical thinking, understood as an essential element to address the health needs of the population, has as its first reference point the International Conference on Primary Health Care, held in 1978 in Almaty, Kazakhstan, in what was then the Union of Soviet Socialist Republics (USSR). This event promoted primary health care as a strategy to address health inequalities, including the integration of TM practitioners as part of community health teams (WHO, 1978).

Subsequently, in 2002, the WHO published its strategy on traditional medicine, addressing two concepts antithetical to the biomedical model: TM and CAM. Firstly, TM encompasses manual, spiritual, herbal, mineral and animal-based systems, therapies and practices; and secondly, CAM is defined as a set of practices and therapies that do not belong to a country's own tradition, nor are they part of its health system (WHO, 2002). These clarifications become problematic when establishing that the main distinction between the two concepts is their application and origin in developing and developed countries (Caminal *et al.*, 2006). In this sense, the WHO related TM to regions such as Africa, Latin America, Southeast Asia and the Western Pacific, associating its use and origin to historical and cultural circumstances, beliefs, and the accessibility and affordability it represents for the population in these regions. On the other hand, he pointed out that, for Europe, Canada, the United States and Australia, the term MT transmuted to MAC; justifying its use as part of a questioning of users towards biomedicine and a concern about the adverse effects of medicines (WHO, 2002).

Twelve years later, the WHO presented an update of its Strategy on Traditional Medicine (2014-2023), where it redefined TM as the sum total of knowledge, skills and practices based on the theories, beliefs and experiences of different cultures, whether explainable or not, used to maintain health and prevent, diagnose, ameliorate or treat physical and mental illness (WHO, 2013). Although this new definition recognises the complex, symbolic and cultural nature of other systems and models of care, throughout the document there is a tendency to encompass everything that is excluded from biomedical practice and knowledge as part of the same concept, which in this strategy is implemented through the merging of two terms: traditional and complementary medicine (TCM). This is of utmost importance, considering that the WHO has not established clear differences between what it calls TM and CAM, at least not beyond what is institutionalised or incorporated in health systems and what comes from the tradition of each country. It is from the ambiguity generated by the definition and distinction of these terms that, in international discourses on the integration of traditional medicine as a resource of health systems, the so-called CAM is intertwined.

From this perspective, it is possible to appreciate how, from the international discourses, two essential points are established to discuss the issue of the integration of MNCs in health systems. The first position is based on the search for strengthening universal coverage through the integration of NQF practices and professionals in primary health care (WHO, 1978, 2002, 2002, 2008, 2013, 2018), especially because of the correspondence it presents with the values of primary health care, i.e., person-centred care, the preventive approach to diseases and the promotion of autonomy and the right of the user (Dalcanale and Carvalho, 2012; Mendes *et al.*, 2019).

This first position can also be observed in general terms in the United Nations (UN) 2030 agenda, which added the guarantee of a healthy life and the promotion of well-being as goal 3. Thus, target 3.8 links universal coverage to financial risk protection and access to quality, affordable, safe and effective health services. This opens the discussion as to what elements are included in these health services, whether the vision of health can have a holistic perspective from this wellbeing discourse and whether it is possible to help avoid out-of-pocket expenses related to health models outside the hegemonic model, especially in terms of palliative treatments.

The second position is linked to the recognition of multi-ethnic diversity, the revaluation of culture and the rescue of TM knowledge, which may correspond to the implementation of the intercultural approach to health (ILO, 2014; WHO, 2008).

4. CONCEPTUAL DELIMITATION: NON-CONVENTIONAL MEDICINES, ALTERNATIVE MEDICINE, COMPLEMENTARY MEDICINE AND INTEGRATIVE MEDICINE

While there is no consensus term or universal definition, rather a notion that is adapted to the socio-cultural and health conditions and needs of countries (Kaptchuk and Eisenberg, 2001), it is possible to find a wide variety of terms that have been used both to legitimise and delegitimise those therapeutic and diagnostic practices that are not part of the hegemonic medical system and that indicate ideological and power implications between different medical systems and models, especially when their definition indicates exclusion or otherness in relation to CM (Cant, 2017; Coulter and Willis, 2007; Gale, 2014). In this sense, one of the few consensuses around so-called NQFs is to recognise their lack of clarity both terminologically and taxonomically (Alonso *et al.*, 2008; Caminal et al., 2006; Gale, 2014; Pegado, 2020).

According to a review of the literature, the most commonly used appellatives in academia that refer to other medical systems, models of care or therapeutic practices are: "unconventional", "alternative", "complementary" and "integrative". These differ from other terms in that they do not carry a negative connotation, but rather allude to a link to biomedicine (Ng *et al.*, 2016). As a critique of the above, Gale (2014) questioned the neutrality of these appellations. On the one hand, he noted the difficulty of lumping together a wide variety of medical systems, practices and therapeutic products, which, while they may have similarities, can also have significant differences between them. On the other hand, he exposed the symbolic violence behind these terms, which, rather than an articulation with biomedicine, highlights its dominance and dualism in the medical field.

Another aspect to be mentioned is that this dichotomous comparison is also used to establish some characteristics attributed to so-called MNCs, which biomedicine lacks. In this case, reference is made to a comparison between a holistic, individualistic (a particular treatment), intuitive and empowering vision of NQMs vs. a vision of reductionism, generalisation, deduction and control of the patient's treatment exercised by biomedicine (Barrett et al., 2003).

For their part, Coulter and Willis (2007) pointed out that one of the characteristics that seems to link the NQM universe is vitalism, which supports an approach called vis medicatrix naturae (the healing power of nature), meaning that the body tends to heal itself. Under this approach, the physician only facilitates the healing of the body (Coulter and Willis, 2007). Such generalisations encourage assigning the same characteristics to all NQFs, even when they have manifested substantial changes in their practice.

Another example is the promotion of user autonomy as an attribute granted to CM. This autonomy is reflected in taking responsibility for one's own well-being. However, Menéndez (2003) pointed out that asymmetry in the doctor-patient relationship is not only present in biomedicine, but also in other medical systems and is even conceived as necessary for healing. In view of this, Ning (2012) alluded to the need to discard binary oppositions, especially when we are not faced with a debate between two unique medical systems or models (biomedical vs. alternative-complementary) that appear to be opposed due to their scientific validity (Rojas *et al.,* 2013), but rather with various worldviews of health-illness with their respective diagnostic and therapeutic constructions (Duarte, 2003). In this way, it is recognised that the different medical systems and models, including biomedicine, are social products that influence each other and are mutable based on the needs of the population (Tovey *et al.,* 2003).

To illustrate the above, it was considered relevant to place special emphasis on the evolution of the terms applied in the NQF research centre in the United States, a reference in this area. In 1998, the National Center for Complementary and Alternative Medicine (NCCAM) mentioned integrative medicine in its reports with the intention of positioning it as an objective of the institution, as can be seen in the following statement:

> As CAM interventions are incorporated into conventional medical education and practice, the exclusionary term "complementary alternative medicine" will be replaced by the more inclusive term "integrative medicine". Integrative medicine will be seen as providing novel knowledge and tools for human health, practised by health care providers trained and knowledgeable in the multiple traditions and disciplines that contribute to the healing arts. (NCCAM, 2000, p. 5)

Years later, the centre changed its name to The National Center for Complementary and Integrative Health (NCCIH), noting that the modification not only reflected the institution's commitment to researching more promising approaches to health, but also the changing consumption of its population. With this modification, the institution defined the concept of integrative medicine as follows:

> A style of practice that places a strong emphasis on a holistic approach to patient care while focusing on reducing the use of technology. Physicians who advocate this approach generally include selected complementary practices in the care they provide to patients, and many have established settings that include complementary practitioners. (National Center for Complementary and Integrative Health, 2016, p. 6)

Similarly, in 2017, the WHO's Traditional and Complementary Medicine Unit changed its name to the Traditional, Complementary and Integrative Medicine Unit. This indicates consideration of the debates surrounding the concepts of TCM, particularly in noting that it maintains a project aimed at defining and understanding integrative medicine (WHO, 2019).

Based on the above, the following question was asked: What is enunciated when any of the terms alternative, complementary, integrative, unconventional are referred to, and can they be used equivalently? In response to this, four general positions were considered.

The first recognises the unique rationality of other medical systems or models of care present in the different meanings, values and both technical and socio-cultural terms about health, illness and treatment that are exercised on and by the user population (Menéndez, 1994). For example, Borrell (2005) stated that alternative medicine is sustained as a matter of a person's desire or will to justify illness, or to seek solutions to illness by means of theories that are unassailable by scientific logic. Consequently, the author defined alternative medicine as "clinical practice that acts on the basis of a single model of illness, that is, a model that seeks to explain all the complexity of health and illness, and a model that also shuns verification and falsification" (Borrell, 2005, p. 311).

The second position uses the terms unconventional medicine, alternative medicine and complementary medicine without distinction, demarcating them from what they are not (Ng et al., 2016). That is, they are those medical systems or therapeutic or diagnostic practices that are not part of the official health system, of schooled medical practice, and do not have scientifically considered support for their efficacy, effectiveness and safety (Eisenberg et al., 1993). In the same vein, Zollman and Vickers defined complementary medicine as a group of therapeutic and diagnostic disciplines that exist largely outside institutions where conventional medical care is taught and delivered. They also mentioned that between 1970 and 1980, these were usually provided as a treatment option distinct from biomedical offerings, and thus became collectively known as alternative medicines. However, over the years and under the notion of complementing two distinct medical systems, the concept of complementary medicine began to be used, although this adaptation was not applied by all researchers (Zollman & Vickers, 1999).

In this regard, Coulter and Willis expressed that the term "alternative" may imply a primary role in health care, as it is understood as a replacement for the biomedical model. In contrast, the appellation "complementary" exposes a secondary role of other diagnostic and therapeutic conceptions (Coulter and Willis, 2007). For their part, Wieland et al. (2011) proposed an operational definition to clarify the characterisation of systems, therapies, practices or modalities encompassed by CAM, based on three criteria:

1. The therapeutic practice is based on theories of a medical system outside the Western allopathic model, then (from the current US and European perspective) it is labelled as MAC.

2. The therapy or practice is standard for a medical condition and accepted by the mainstream medical system. That is, the therapy or practice is accepted when there is government authorisation of its practitioners, it is covered by health insurance, and it has recommendations or practice guidelines. It is important to note that, under this criterion, a treatment-condition linkage must be made, because the same treatment may be standard for one condition, but 'alternative-complementary' for another.

3. Self-care therapies and therapies that are not administered by conventional physicians or in a hospital setting.

Despite the above criteria, the authors recognised that defining OMCs from a biomedical perspective is limited by the fact that this perspective changes over time and, with it, the line of demarcation between biomedicine and medicines or therapeutic practices that are conceived as external to hegemonic medical practice. In other words, by establishing that OMCs depend on the evidence accepted by the dominant system, which consists mainly of the application of the same

methodological criteria as biomedicine, then the identification of their therapies and practices would require periodic re-evaluation as the evidence increases and changes over time, and the dominant system incorporates them into both its practice and its principles. Additionally, the authors considered that validated evidence, or even the absence or paucity of evidence, should not be a criterion for identifying CAM, given that there are currently treatments emerging from conventional medicine that also lack sufficient evidence of efficacy. Likewise, there are therapies considered to be CAM that have studies supporting their efficacy for certain medical conditions (Wieland *et al*., 2011).

The third position denies as necessary the practice of systems or models of care other than the biomedical one. In this position, a critique was identified based on showing as antagonistic any practice that is far removed from hegemonic medical thinking. Thus, Fontanarosa and Lundberg stated in their study, Alternative medicine meets science, that there is no such thing as alternative medicine. Although the authors acknowledged the existence of a wide variety of practitioners of other forms of medicine, their narrative sought to point out that medical practice should be that which demonstrates its safety and therapeutic efficacy through rigorous scientific method, and if it does not pass validation standards, its sole purpose is justified by its cultural and historical interest (Fontanarosa & Lundberg, 1998). In the same vein, Angell and Kassirer (1998) confirmed that the existing separation between what is considered alternative medicine and so-called conventional medicine is proven safety and efficacy. Therefore, the authors denied that the scientific method can be applied to alternative remedies and invalidated the speculations, testimonies and anecdotes that verify the efficacy of such forms and models of care. Under such a scenario, they placed special emphasis on the need to subject any therapeutic practice to the same scientific tests to which biomedicine is subjected (Angell & Kassirer, 1998).

Under these positions, the main differences between conventional medicine or biomedicine and the so-called MNCs are, firstly, the diversity of worldviews of the health-disease process, aetiological factors and their own diagnostic models. Secondly, the methodological framework that supports their efficacy and safety, based on hegemonic medicine and its narrative legitimised by a hegemonic form of knowledge (Nunesa & Louvisonb, 2020). Therefore, until the same methodological practices are applied as biomedical medicine, they are not considered for horizontal integration into health systems.

Finally, the fourth position alludes to the term and model of integrative medicine, which unlike the previous terms, its definition describes the characteristics of a new model of health and wellbeing where biomedicine is merged with NQM practices and therapies that have been validated from scientific standards of the mainstream system (Ng *et al*., 2016). Beyond a combination of therapies considered, until now, complementary, it aims to offer treatment options to the patient; as well as humanised and holistic care underpinned by evidence that approves the efficacy of the interventions. It is therefore considered by some as a new health paradigm (Otani & Barros, 2011).

In this regard, Templeman and Robinson indicated that the articulation of biomedicine and NQFs may present different levels of equity, power, autonomy and control. This may depend on the selection of evidence which, on the one hand, may be a combination of evidence based on biomedical criteria plus the integration of experience-based evidence from both biomedical practitioners and non-conventional medicines. On the other hand, there may be a selective incorporation of non-conventional therapeutic practices that have been endorsed exclusively by biomedical criteria (Templeman & Robinson, 2011).

While the term integrative medicine has been approached by various authors as a new model of care oriented towards the well-being of the user (Crocker et al., 2017; Maizes *et al.*, 2009; Rosch, 1998; Schveitzer *et al*., 2012), Hollenberg and Muzzin (2010) criticised the epistemological implications around integrative medicine and considered that a biomedical perspective still dominates this model because of the following:

> Currently, biomedicine devalues Complementary Alternative Medicine (CAM) knowledge; focuses exclusively on positivist evidence; fails to comprehensively understand CAM paradigms; and is more interested in its technical value. (Hollenberg & Muzzin, 2010, p. 52).

The authors also pointed out that the subordinate relationship between biomedicine and NQFs is observed from the appropriation paradigm and the assimilation paradigm. In the former, biomedicine appropriates some aspects of other medical systems without acknowledging the original worldview from which a certain practice, therapy or product was taken. In doing so, it is notable that the biomedical diagnostic perspective is prioritised over the NQM perspective, but the healing technique is maintained. In terms of the assimilation paradigm, biomedicine takes over all knowledge from another medical system and reinterprets it, giving it new terms and meanings (Hollenberg & Muzzin, 2010).

If this critique is considered, could it really be implied that the practice of a different model of health is being analysed and integrated? In relation to this, Menéndez (2020) emphasised that the implementation of other therapeutic proposals as a counter-hegemonic strategy has not generated substantial changes in the biomedical model. Rather, these are aligned and appropriated by biomedicine through its constant pragmatism. An example of this is chiropractic in countries such as Australia or New Zealand (Dew, 2003), or midwifery in Mexico (Argüello & Mateo, 2014; Güémez, 2007).

5. EVIDENCE AS A LEGITIMISING ELEMENT OF NON-CONVENTIONAL MEDICINES

One of the difficulties in discussing the practice and integration of NQFs in healthcare systems is the generation of evidence. In this regard, two general positions have been considered that reflect the perception of the biomedical field. On the one hand, there are both researchers and biomedical professionals who insist on the application of principles and standards that are considered rigorously scientific. On the other hand, those who defend the possibility of using different methods to test the efficacy of treatments considered non-conventional, arguing that there are therapies, practices or treatments that cannot be subjected to a method considered scientific, specifically from a clinical setting (Keshet, 2009).

The first position holds that any type of treatment, therapy, product or diagnostic or curative practice must be validated by the application of rigorous standards of scientific research that can prove its safety and efficacy (Ernst, 2000, 2002; Fontanarosa & Lundberg, 1998). The latter is inevitably associated with Evidence-Based Medicine (EBM), whose principles include using the best available evidence to decide whether a given treatment, procedure or intervention can be applied, which necessarily implies the hierarchy of evidence (Manterola *et al.,* 2014; Sackett, 1996).

While it is not the aim of this article to elaborate on the different classifications of levels of evidence, it was considered relevant to mention that this ranking takes into account the validity, methodological quality and potential for bias of the research. This places the randomised controlled trial at the top as the best evidence, followed by the non-randomised controlled trial, cohort, case-control studies, comparisons over time with or without intervention, and descriptive studies or expert committee reports based on clinical experience. Given this need for rigorous evidence, which is also focused on a purely clinical aspect, Keshet (2009) noted that biomedical discourse seeks to secure its dominant position through discursive practices based on emphasising the scientific qualities that distinguish its field and practice from those that are considered less scientific and therefore have less jurisdiction in the medical field.

The second position holds that the methods for gaining knowledge in a healing art must be consistent with its underlying understanding and theory of disease (Tonelli & Callahan, 2001). In this regard, Keshet (2009) mentioned that diverse research designs are needed to evaluate the broad spectrum of techniques and products of non-conventional medicines, as it is impossible to examine the efficacy of some of their modalities, e.g. mechanical therapies such as massage, through double-blind trials or randomised clinical trials. Under this consideration, evidence supporting the efficacy and safety of some NQT modalities can be built through case studies or observational studies, especially if it goes beyond clinical efficacy, considering also symbolic efficacy. The latter is understood from the doctor-patient relationship, in terms of the belief in the aetiology of the disease, the belief in the quality or healing power of the doctor and, therefore, of the treatment, and the acceptance of these beliefs by a specific group. In this sense, the translation of a disease into an intelligible reality for the patient will be of vital importance (Cernadas, 2006).

In addition, Keshet (2009) acknowledged that some alternative practitioners oppose the idea of integrating their therapeutic practices into mainstream medicine for fear of losing their unique philosophy if their practices are researched in biomedical terms. This aligns with the critique of hegemonic health thinking, which is seen as colonising the knowledge of diverse collectives (Nunesa & Louvisonb, 2020), appropriating diverse concepts at the expense of the depth and explanatory burden it originally held (Istúriz *et al.*, 2012). Undoubtedly, this argument is interesting in this research, since, at the time of the search for information, the research and scientific articles found focused on the perspective of conventional doctors answering questions such as: Why do they integrate non-conventional medicines into their practice?[(63-66)]. This is understood as an exclusion of the voice of the practitioners themselves of so-called alternative models and forms of care.

Barry (2006) placed special emphasis on the need to apply other research methodologies that not only focus on the physiological effects of a treatment, but also on the effects of alternative therapeutic practices on beliefs about health, healing and illness, transitions in the meaning of illness, experiences of spiritual healing, or the relationship between patient and therapist. This, with the intention of understanding what effectiveness is for alternative therapists, as well as for patients who come to these types of therapies, who continue their treatments and confirm an improvement in their wellbeing.

Another argument against the construction of evidence from the criteria of the biomedical system is that it can have a deeply political interpretation. On the one hand, it can be used as a means to legitimise its domination of the medical field by setting the standards of what is considered safe

and effective. On the other hand, there has been an interest in research into those therapies or modalities that appear to be economically viable, for example, herbalism (Barry, 2006).

Barry also stated that NQF evidence is considered therapeutically effective for biomedically diagnosed disorders or conditions and as measurable through research strategies based on what is considered science through the randomised clinical trial. Therefore, this type of evidence only works when the therapy has mutated into a medicalised version, which implies that it has been stripped of its philosophy or principles of reference (the worldview of illness, its models of prevention and diagnosis, the role of the therapist or practitioner). From this point of view, the author pointed out that the need for rigorous evidence based clinical trials can act as a reformulation of the very nature of a therapy considered unconventional, generally in the direction of medicalisation (Barry, 2006).

From another perspective, Tesser and Dallegrave took up Ivan Illich's 1978 work Medical Nemesis to discuss the medicalisation function of non-conventional medicines. Thus, beyond referring to the application of biomedical criteria in research, they focused on the role and interaction of the user with the different therapeutic practices and knowledge. In this way, they concluded that medicalisation can occur in any rationality or medical knowledge when the user loses his or her autonomy and generates dependence on treatments and professionals (Tesser & Dallegrave, 2020).

6. CONCLUSIONS

To conclude, it is worth noting the difficulty implicit in attempts to provide a global definition of the various medical systems, models and therapeutic products, especially when they are understood as unalterable to historical, social, economic, cultural, and, as described above, epistemological changes of both practitioners and consumers. Thus, for example, Menéndez (1994, 2003, 2015, 2020) suggested the need to understand the various forms of healing and diagnosis, beyond their technical rationality, because these can be interpreted, adapted and, as described, subordinated according to the needs of biomedical practice. Therefore, it is also necessary to make an analysis of the socio-cultural rationalities that are established with the subjects who attend to their ailments.

This highlights the need to break with the dichotomous schemes that persist when it comes to integrating other forms and models of care. While it is essential to offer users a range of safe treatments, it is also essential to provide the necessary conditions for them to cover their health needs, despite the fact that they come from worldviews or medical rationales that differ from the biomedical model. In this respect, Eddowes stated that it is not a question of who cures the evil best, but why the evil comes and how to eradicate it (Eddowes, 1985). In this sense, priority should be given to users' experiences, beliefs and knowledge about health-illness, as well as their role and interaction with the diverse range of medical models and systems on offer.

The WHO (2002) also mentioned that traditional, complementary and alternative medicine elicits a wide range of reactions, from uncritical enthusiasm to uninformed scepticism. This was observed in articles generalising certain virtues as an essential part of MNCs or certain generalising weaknesses of biomedicine, which might even also correspond to elements external to its postulates such as the health infrastructure of countries. The truth is that one cannot succumb to the different ways of understanding and caring for health, as both have limitations, strengths and, most importantly, each can contribute to the well-being of the individual by meeting different needs.

Finally, it is proposed that the discussion of the terminology surrounding NQFs is relevant, as it demonstrates the primacy of biomedicine over other therapeutic and diagnostic practices. On the other hand, the recognition of therapeutic diversity leads to a glimpse of how the hegemonic medical model is being challenged, especially in terms of the behaviour of both users and health professionals. The latter can be seen in the discourses surrounding the integrative medicine model, which, by assimilating and including certain elements of NQM, modifies its practice for the benefit of the user. Although some criticisms of this model were made, beyond pointing out the authority of one medical model over another, it is necessary to reflect on new forms of articulation that promote equity between different health knowledge.

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Conceptualisation: Carrillo Sánchez, Cristina Guadalupe **Writing-Preparation of the original draft**: Carrillo Sánchez, Cristina Guadalupe. **Writing-Revision and Editing**: Márquez Mireles, Leonardo Ernesto. **All authors have read and accepted the published version of the manuscript.**

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AUTHORS

Cristina Guadalupe Carrillo Sánchez
Master's degree in Sociology of Health. PhD student in Latin American Studies in Territory, Society and Culture. Currently studying health policies around traditional medicines, complementary alternative medicines and integrative medicine.
Orcid ID: http://orcid.org/0000-0003-0377-4442
Google Scholar: https://scholar.google.com.mx/citations?hl=es&user=V5h_b38AAAAJ

Leonardo Ernesto Márquez Mireles
Full-time Research Professor at the Faculty of Social Sciences and Humanities of the Autonomous University of San Luis Potosí. Researcher in cultural ecological studies on peasants, rural development, anthropology of food.
Orcid ID: http://orcid.org/0000-0001-6732-8156
Google Scholar: https://scholar.google.com.mx/citations?user=oHxOIUsAAAAJ&hl=es