In Theory

Negotiating Integrative Medicine: A Framework for Provider–Patient Conversations

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Efforts to integrate complementary and alternative medical (CAM) therapies into conventional medical settings are creating a variety of negotiation challenges between various stakeholders. Focusing on the two-party encounter between physician and patient offers a way to understand the application of principled negotiation to perhaps the most fundamental and emotionally charged place within the health care system in which the introduction of CAM therapies is likely to disrupt relationships and produce conflict. This article suggest ways in which the theory and analysis of principled negotiation can add to current liability and ethical frameworks, and might thereby contribute to optimal future health care by helping to wisely integrate CAM therapies into conventional medical care.

The inclusion of complementary and alternative medical (CAM) therapies, such as chiropractic, acupuncture and oriental medicine, massage therapy, and herbal medicine, into conventional medical therapies is creating an escalating series of unresolved, and perhaps largely unrecognized, negotiation challenges among the various players in the U.S. health care system — most notably doctor and patient. Such negotiation

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challenges, while historically endemic to the development of medicine and the health care professions in this country, present new puzzles and possibilities.

The practice of medicine in the United States began as competition among groups of rival sects, each advancing different theories and services in an unregulated environment (Rothstein 1972; Cohen 1998). By the late nineteenth century, scientific medicine had begun to triumph over political, philosophical, and economic competitors such as homeopathy and herbal medicine. Through the enactment of medical licensing laws, which controlled whether providers with specified training could be given a state license to practice medicine, scientific or so-called regular medicine assumed a position of legally sanctioned dominance in health care, and ultimately evolved into the "conventional" medical care we know today (Cohen 1998).

"Conventional" care has become the standard in hospitals and other modern health care facilities. Philosophically, this type of care is rooted in Cartesian dualism: the notion that the *outer* world of the body is objective and amenable to rigorous scientific inquiry, while the *inner* world of the mind is subjective and only marginally accessible; and in Newtonian physics, with its understanding of the body (and heavenly bodies) as objectively analyzable in terms of mechanical parts and laws. Thus, at least in the U.S., an individual visits a licensed medical doctor first for conventional diagnosis and treatment. Conventional medical diagnosis follows scientific principles by classifying diseases into standard categories, and conventional medical treatment typically relies on technologically validated mechanisms such as prescription pharmaceuticals and surgery to cure the diagnosed disease. The process is characterized, some critics would argue, by reductionism — the reduction of a complex individual to a standardized disease category; and mechanism — the reduction of complex interactions of emotions, physiological processes, environmental influences, and even, perhaps, spiritual forces, to engineering changes among a series of parts (Cohen 1998).

This system of conventional care typically excels in treating acute and emergency conditions, but it is less successful with chronic diseases and with diseases that have multifaceted causes and symptoms. Furthermore, diseases such as AIDS, chronic fatigue, and cancer have challenged the dominance of conventional care and the medical model of diagnosis and treatment, as has the advent of intractable problems in medical ethics such as decision making surrounding dying, issues in genetic engineering and cloning, and the use of various reproductive technologies (Callahan 1990). As a result, movements have arisen both within conventional medicine and without to try to improve on the limitations of conventional care, and move beyond the reductionism and mechanism that have been the twin legacies of Cartesian dualism and Newtonian physics in medical care.

In the 1960s, health care consumers expressed renewed interest in the notion of "holistic" health care, with a stated aim to treat the *whole* person as one effort to overcome some of the perceived limitations of conventional care. The notion of holism came from earlier work by Jan Smuts who argued in 1926 that all organisms, including human beings, have "whole-making" tendencies, and that the drive toward such wholeness is a creative, evolutionary force in health and human development (Smuts 1926). The notion of holistic care thus implied an effort to address the environmental, psychological, social and cultural, and even spiritual aspects of illness — in addition to physiological conditions.

The clash between conventional medical care and the holistic model (or "unconventional medicine" as it was termed by the "conventional" community) led to entrenchment of positions, acceleration of rhetoric, and accusations from both camps. For example, in the 1950s, the Code of Ethics of the American Medical Association (AMA) forbade physicians from referring patients to "cult" practitioners such as chiropractors, and declared such associations to be unethical (Gevitz 1988).

Epithets flew back and forth and found legal expression in the prosecution of various healers for the unlicensed practice of medicine (*Stetina v. State* 1987). However, by the 1980s, chiropractors were licensed in most states; and the chiropractic profession successfully sued the AMA for anti-competitive practices. In its ruling, Seventh Circuit Court found that the AMA had engaged in a "nationwide conspiracy" to eliminate the chiropractic profession (*Wilk v. American Medical Association* 1983).[1]

The war of epithets still continued, however, with the AMA's Council on Scientific Affairs declaring as recently as 1996 that "some of the interest in alternative medicine . . . [is a result of] New Age interest in 'channeling' and astrology, modern 'witch trials' concerning Satanic child abuse rituals, and alleged capture by space aliens" (Council on Scientific Affairs 1996: 16).[2] In 1998, editors of the *Journal of the American Medical Association* declared that there "is no alternative medicine . . . only scientifically proven, evidence-based medicine supported by solid data or unproven medicine" (Fontarosa and Lunderberg 1998). In a 2001 article entitled "Alternative Medicine and Common Errors of Reasoning," one researcher stated: "Because one's concept of health is entwined with one's fundamental assumptions about reality, an attack on someone's belief in unorthodox healing becomes a threat to his or her entire metaphysical outlook" (Beyerstein 2001). In rebuttal to this position, John Astin pointed out that if one "simply substitutes 'orthodox' for 'unorthodox' in this quote, one has a reasonable explanation for the biased and largely non-evidence based tone and approach" taken by many conventional researchers (Astin 2002).

Such oppositional positions have created a variety of legal and social barriers to integration of CAM therapies within conventional care. Such

barriers have included not only political and legal, but also institutional obstacles such as those surrounding the process of credentialing CAM providers like chiropractors, acupuncturists, and massage therapists (Cohen and Ruggie 2004). Principled negotiation analysis may offer a useful framework for some reconciliation between the conventional and CAM communities, which have been adverse in one form or another since colonial times.

This article: (1) describes and frames the negotiation problems with the effort to integrate CAM therapies into conventional care; (2) explores unresolved legal and ethical issues; (3) discusses several levels of negotiation challenges and the lessons these unresolved issues tend to create; (4) describes problem-solving frameworks taken from a liability analysis and an ethical analysis; and (5) surmises ways in which the theory and analysis of principled negotiation might contribute to optimal future health care by helping to create new systems that effectively integrate CAM therapies.

Complementary and Alternative versus Integrative Health Care

In the medical literature, the term "complementary and alternative" (CAM) has been used to describe therapies that historically have not been widely taught in U.S. medical schools or generally have not been available in most U.S. hospitals (Eisenberg et al. 1993). Such therapies thus generally have been delivered outside conventional medical models and settings (NCCAM 2003). The most commonly used CAM therapies include herbal remedies, massage therapy, megavitamins, folk remedies, energy healing, and homeopathy (Eisenberg et al. 1998); while the most commonly licensed CAM providers are chiropractors, acupuncturists and practitioners of traditional oriental medicine, massage therapists, and naturopathic physicians (Cohen 1998: 34; Eisenberg et al. 2002). In many cases, the therapies offered by these licensed providers overlap with the most popular CAM therapies. One of the reasons for the popularity of certain CAM therapies over others is that they can be used for self-help — without seeing a provider.

In 1993, a landmark article published in the *New England Journal of Medicine* revealed that at least one in three Americans is using these therapies (Eisenberg et al. 1993). A 1998 follow-up study, published in the *Journal of the American Medical Association*, found a 47 percent increase in total visits to complementary and alternative medicine practitioners — up from 427 million in 1990 to 629 million in 1997. In 1997, total out-of-pocket expenditures relating to alternative therapies were estimated at $27 billion (Eisenberg et al. 1998). Similarly, a 2000–2001 survey of 5,810 hospitals by the American Hospital Association (2002) reported that 15 percent of the respondents offered CAM therapies.

As a result of these and other epidemiological studies, some medical professional and regulatory organizations have begun to shift from a stance and rhetoric hostile to CAM therapies toward recognition that clinicians must learn the medical evidence concerning individual CAM therapies, and thereby address patient interest in including such therapies in conventional (biomedical) care (Straus 2000). For example, the position of the AMA has evolved since the *Wilk* case to its present recommendation that physicians "routinely inquire" concerning use of CAM therapies by their patients, and "educate themselves and their patients about the state of scientific knowledge" regarding the CAM therapy that may be "used or contemplated" (AMA 1997). In similar fashion, the American Academy of Family Physicians (AAFP) now advocates the evaluation of CAM therapies "through various means including evidence-based outcomes as to their safety and efficacy." The AAFP's (1997) position paper asserts that the organization "believes that physicians can best serve their patients by recognizing and acknowledging the availability of such alternatives and by educating themselves" concerning the risks and benefits.

Together with increased support among medical professional organizations for conversations with patients concerning use of CAM therapies, the National Institutes of Health has recognized the need for research into safety, efficacy, and mechanism of CAM therapies by establishing a National Center for Complementary and Alternative Medicine (NCCAM) with its own grant-making authority. The NCCAM research budget has grown exponentially since the initial $2 million grant in 1992 to its predecessor, the Office of Alternative Medicine, to well over $100 million in 2004. Furthermore, NCCAM has moved beyond the original language of "CAM therapies" toward a notion of "integrative medicine." The term denotes health care that "combines mainstream medical therapies and CAM therapies for which there is some high-quality scientific evidence of safety and effectiveness" (NCCAM 2003).

These developments suggest an evolving worldview within the medical profession toward recognition of integrative medicine. For example, now there are numerous independent clinics, as well as hospital-based centers, pioneering efforts to deliver "integrative medicine" or "integrative health care" across the U.S. (Cohen and Ruggie 2004). Currently, a consortium of academic health centers involved in integrative medicine is evolving an ambitious educational and research agenda for medical schools (Snyderman and Weil 2002).

However, such developments do not exactly establish a wholehearted shift to an environment in which conventional and CAM providers can easily form an integrated community, or refer patients to one another, or even fully respect the possibilities — as well as limitations — of the therapies within each domain. One of the concepts outlined in the book *Difficult Conversations* may be helpful in framing a next step in integrative

medicine: the notion of the "And Stance," a way of recognizing complexity and that both views — conventional and CAM — may have validity (Stone, Patton, and Heen 1999: 30). Despite the advent of "integrative" care, institutional change is slow and beset by a variety of forces, including limited perspectives and inadequate understanding of the potential ethical challenges in balancing patient desires and institutional mandates (Cohen and Ruggie 2004). Moreover, many CAM providers fear being "co-opted" by the forces of conventional care (Kaptchuk and Eisenberg 2001) or are concerned that integration and regulation will deprive them of the individuality that makes CAM therapies unique (Eisenberg et al. 2002).

Unresolved Legal and Ethical Dilemmas

Liability and other legal, regulatory, ethical, and policy issues remain undecided and in flux, creating anxiety and indeterminacy both for conventional clinicians who are asked to counsel their patients concerning use or avoidance of CAM therapies (Weintraub 1999) and for institutions asked to advise their clinicians. Although professional organizations such as the AMA have advised physicians to *inquire* about patient use of CAM therapies, they fail to provide specific guidance for clinicians about which therapies to recommend, accept, or discourage, and how to discuss patient requests for such therapies. Furthermore, professional organizations have failed to address liability concerns or to offer specific advice for occasions where clinicians disagree with patient perspectives and choices (Cohen and Ruggie 2004). Nor have hospitals and other health care institutions necessarily filled in the gap, or addressed specific clinical scenarios clinicians might face. Some institutions have even refused to draft policies to help guide clinicians through such matters as handling patient interest in dietary supplements (Walker 2000).

The present inadequacy of guidance among institutions and associations creates a tension for those wishing to advise patients responsibly and, at the same time, to limit their potential liability risk. Clinicians are caught between the Scylla of denial and evasion (professing ignorance regarding CAM therapies and/or refusing to offer the patient any meaningful recommendation), and the Charybdis of recommending therapies that may, despite best intentions, result in patient harm, thus heightening liability risks as well as potentially endangering the clinician's professional reputation and licensure. This can create a Hobson's choice: to be rejected by your patient if you "don't ask and don't tell" (Eisenberg 1997) about CAM therapies, or be sued if you do but fail to adequately describe potential risks and benefits (Cohen 2000).

The problem is exacerbated by warnings from some major medical leaders regarding the risks of "untested and unregulated" CAM therapies (Angell and Kassirer 1998), and case reports and other literature documenting safety issues and adverse effects of herbal remedies (Ernst 1998;

Piscitelli et al. 2000). The "doctor's dilemma" regarding CAM therapies is further heightened by the paucity of relevant judicial opinions in the liability arena, and by some difficult language in one of the few cases on point.

In *Charell v. Gonzales*, a New York court found a physician negligent for recommending nutritional care for cancer (*Charell v. Gonzales* 1997). The court concluded: "No practitioner of alternative medicine would prevail . . . the term 'non-conventional' may well necessitate a finding that the doctor who practices such medicine deviated from accepted medical standards" (*Charell v. Gonzales* 1997). Such language, although not necessarily binding on courts outside New York, is suggestive of malpractice per se — automatic liability once a clinician embraces a therapeutic recommendation involving CAM therapies (Cohen 2000).

Added to this conundrum are the unresolved ethical issues around advising patients when the clinician disagrees with the patient's choice of CAM therapies (Adams et al. 2002). For example, when a patient decides to forgo a conventional therapy (such as chemotherapy for cancer care) in favor of CAM therapies that may, from the clinician's perspective, have an inadequate evidentiary base, the clinician (e.g., oncologist) may feel caught between the ethical poles of *nonmaleficence*, refusing to sanction a dangerous medical choice, and *beneficence*, continuing in therapeutic relationship with the patient (Adams et al. 2002). From a liability perspective, the clinician in this same situation may be caught between articulating his or her opinion and thereby abandoning the patient (or being rejected by the patient), and remaining clinically involved but risking a lawsuit by the patient or patient's family if the CAM therapy fails the patient.

Negotiation Challenges and Lessons

In short, while clinicians and health care institutions can no longer ignore CAM therapies, they face a quandary about what to tell patients.

Multiple Communication Failures

The current state of legal, regulatory, ethical, and institutional chaos, combined with inadequate guidance from professional organizations, seems to pose an often unsolvable, and certainly legally and ethically perplexing, set of dilemmas to clinicians and institutions (Cohen and Ruggie 2004). Thus, to the extent that the increasing attention to CAM therapies creates a set of difficult conversations for clinicians, institutions, patients and patients' families, no one — not professional organizations, legislators, or consumer advocacy groups — has creatively met the challenge with consensus policies and procedures to help guide those conversations.

This failure leaves the parties frozen into the kind of positions that the authors of *Getting to YES* discourage: a kind of black-and-white, either/or scenario in which "they tend to lock themselves into positions" and defend against attack, making it less and less likely that any conversation will

"wisely reconcile" their mutual interests (Fisher, Ury, and Patton 1991; Stone, Patton, and Heen 1999). Specifically, once the patient and the clinician each take a position on the use of CAM therapies, their positions may be diametrically opposed. Consider, for example, the following two cases (Adams et al. 2002):[3]

> *Case A: The Patient Who Wants Use CAM Instead of Conventional Therapies.* The patient has a premalignant condition that can be completely cured through surgery, but if left untreated, can progress to invasive cancer. The patient tells her MD that she plans to pursue meditation, colonics, and yoga and to work with her Reiki master rather than have surgery.
>
> *Case B: The Patient Who Seeks MD Advice Regarding Inclusion of CAM Therapies.* The patient, a woman with recurrent metastatic ovarian adenocarcinoma, asks her oncologist to provide her with conventional treatment but be open to evaluating and guiding her regarding available CAM therapies. The patient's insurance plan requires that she be seen by a particular oncologist.

The differing positions of patient and physician are illustrated for each case in Table One.

This not uncommon scenario — the digging in to adverse positions, combined with the physician's refusal (or inability) to engage in shared

Table One
The Positions of Patient and Physician in Case A and Case B

Case A: Patient Position "I believe in the body's ability to heal itself; and the importance of the relationship between illness and mental, emotional, and spiritual health. Even if you told me I would die next month without surgery, I still wouldn't have it."	**Case A: MD Position** "If you delay treatment by trying some of these other methods, none of which have been shown to be effective in treating your condition, you may end up with cancer, which will be much more difficult, if not impossible, to cure."
Case B: Patient Position "I would like you to help me evaluate complementary and alternative medical approaches to my treatment."	**Case B: MD Position** "I refuse to recommend CAM treatments because they have not been subjected to scientific scrutiny. You risk your health in seeking these types of care."

decision making — leaves the patient without the necessary information to make a meaningful, clinical decision. Furthermore, it leaves the patient isolated from the very clinician the patient is counting on to save his or her life. At the very least, this situation potentially damages the therapeutic relationship. As *Getting to YES* points out, "[p]ositional bargaining becomes a contest of wills [that] sometimes shatters the relationship between the parties" (Fisher, Ury, and Patton 1991: 6). As the relationship involves health and also may have a therapeutic or healing dimension — particularly in light of the so-called placebo effect in which relationship itself may have health-enhancing effects — such disruption is unfortunate and may have severe, although unintended, consequences.

At the same time, this situation leaves the MD with few perceived options, none of which are attractive. In both Case A and Case B, the most obvious choices to many conventional care providers are: (1) to insist that the patient receive conventional care; (2) to acquiesce to the patient, without helping or attempting to set limits when therapies are presented that may be unsafe or lack efficacy; and (3) to neither insist on the MD's position (refuse to provide CAM care or information) nor bow to the patient's position (provide CAM care or information that the MD does not believe is effective), but instead withdraw from the whole situation and stop caring for this particular patient. Each choice has consequences, as illustrated in Table Two.[4]

In the face of such unattractive options, physicians might choose to try to opt out of the dilemma by providing the patient with a choice that seems to respect the patient's autonomy, but effectively "disempowers" the patient and renders the notion of a choice absurd. Roger Fisher relates a version of this kind of conversation:

> The patient says: "I'd rather not have surgery. Tell me what you think I should do."
>
> The physician replies: "I think you should have surgery — but it's your decision."[5]

In this scenario, the physician is giving mixed signals: simultaneously letting the patient know that the patient must take responsibility for the decision and, at the same time, signaling that the decision *not* to have surgery is wrong. Again, the potential damage to the therapeutic relationship is implicit in this difficult conversation gone wrong: the patient may see the physician's statement as demonstrating how little the physician cares about the relationship (Fisher, Ury, and Patton 1991). Furthermore, in choosing either option one or two, the physician may be either trading the relationship for the position or trading the position for the relationship (Fisher, Ury, and Patton 1991).

Table Two
Choices and Their Consequences in Case A and Case B

Choice	Consequences
1. *Insist* that this patient receive conventional care.	Patient may refuse to comply, leading to a potential rupture in the relationship as well as to patient injury. In addition, the combination of these factors can be a precursor to lawsuit.
2. *Acquiesce* to the patient's insistence on receiving CAM therapies, not knowing how to respond to the patient's request other than a blanket denial.	If the patient uses an unsafe CAM therapy and is injured or dies, the MD could conceivably be liable for negligence (failure to provide standard treatment). Acquiescence in such a case may also contravene the MD's belief in evidence-based medicine, and the ethical and professional obligation to "do no harm."
3. *Withdraw* from care for this particular patient.	If the patient dies and the family sues, the MD could be liable for patient abandonment. In addition, by withdrawing from care, the MD may violate the obligation to "do no harm."

Multiple Levels of Required Negotiations

In discussing integrating conventional and CAM therapies, the negotiation challenges are even broader than those between physician and patient. They involve at least six additional groups of constituents, each with their own interests, including: CAM providers (such as chiropractors and acupuncturists); allied health providers (such as nurses and psychologists); policy makers and regulators; consumer groups; industry (e.g., manufacturers of dietary supplements, and other CAM substances and devices); research scientists; and insurers.[6] The range of interests listed in Table Three is illustrative and representative, not exhaustive.

Of course, Table Three could be critiqued as oversimplifying the various interests; and it could be argued that the different interests are, in fact, overlapping rather than exclusive — for example, both patients and many regulators would like to enhance the ability of the consumer to access CAM therapies freely in an environment untainted by fraudulent conduct. However, the table focuses on the hypothesized primary interest

Table Three
Constituent Groups and Their Hypothesized Primary Interest

Constituent Group	Hypothesized Primary Interest
Patients and their families	Cure of identified disease
Physicians	Success of proposed intervention(s) while "doing no harm"
Allied health providers	Facilitation of effectiveness of medical intervention
CAM providers	Facilitation of healing
Policy makers and regulators	Prevention of fraud
Consumer groups	Access to pluralistic treatment modalities
Industry	Profit on approved drugs and devices
Research scientists	Safety and efficacy of proposed therapeutic interventions
Insurers	Cost-effectiveness

in order to show the potential conflicts between the various groups' main interests.

As Table Three illustrates, while both patients and regulators may be concerned with potential fraud, patients are more likely to have cure as their primary interest, regulators to have fraud control as the primary interest, and consumer groups to emphasize access to CAM therapies (Cohen 2000, 2003). Take the patient who seeks access to a therapy that has not been approved as safe and effective by the federal Food and Drug Administration (FDA); the patient is likely to emphasize the need to obtain such a product for cure, while the FDA is likely to emphasize the need to protect patients from their own gullibility, vulnerability, and desperation (Cohen 1998, 2002). Often, clashes of primary interests like these have played out in ethical terms, as a conflict between medical paternalism (the desire and perceived obligation to protect patients from their own foolish choices) and respect for patient autonomy (the wish to protect knowing, voluntary, and intelligent choices).

In addition to the various communities and multiple stakeholders within each community — each of which may have overlapping and conflicting positions and interests — the shift from conventional care toward integrative health care may involve negotiation in multiple domains including: legal and ethical; business and economic; professional and regulatory; political; institutional; and social and cultural. Some of the key issues to be negotiated within each domain include those listed in Table Four.

Of these six domains, the category of legal issues has been analyzed extensively in the author's previous work and includes such areas of

Table Four
Key Issues to be Negotiated within Each Domain

Domain	Key Issues to Be Negotiated
Legal	How to offer CAM therapies and practice innovatively without getting sued. How to discuss CAM with patients.
Business and economic	How to address the expense of integrative care teams (e.g., providing care by teams of MDs, nurses, acupuncturists, chiropractors, nutritionists, and others). The problem of general lack of reimbursement for CAM care.
Professional and regulatory	What modalities should be accepted as valid or proscribed. Which CAM schools should be accredited and accepted as valid.
Political	Who gets licensed. What can a licensed provider do or not do. Should nonlicensed providers be allowed to practice. When should licensed providers offering CAM be subject to professional discipline.
Institutional	How will hospitals credential CAM providers. How will hospitals handle dietary supplements.
Social and cultural	What should clinicians (and the law) do when patients demand therapies that either are deemed unsafe or are not FDA approved. How should clinicians, institutions, and regulators handle inclusion of spirituality within medicine and potential abuses of spiritual authority.

the law as: (1) licensure and credentialing; (2) scope of practice; (3) professional discipline; (4) malpractice liability; (5) the right of access to treatments; (6) third-party reimbursement; and (7) health care fraud (Cohen 1998). Of these seven legal issues, the fear of malpractice liability seems to be one of the greatest challenges to use of "principled negotiation" (Fisher, Ury, and Patton 1991) in conversations between clinicians and patients around the application (or avoidance) of CAM therapies. Thus, before turning to possible ways that negotiation theory and analysis might help break the logjams identified previously, it may be helpful to review the analysis based on liability concerns and the analysis of negotiation issues based on related ethical concerns.

Applying Liability and Ethical Analyses to Clinical Decision Making

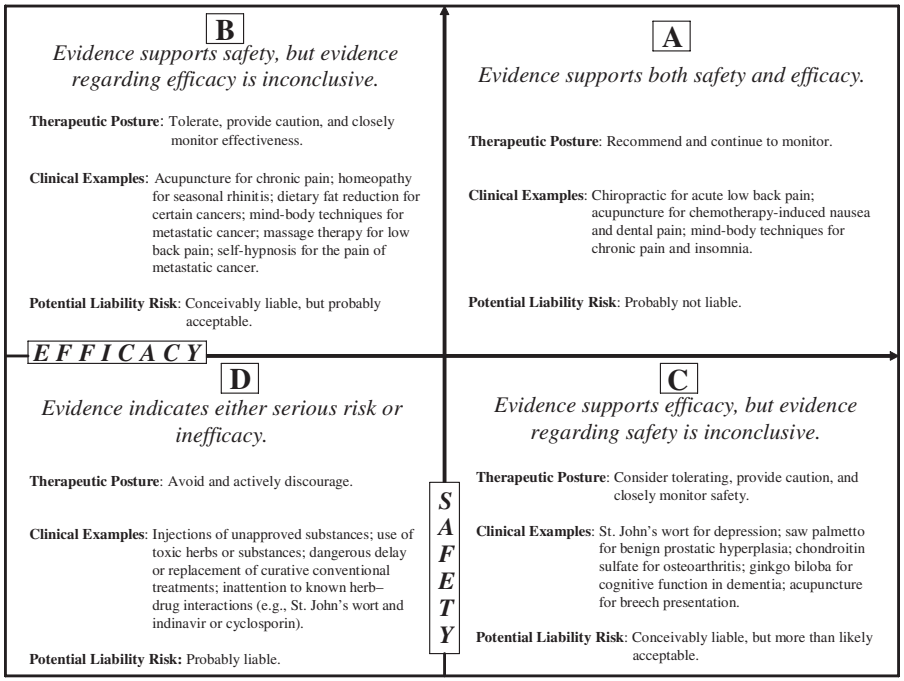
Two existing models offer a liability analysis and an ethical analysis, respectively, to clinical decision making involving patient requests to use CAM therapies. These two models provide a starting point for considering potential negotiation interests on the part of physician and patient.

The Liability Analysis

The liability analysis starts with the observation that liability for malpractice (negligence) involving CAM therapies falls under the same definition that is generally used for medical malpractice: clinical care below applicable professional standards that causes patient injury (Cohen 1998). Generally, in assessing whether clinical care has met or fallen below applicable professional standards, experts are likely to testify regarding the accepted safety and efficacy of the therapeutic modality used. Accordingly, clinicians seeking to assess their potential malpractice liability risk in counseling patients concerning CAM therapies should evaluate whether the medical evidence: (A) supports both safety and efficacy; (B) supports safety, but evidence regarding efficacy is inconclusive; (C) supports efficacy, but evidence regarding safety is inconclusive; or (D) indicates either serious risk or inefficacy (Cohen and Eisenberg 2002).

Thus, if (A) the medical evidence supports both safety and efficacy, liability is unlikely, and clinicians should recommend the CAM therapy. However, if (D) the medical evidence indicates either serious risk or inefficacy, liability is probable, and clinicians should avoid and actively discourage the patient from using the CAM therapy. If the medical evidence (B) supports safety, but evidence regarding efficacy is inconclusive, or (C) supports efficacy, but evidence regarding safety is inconclusive, then clinicians should caution the patient and, while accepting the patient's choice to try the CAM therapy, continue to monitor efficacy and safety, respectively. In either case (B) or (C), liability is conceivable but probably unlikely, particularly in case (B) where the product is presumably safe (Cohen and Eisenberg 2002).

Model One



This risk assessment framework is summarized in Model One, which includes clinical examples, and is offered with the caveat that as medical evidence regarding safety and efficacy for any given therapy changes, the therapy may shift from one grid to another.

The model attempts to offer clinicians a useful framework for assessing potential liability risk based on the existing medical evidence. One limitation, however, is that the model is too static: it merely gives clinicians three options: (1) recommend; (2) avoid and discourage; and (3) tolerate/accept while monitoring. In fact, medical risks change over time according to many factors, including disease progression, prognosis, and the impact of combinations of the various therapies. Thus, in actuality, clinician and patient may be required to have not one but a series of conversations over time, as the patient uses some combination of conventional and CAM therapies with varying effects.[7]

Furthermore, integrative care presumes a model of shared decision making (Snyderman and Weil 2002) rather than a hierarchical decision by the clinician to accept, avoid, or tolerate. In this model, clinicians and patients are equal partners in a joint process regarding care. This is why negotiation analysis is necessary.

The Ethical Analysis

The ethical analysis also offers a useful but perhaps limited framework for clinicians contemplating whether and how to advise patients who inquire concerning use (or avoidance) of CAM therapies. Like the liability analysis, the ethical analysis expands the historic characterization of CAM therapies in terms of dichotomous dualities (e.g., ethical/unethical). That characterization followed rhetoric between the two camps such as the notion of "*un*conventional" versus "*un*orthodox" or "alternative" medicine.

The ethical analysis expands the language of clinician choices by including multiple factors in decision making; some of these factors are closer to the physician's education, training, and predisposition, and others to the patient's. The seven factors are (Adams et al. 2002):

1. severity and acuteness of illness;
2. curability with conventional treatment;
3. invasiveness, toxicities, and side-effects of conventional treatment;
4. quality of evidence of safety and efficacy of the CAM treatment;
5. degree of understanding of the risks and benefits of conventional and CAM treatments;
6. knowing and voluntary acceptance of those risks by the patient;
7. persistence of patient's intention to utilize CAM treatment.

These factors can be applied to the two cases previously mentioned. In Case A, the patient's illness can be cured with conventional, although invasive, treatment (surgery); the evidence for CAM is low but the patient understands and accepts risks, and insists on trying CAM therapies. The conclusion would be that it is ethical for the physician to allow the patient to try her regimen of CAM therapies so long as the clinician continues to monitor her condition conventionally (Adams et al. 2002). If the risk of cancer increases beyond a tolerable threshold, the physician should intensify attempts to persuade the patient that it is time to return to conventional methods of treatment.[8]

In Case B, many adjunctive CAM therapies for cancer care are supported by medical evidence and are not dangerous (Weiger 2002). Therefore, the clinician should be aware of pertinent evidence and be willing to consider any intervention (CAM or allopathic) that has an acceptable risk–benefit balance (Adams et al. 2002). The clinician's ethical obligation thus is to apprise the patient of acceptable options, and make a recommendation that respects the patient's value system (Adams et al. 2002).

The ethical analysis, although useful in expanding the range of factors to consider, does not offer clinicians a strategy for appropriately balancing

the various factors and negotiating conversations accordingly with patients. Again, the analysis leaves the clinicians with a narrow range of options equivalent to accept/avoid and discourage/tolerate.

Furthermore, clinicians and patients may still be tempted to dig in to conflicting positions — or at least places of emphasis — within the analysis of these factors. For example, clinicians are likely to overemphasize (relative to patients) the fourth factor — the quality of evidence of safety and efficacy of the CAM treatment; whereas patients may be very sensitive to the invasiveness, toxicities, and side-effects of the conventional treatment (first factor), and are likely to underestimate the risks and benefits of conventional and CAM treatments (fifth factor) and to persist in their intention to use the CAM therapy (seventh factor). Thus, the ethical analysis, once made, still requires a *negotiated* exchange between clinicians and patients, and some clear basis for a principled negotiation.

Applying a Negotiation Analysis to Clinical Decision Making

Given the limitations of the existing analyses, the field of integrative health care would probably benefit from detailed application of negotiation theory and analysis to clinical decision making regarding the use (or avoidance) of CAM therapies.

A Useful Framework

A robust analytic framework may be of value not only to clinicians and patients, but also to the institutions that guide professional practice involving CAM therapies and the professional organizations that educate, train, accredit, and govern practitioners. Such a framework, if useful, should also have the ability to test whether the ethical and legal frameworks presented truly result in workable conversations containing principled negotiations.

Without necessarily attempting an exhaustive analysis, this section offers some preliminary ideas for such a framework (or series of frameworks attuned to the level of negotiation — e.g., clinical, institutional, professional). The proposed framework focuses on the negotiation between clinicians and patients regarding use or avoidance of CAM therapies. For the moment, this two-party encounter offers a way to understand the application of principled negotiation to perhaps the most fundamental and charged place within the health care system where the introduction of CAM therapies is likely to disrupt relationships and produce conflict. The following analysis will focus particularly on suggestions for clinicians, who are often called to guide patients in an uncomfortable borderland between medical evidence and personal belief systems.

As a starting proposition, principled negotiation aims to "produce a wise agreement," be efficient, and "improve or at least not damage the

relationship between the parties" (Fisher, Ury, and Patton 1991: 4). The suggestion seems especially relevant to considerations involving CAM therapies. As the clinician–patient relationship has a unique feature in that it is a *healing* relationship, the quality of the therapeutic relationship itself may have an effect on health.

Principled negotiation offers a well-accepted framework for negotiating in general, and has particular utility in this situation. Four major techniques within the framework are: (1) separating the people from the problem; (2) focusing on interests, not positions; (3) inventing options for mutual gain; and (4) insisting on using objective criteria (Fisher, Ury, and Patton 1991: 15). Additional techniques include knowing one's BATNA (best alternative to a negotiated agreement) and building a good relationship to ease joint problem-solving.

Beginning with the first technique — the need to address the substantive issues separately from the personalities involved — many patients may have preconceptions (biases) about physicians, the latter's openness to CAM therapies, and/or evidence-based medicine (J. Cohen 2000), whereas physicians may have preconceptions (or biases) about patients' interest in such therapies (Astin 2002). In short, "People tend to see what they want to see . . . to pick out and focus on those facts that confirm their prior perception and to disregard or misinterpret those that call their perceptions into question" (Fisher, Ury, and Patton 1991: 21). In Case B, the physician may misperceive the patient as naive, gullible, or uninformed, whereas the patient may misperceive the physician as overly rigid, unyielding, and inflexibly tied to preconceptions about the evidence.

Principled negotiation emphasizes communication and empathy: putting one's self in the other party's shoes (Fisher, Ury, and Patton 1991). As a group of CAM researchers observed, "Only by letting go of previously held beliefs can new learning and discovery ever take place" (Astin and Ernst 2001). One of the gaps clinician and patient must bridge concerning CAM therapies is the relative role of medical evidence and of personal experience, intuition, or trust in evaluating the potential safety and efficacy of any given therapy. For instance, in Case A, the physician may find little or insufficient evidence in the medical literature that colonics, meditation, yoga, and Reiki can cure a premalignant condition; yet the patient may have anecdotal information based on others' experience. In this case, it would be a mistake for the physician to completely discount the patient's value system and dismiss this perspective about these treatments as gullibility, and an equal mistake for the patient to completely discount the physician's value system, with its concomitant commitment to scientific method. Rather, each must step into the shoes of the other in a negotiated exchange that respects the value of the way the other sees the world.

Active listening is an important component to this approach. The clinician, for example, would be called on to hear (if not invite) expression by

the patient of any vulnerability and frustration with conventional care received. It might also be helpful to invite discussion of any information the patient may have received regarding CAM therapeutic approaches, and the source of this information. This would facilitate understanding the reasons for patient's proposed choices. The clinician then could present an evidence-based perspective in a respectful and nonjudgmental way, acknowledging any limitations of the available evidence and of reliance on the evidence compiled to date. Not surprisingly, such an approach is likely to reduce liability risk, as effective physician–patient communication tends to reduce malpractice exposure. Thus, a sensible negotiation strategy involving separating the people from the problem is essential for clinicians seeking to reduce such risk when advising on the integration of CAM therapies.

Turning to the second element of principled negotiation, in moving from positions to interests, the two parties share a common interest in restoring the patient to health as quickly and fully as possible. Although they may differ in emphasis and sense of responsibility (and some clinicians may be more or less paternalistic than others), the shared interest in promoting health addresses one of the patient's most basic needs, "those bedrock concerns which motivate all people" (Fisher, Ury, and Patton 1991: 48). Negotiations are unlikely to progress if one party — in this case the patient — believes that their basic needs are being threatened by the other (Fisher, Ury, and Patton 1991). Therefore, in both Case A and Case B, the clinician is advised to move from a position that negates and threatens the patient's *self-perception* of what is necessary and appropriate for restoration of health to an emphasis on their shared interest.

Differing interests that are complementary can also lead to a deal (Fisher, Ury, and Patton 1991). Thus, if the physician is interested in a cure (as soon as possible and without delay) and the patient is interested in a cure (without unnecessary invasion or trauma) and healing that promotes wholeness on all levels as well as physical health, the two may be able to work out an arrangement in which the patient tries the desired CAM therapy for a defined period of time and, if such therapy fails to reach a pre-specified benchmark of health, the patient agrees to return to the conventional care advised by the physician. Such a "wise agreement" (Fisher, Ury, and Patton 1991: 43) respects both parties' interests and values their complementary approaches. It also engages shared decision making: a process of conversation and dialogue rather than the bureaucratic and authoritarian model that traditionally has accompanied informed consent (Katz 1994).

The third suggestion involves inventing options for mutual gain. Here, again, clinicians and patients may need to move beyond the either/or and yes/no dilemmas presented in Cases A and B. The liability assessment framework suggests several strategies that provide a range of options: most

prominently, the clinician and patient, as mentioned, can agree to try CAM care for a period of time while continuing conventional monitoring so that the clinician can intervene with conventional medical care when necessary (and so that the patient is open to such intervention). In such an agreement, the clinician and patient are more likely to become partners rather than ideological adversaries.

By working together, ideally they can invent options that satisfy the patient's interest in pursuing CAM therapies while satisfying the clinician's obligation to do no harm and practice in an evidence-based manner. Such collaborative decision making, including generating options together, is a premise of integrative care with its movement from hierarchical approaches to those enhancing patient feelings of participation and empowerment.

In this context, Roger Fisher and Elliott Fisher (1999) have argued that in the end, the quality of a medical decision should be judged not only by outcome, but also by the quality of the decision-making process. This includes "not only the care with which the decision is reached but also how satisfied the patient, physician, and other affected parties are with both the decision-making process and the substance of the final decision" (Fisher and Fisher 1999: 190). A good decision requires effective communication between clinician and patient, including contemplation of a "well-considered alternative to agreement with the physician's final proposal" (Fisher and Fisher 1999: 190). Inventing options for mutual gain that incorporate both conventional and CAM therapies may offer a decision-making process that respects the values and emphases of both sides.

The final plank in principled negotiation involves insisting on objective criteria to settle differences. A salient question here is whether the legal and ethical frameworks presented earlier in fact provide objective criteria. Certainly, the quality of medical evidence concerning safety and efficacy provides one yardstick for assessing known potential risks and benefits of a given CAM therapy; and even if the patient does not value the medical evidence to the same extent or in the same way as the clinician, attention to the evidence can help guide a foundational discussion between the two. Similarly, the medical evidence may, as suggested, offer a series of end points that, if reached by the patient, could suggest a mutually agreed-upon decision to either renew or continue to forgo conventional care in favor of CAM options for a prescribed period.

Puzzles and Possibilities

Thus, in addition to liability and ethical analyses, the framework of principled negotiation may offer a helpful way to work through the conflict between medical and holistic/CAM models of care. The liability framework focuses on worst-case scenarios, and asks the question: "Under what circumstances am I most likely to be sued?" The answer, according to the grid,

Table Five
Main Question Each Framework Asks

Liability Framework	Ethical Framework	Principled Negotiation
How can I best avoid an unnecessary and burdensome lawsuit?	What mix of ethical factors best balances patient autonomy and professional medical concerns?	What interests, options, and objective criteria will produce a wise agreement that is fair to both sides and preserves the therapeutic relationship?

is simple: avoid region D, be safe in region A, use caution in regions C and B (where either safety or efficacy are disputed). The ethical framework balances considerations of interest to the patient and to the clinician; it offers a multifactorial analysis in which the combination of various circumstances may tip the scales one way or another.

Principled negotiation distills the puzzle into interests, options, and criteria. Thus, returning to the two cases discussed earlier, Case A (in which the patient wants to use CAM therapies instead of conventional care) and Case B (in which the patient merely seeks the physician's advice concerning CAM therapies of potential utility), principled negotiation adds a process rather than an end point, as illustrated in Table Five. The very questions it asks aim to refocus the parties on how to work together toward a win-win, rather than on avoiding worst-case scenarios or wrestling with multifactorial balancing.

The solutions that principled negotiation offers also tend to move the parties away from entrenched positions and to expand the range of potential outcomes, as suggested in Table Six.

Although principled negotiation clearly adds to the liability and ethical frameworks, its methods may not entirely solve this new and complex shift in U.S. health care. One consideration involves the considerable emotion the patient may have invested in making autonomous choices regarding CAM therapies, and/or in rejecting certain CAM therapies such as the recommended chemotherapy in Case A. Certainly, as emotions lie behind positions, principled negotiation encourages the effort to "make emotions explicit and acknowledge them as legitimate" (Fisher, Ury, and Patton 1991: 4). At the same time, illness brings up intense emotions, as it engages what may be our greatest shared vulnerability as humans: the fragility of the body; our greatest collective fear: our eventual bodily deterioration and death; and our greatest arena of shared speculation: what — if anything — lies beyond the dissolution of the body (Becker 1973).

Table Six
Solutions/Approaches Each Framework Proposes to Cases A and B

Liability Framework	Ethical Framework	Principled Negotiation
1. Encourage therapies of proven safety and efficacy. 2. Discourage therapies of proven danger and inefficacy. 3. Cautiously tolerate and monitor therapies of unknown safety or efficacy.	1. Discourage CAM therapies if the illness is severe and acute or curable conventionally without undue invasiveness, toxicities, or side-effects; therapy lacks sufficient evidence; and patient poorly understand and marginally accepts risks. 2. Allow CAM therapies if the illness is not severe, acute, or easily curable conventionally; the CAM therapy has sufficient evidence; and the patient understands and accepts the risks.	Find that ultimate combination of CAM therapies and conventional care (while continuing to monitor conventionally) that optimizes respect for the shared interest in the patient's well-being and optimally accounts for the potential risks and benefits of the various tools from all the healing traditions (conventional and CAM) available to clinician and patient.

All this suggests a heightened need for a frank discussion between clinician and client in which mutual fears, vulnerabilities, and perceptions around power (or lack thereof) are explicitly acknowledged (Brody 1992). Principled negotiation offers a workable map to begin to navigate the intense emotions around the journey of the body.

Furthermore, the traditional therapeutic distance between clinician and healer suggests a tendency by clinicians, perhaps in self-protection, to detach or move away from explicit acknowledgment of emotions. As suggested, the notion of integrative medicine critiques this therapeutic distance as unnecessary and unhelpful. And, as Case B suggests, when the clinician comes with pre-existing biases and perspectives regarding particular therapies, such perspectives may have the tendency to increase — rather than decrease — any pre-existing therapeutic distance. Clinicians who are prone to emphasize cool therapeutic distance cannot simply be "warmed up" by references to stated principles of integrative care.

Principled negotiation's emphasis on using objective criteria may offer one helpful approach to structure conversations that may bring up intense emotions. In fact, principled negotiation's notion of objective criteria

resonates with the legal and ethical obligation of informed consent. This obligation essentially mandates disclosure and discussion of all risks and benefits material to a treatment decision. As regards inclusion of CAM therapies, this means that clinicians may be obligated to offer the patient full disclosure about the risks and benefits of: (1) the conventional therapy; (2) the CAM therapy; and (3) delaying or deferring one therapy for the other that should also include an honest discussion of preconceptions and biases.[9] The discussion of risks and benefits can make use of objective information from evidence-based medicine as one set of criteria by which clinicians and patients can assess whether and how to proceed.

Naturally, there may be constraints on the clinician's ability to learn about a range of CAM therapies, and to communicate such information within the time allotted for a patient visit. Furthermore, some conventional clinicians may view recommendations regarding CAM therapies or referrals to CAM providers as threatening to their sense of identity or adherence to a certain range of medical theories and practices. And again, as emotions can bypass the logical circuitry of objective criteria, there is the danger that clinician and patient may once again lapse into positional bargaining over the legitimacy of such criteria. (Such dangers are inherent in any negotiation over medication, surgery, and conventional medicine, and may only be exacerbated when clinicians and patients differ regarding their philosophical orientation toward or against a given medical system such as Ayurvedic or traditional oriental medicine.)

In this article, the overall analysis of the potential contribution of negotiation theory to integrative care limits discussion to the four planks of principled negotiation advocated in *Getting to YES*, and does not bring in additional theoretical constructs. However, by drawing parallels between existing liability and ethical frameworks, and principled negotiation as outlined by Fisher, Ury, and Patton, this analysis aims to fill in some of the blanks between these diverging perspectives, and to improve the ability of clinicians to counsel patients regarding inclusion of CAM therapies in ways that respect parties' value systems, underlying beliefs, and diverse, yet complementary, interests.

Conclusion and Prognosis for the Future

This article has described the ongoing shift from conventional care alone to a medical system in which CAM therapies (such as chiropractic, acupuncture, herbal medicine, and massage therapy) are integrated with prescription of pharmaceuticals, surgery, and high-technology medicine. The article has delineated ways in which liability and ethical analysis may be useful in helping clinicians discuss use or avoidance of CAM therapies with patients, and has elucidated the limitations of these approaches that suggest an opportunity for future contribution by other areas of negotiation theory. The article has offered a preliminary outline of ways in

which negotiation theory and analysis might enhance the earlier frameworks by contributing methods for clinicians and patients to discuss the various therapeutic options that integrate the different kinds of care.

Clearly, as integrative medicine spreads, it is likely to engender conflicts at various levels of the health care system: from the one-on-one conversation between doctor and patient to the broader conversation between departments within a health care institution about whether, how, and at what rate to integrative CAM therapies (e.g., ensconcing an acupuncturist in the anesthesia department or a chiropractor alongside the orthopedic surgeon). Much more theoretical and empirical work needs to be done to help bridge these divergent worlds and multiple levels of potential conflict. Principled negotiation offers a useful approach and a good place from which to start the discussion.

NOTES

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1. The quotation is from the Seventh Circuit opinion and is found on 895 F.2d at 362.

2. Council on Scientific Affairs cites C. Krauthammer, The Return of the Primitive, *Time*, January 20, 1996, 82.

3. The cases are drawn from actual cases experienced by or reported to Dr. Karen Adams; the quotations are from the published article by Adams et al. in *Annals of Internal Medicine* (2002).

4. These choices are discussed but not explicitly spelled out in the same fashion in the *Annals of Internal Medicine* article by Adams et al. (2002).

5. This scenario was described by Roger Fisher during a talk entitled "Negotiating Complementary Medicine," given at the PON Dispute Resolution Forum in November 2003.

6. There also may be different subgroups within each of the constituents enumerated here, each with different interests. For example, among policy makers and regulators, the Food and Drug Administration may view an issue involving consumer access to specified CAM therapies differently from a particular state legislature; similarly, among CAM providers, chiropractors (or chiropractic associations) and massage therapists may have different interests, particularly if they have overlapping scopes of practice (Cohen 1998: 55); likewise, allied health providers may disagree about the best care algorithm (e.g., nurses and physical therapists) or may disagree about the kind of intervention (e.g., nurses versus psychologists) or whether the intervention should involve pharmaceutical prescription (e.g., a psychiatrist's prescription for depression) or a behavioral process (e.g., a recommendation from a cognitive psychologist).

7. I am grateful to participants in the PON Dispute Resolution Forum for this observation.

8. The clinician who finds this approach unacceptable and who sees this strategy as "giving tacit approval to an irresponsible decision" should refer the patient to "a more like-minded" physician (Adams et al. 2002). Fisher and Fisher (1999: 190) likewise advise that when the patient and clinician disagree on the proper medical choice the patient should seek (and the clinician help find) another provider who is more amenable to the patient's perspective.

9. In this regard, the AMA cautions that patients who choose CAM therapies "should be educated as to the hazards that might result from postponing or stopping conventional medical treatment" (AMA 1997).

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