Chapter 2
CAM Use From Western and Asian Perspectives:
Overview of Different Cultural Beliefs of CAM Medicine and Prevalence of Use

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ABSTRACT

This chapter will discuss the impact on the provision and integration of complementary and alternative medicine (CAM) into the patient's medical pathway and in turn, the prevalence of usage, not only for treatment but also prevention. Similarities and differences of these issues between Western and Asian perspectives will be presented. The authors will provide an overview of regulatory organisations which influence this provision, as well as advertising within the cultures which will have impact on belief of efficacy, which in turn will increase the placebo effect (thereby increasing efficacy). Due to a lack of evidence for CAM advertising in Asian cultures, further research is needed.

GENERAL PERSPECTIVES ON CAM

With a long history of complementary and alternative medicine (CAM) use in certain cultures, CAM appears far more integrated in some nations rather than others. This integration seems to be due to the concurrent use of CAM with the development of orthodox medicine. Also CAM emerged prior to the need for evidence based medicine, which demands a significant p-value in a randomised controlled trial. CAM had built a good anecdotal evidence base by the time orthodox medicine emerged, which then enabled its use to be maintained over recent years within certain cultures, such as Asian ones. For example, the Thai population began to use herbal medicine for the treatment of various symptoms and

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diseases and for promoting well-being before 1238 A.D (He, 2015). Indeed, Thai traditional medicine has been the main intervention for health care until the early 20th. Century (Chokevivat, & Chuthaputti, A. 2005). Prior to this, traditional Chinese medicine (TCM) was born in the Chinese culture with its roots within a philosophy such as Buddhism, more than 2,500 years ago (He, 2015). During the Ming and Qing dynasties (1368AD-1911AD) thanks to the advancement of paper making and printing, TCM spread to other countries of the Western continent (He, 2015). However, as the word spread from Asia about TCM, so the news reached Asia about orthodox medicine, leading to a change in cultural beliefs. In 1928, the Central Committee on Hygiene of China, put forward a motion to 'abolish Chinese medicine in order to remove the obstacles to the cause of orthodox medicine and hygiene.' (Wang, 2013). In 1949, the People's Republic of China, outlawed the use of Chinese medicine in hospitals, and during the Cultural Revolution in 1966-1976 many practitioners were either jailed or killed (Wang, 2013). Therefore, in 1976, a document was submitted to the Chinese government, saying that there were almost no traditional doctors left (Wang, 2013). This led to the establishment in 1979 of the National Association of Chinese Medicine, and many traditional texts were edited and republished (Wang, 2013). Now CAM use, especially TCM, is accepted more by governments in Asian rather than Western areas (Bautista, et al., 2011). For example, there is still a department within the Ministry of Public Health in China, specifically dealing with TCM (Hesketh & Zhu, 1997). Its aim is to support the use and integration of TCM within cultures and to create a framework in which CAM can be delivered. Today, China is regarded as one of the most integrated health systems in the world where TCM is embedded within medical training (Chung et al., 2011). Furthermore, a study found that 82% of orthodox medical doctors in China had referred patients to TCM practitioners (Harmsworth & Lewith, 2001), compared to 41% in the UK (Lewith, et al., 2001).

PREVALENCE OF CAM USE

The prevalence of the use of CAM varies between countries due to economic, cultural and social factors. For example, in countries where CAM has cultural and historical influences, such as Singapore and Korea, although orthodox health care systems are quite well established, 76% and 86% of their population still use TCM (World Health Organisation, 2012). CAMs are widely used and valued around the globe. These medicines, which are often proven to be safe, ensures that all people have access to care, when many have no access to orthodox medicine. For example, the ratio of traditional healers to population in Africa is 1:500 whilst to medical doctors it is 1:40,000 (Abdullahi, 2011). Indeed for many millions of people, herbal medicines and traditional treatments are the main, and sometimes only source of healthcare (World Health Organisation, 2014). Furthermore, it is argued that CAM may reduce healthcare costs and contribute to the economic development of a number of countries, thanks to not only the agriculture incentive to grow herbs, but also to the internet which has made buying herbs and other CAM products easier globally (World Health Organisation, 2014).

The use of CAM is highest in East Asian countries such as Japan with 76% of patients using CAM (Yamashita, et al., 2002), Malaysia with 69.4% (Siti, et al., 2009), and South Korea with 74.8% using CAM (Ock, et al., 2009). A study in India found that 89% of the doctors which responded to their survey had used CAM (Telles, et al., 2011). A report on the prevalence of use in 2007 in the US, found that 38.8% (83 million) adults and 11.8% (8.5 million) children used CAM (Barnes, et al., 2008), with the estimated total out of pocket expense on CAM for adults in 2007 being approximately $33.9 billion per year (Nahin, et al., 2009) with the most common condition treated being described as musculoskeletal