THE JOURNAL OF ALTERNATIVE AND COMPLEMENTARY MEDICINE
Volume 15, Number 5, 2009, pp. 489–494

DOI: 10.1089/acm.2008.0430

Original Articles

Delphi-Derived Development of a Common Core for Measuring Complementary and Alternative Medicine Prevalence

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Abstract

Assessing complementary and alternative medicine (CAM) use remains difficult due to many problems, not the least of which is defining therapies and modalities that should be considered as CAM. Members of the International Society for Complementary Medicine Research (ISCMR) participated in a Delphi process to identify a core listing of common CAM therapies presently in use in Western countries. Lists of practitioner-based and self-administered CAM were constructed based on previous population-based surveys and ranked by ISCMR researchers by perceived level of importance. A total of 64 (49%) ISCMR members responded to the first round of the Delphi process, and 39 of these (61%) responded during the second round. There was agreement across all geographic regions (United States, United Kingdom, Canada, and Western Europe) for the inclusion of herbal medicine, acupuncture, homeopathy, Traditional Chinese Medicine (TCM), chiropractic, naturopathy, osteopathy, Ayurvedic medicine, and massage therapy in the core practitioner-based CAM list, and for homeopathy products, herbal supplements, TCM products, naturopathic products, and nutritional products in the self-administered list. This Delphi process, along with the existing literature, has demonstrated that (1) separate lists are required to measure practitioner-based and self-administered CAM; (2) timeframes should include both ever use and recent use; (3) researchers should measure and report prevalence estimates for each individual therapy so that direct comparisons can be made across studies, time, and populations; (4) the list of CAM therapies should include a core list and additionally those therapies appropriate to the geographic region, population, and the specific research questions addressed, and (5) intended populations and samples studied should be defined by the researcher so that the generalizability of findings can be assessed. Ultimately, it is important to find out what CAM modality people are using and if they are being helped by these interventions.

Introduction

Complementary and alternative medicine (CAM) increasingly has an established place in integrated health care and health care research. CAM modalities and regimes are more widely available in primary medical care and through the services of private CAM practitioners in all Western industrialized nations, and are the main health care technologies in some third world environments where they are considered mainstream and not CAM. The most frequent use in the West may well be self-prescribed or recommended via nonmedical referral systems. Because the use of CAM has many ramifications that extend beyond medicine and public health to the health and wellbeing of individuals in every community in the

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world, it becomes increasingly important to consider how it may best be defined in order to evaluate prevalence of use.

Prevalence and incidence estimates of CAM use are frequently beset with problems related to standardization, as there is difficulty in defining which therapies and modalities should be considered as CAM. This can invalidate data comparison and interpretation across studies. Despite these problems, many useful surveys of CAM prevalence have been conducted. Barnes et al. showed age-adjusted prevalence of CAM use reported in population-based studies conducted in the United States between 1990 and 2004 (Fig. 1).[1] As indicated by Barnes et al., most of these surveys asked participants to indicate whether they used one or more items from a list of CAM interventions or therapies, and the lists varied considerably among the surveys. This research has underlined the difficulty of comparing variables in one survey with another and re-emphasizes the need for surveys to incorporate standardized methods and definitions.[2–7]

In a systematic review of the prevalence of CAM use, Ernst summarized the available data among random or representative samples of the general population.[6] He concluded that the true prevalence of use of CAM remains uncertain. In a more recent publication, Ernst calls for greater attention to methods when conducting surveys of CAM prevalence, including development and use of questionnaires that are properly validated.[7]

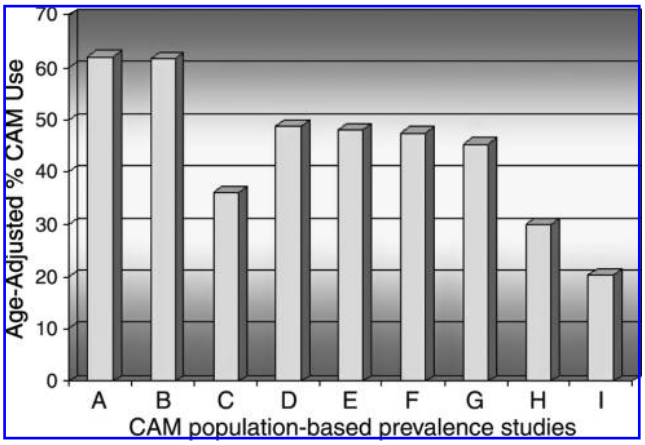

FIG. 1. Based on (**A**) National Center for Health Statistics. 2002 National Health Interview Survey (NHIS). (**B**) 2002 NHIS excluding megavitamin therapy. (**C**) 2002 NHIS excluding prayer for health reasons. (**D**) Eisenberg DM, Davis RB, Ettner SL, et al. Trends in alternative medicine use in the United States, 1990–1997: Results of a follow up national survey. JAMA 1998;280:1569. (**E**) Astin JA. Why patients use alternative medicine: Results of a national study. JAMA 1998;279:1548. Eisenberg DM, Kessler RC, Foster C, et al. Unconventional medicine in the United States: Prevalence, costs, and patterns of use. N Eng J Med 1993;328:246. (**F**) Ni H, Simile C, Hardy AM. Utilization of complementary and alternative medicine by United States adults: Results from the 1999 National Health Interview Survey. Med Care 2002;40:353–358. (**G**) Oldendick R, Coker AL, Wieland D, et al. Population-based survey of complementary and alternative medicine usage, patient satisfaction, and physician involvement. South Med J 2000;93:375. (**H**) Rafferty AP, McGee HB, Miller CE, Reyes M. Prevalence of alternative medicine use: State-specific estimates from the 2001 Behavioral Risk Factor Surveillance System. Am J Public Health 2002;92:1598. (**I**) Paramore LC. Use of alternative therapies. Estimates from the 1994 Robert Wood Johnson Foundation National Access to Care Survey. J Pain Symptom Manage 1997;13:83. CAM, complementary and alternative medicine.

Thomas and colleagues discuss the difficulties of measuring CAM as a unified concept, as different researchers include different therapies in their definition of CAM.[5] There appears to be a tradeoff between the accuracy of estimates obtained and their comprehensiveness. Lists of CAM therapies have been developed and can be used to provide a framework for the selection of a core CAM list for future surveys.[8–14] Specific guidelines have been proposed by Harris and Rees to standardize the measurements of CAM prevalence such as timeframe, distinguishing between practitioner-led and self-medicated or over-the-counter use, and definition of what constitutes a CAM therapy.[4] A formal universal definition may not be either possible or adequate. Treatments considered to be CAM vary depending on disability or disease, population group, country, race/ethnicity, and the specific research question posed. In addition, over time, treatments once considered to be CAM have entered into the mainstream. Accepting these limitations, it may still be feasible to define a standardized set of common treatments that could be used to enable comparisons among surveys. This core list could be supplemented with additional CAM therapies to take into account disease-specific, country-specific, or population-specific CAM therapies.

This study describes the results of a Delphi process designed to develop a common core list of CAM therapies to be used as a baseline in surveys to determine CAM prevalence. The main aim was to identify an agreed core listing of common CAM therapies presently in use across different Western countries.

Materials and Methods

Members of the International Society for Complementary Medicine Research (ISCMR, www.iscmr.org) from Western countries agreed to take part in a Delphi process. The ISCMR board of directors sent out an introductory e-mail describing the project and asking members to participate in a Delphi process. The Delphi process is a technique used to elicit opinions and gather a group response from a panel of experts in an anonymous way that minimizes effects related to group interaction.[15,16] Elements critical to the process include feedback in the form of individual contributions or responses, assessment of the group opinion, opportunity for individuals to revise their original responses following the initial assessment of group opinion, and guaranteed anonymity for the individuals who participate in the process.

An initial list of CAM therapies was developed based on previous population-based surveys.[7–14,17,18] Repeated e-mail invitations were sent to ISCMR members from Western countries ($N = 130$) to request participation, and news items informing the members about the proposed Delphi process were printed in the ISCMR newsletter to maximize participation. ISCMR members from Western countries who elected to participate responded to the initial list of CAM therapies, ranking them individually and anonymously as 1 = very important, 2 = somewhat important, or 3 = not important for inclusion in the core list. Two lists were provided, which were divided into practitioner-based and

self-administered CAM, with an opportunity to add items to the lists. Two Delphi rounds were conducted between December 2004 and May 2005 via e-mail following established Delphi process protocols.[15,16] At each round, CAM therapies with an overall mean score ≥2.0 across all respondents were removed from the list. After each round the CAM therapies were placed in rank order and the results were shown to the panel at the second round. Disagreements across the geographic areas were reported if at least one geographic area ranked a therapy as ≥2.0 and at least one geographic area ranked the same therapy as <2.0. A decision was made to discontinue the Delphi process after two rounds and to report the areas of both agreement and disagreement by geographic region with the realization that geographic-related responses may be important to acknowledge in core lists of CAM along with a universal core list. An opportunity was provided for the reviewers to insert qualitative remarks, and these remarks were taken into account in the revisions of lists between the first and second rounds of the Delphi process.

Results

A total of 64 of the 130 (49%) ISCMR members from Western countries responded to the first round of the Delphi process. In the second round, 39 members (61%) who participated in round one responded to the survey (Table 1). Analysis comparing responders to non-responders showed that the qualifications of responders were similar to those of non-responders. Those who responded to the Delphi process were slightly more likely to be professors and researchers at the Ph.D. level. CAM therapies included in lists for both round 1 and round 2 of the Delphi process are summarized in Table 2. *Qigong* was the only therapy not included in the core list that was added by respondents and carried through to the second round of the Delphi process, with overall support for inclusion.

Table 1. ISCMR Respondents by Geographic Region

Region	*Round 1* (n = *64*)	*Round 2* (n = *39*)
United States	29%	24%
United Kingdom	25%	33%
Canada	22%	17%
Western Europe	17%	19%
Response rate	64/130 (49%)	39/64 (61%)

ISCMR, International Society for Complementary Medicine Research.

Practitioner-based CAM

Practitioner-based CAM therapies that were considered important overall (mean < 2.0) for the core list include acupressure, acupuncture, anthroposophical medicine, aromatherapy, Ayurvedic medicine, Traditional Chinese Medicine (TCM), chiropractic care, guided imagery/relaxation therapy, herbal medicine/medical herbalism/phytotherapy,

Table 2. CAM Therapies Included in Practitioner-Based and Self-Medication Lists from Rounds 1 and 2 of the Delphi Process

Practitioner-based list	*Round 1*	*Round 2*	*Self-medication list*	*Round 1*	*Round 2*
Acupressure[a]	×	×	Acupressure	×	
Acupuncture[b]	×	×			
Alexander technique	×		Alexander technique	×	
Anthroposophical medicine[a]	×	×	Anthroposophical medicine	×	
Aromatherapy[a]	×	×	Aromatherapy	×	
Ayurvedic medicine[b]	×	×	Ayurvedic medicine[a]	×	×
Bioelectromagnetic therapies	×		Bioelectromagnetic therapies	×	
Traditional Chinese Medicine[b]	×	×	Traditional Chinese Medicine products[b]	×	×
Chiropractic care[b]	×	×			
Flower essences (e.g., Bach)	×		Flower essences (e.g., Bach)	×	
Guided imagery/relaxation therapy[a]	×	×	Guided imagery/relaxation therapy[a]	×	×
Healing/Reiki	×				
Herbal supplements	×		Herbal supplements[b]	×	×
Herbal medicine/medical herbalism/phytotherapy[a]		×			
Homeopathy[a]	×	×	Homeopathy products[b]	×	×
Hypnotherapy[a]	×	×			
Massage therapy[b]	×	×			
Meditation, any type	×		Meditation, any type[a]	×	×
Naturopathy[b]	×	×	Naturopathic products[b]	×	×
Nutritional therapy[a]	×	×	Nutritional products[b]	×	×
Osteopathy[b]	×	×			
Qigong	×		*Qigong*[a]	×	×
			Prayer	×	
Reflexology	×		Reflexology	×	
T'ai chi	×		*T'ai chi*[a]	×	×
Yoga[a]	×	×	Yoga[a]	×	×

[a]Overall agreement for the core list but disagreement by geographic regions.
[b]Agreement for the core list overall and across geographic regions.
CAM, complementary and alternative medicine.

Table 3. Practitioner-Based CAM Agreement by Region in Round 2

Practitioner-based CAM	*United States* (n = 10)	*United Kingdom* (n = 14)	*Canada* (n = 7)	*Western Europe* (n = 8)
Acupuncture	1.1 ± 0.3	1.1 ± 0.3	1.1 ± 0.4	1.1 ± 0.4
Ayurvedic medicine	1.3 ± 0.5	1.7 ± 0.8	1.3 ± 0.5	1.6 ± 0.9
Traditional Chinese Medicine	1.1 ± 0.3	1.0 ± 0.01	1.0 ± 0.01	1.3 ± 0.7
Chiropractic care	1.2 ± 0.4	1.1 ± 0.4	1.3 ± 0.8	1.4 ± 0.5
Herbal medicine/herbalism	1.0 ± 0.01	1.1 ± 0.3	1.0 ± 0.01	1.0 ± 0.01
Homeopathy	1.4 ± 0.7	1.1 ± 0.3	1.0 ± 0.01	1.3 ± 0.5
Massage therapy	1.6 ± 0.5	1.6 ± 0.7	1.4 ± 0.8	1.5 ± 0.5
Naturopathy	1.2 ± 0.4	1.5 ± 0.7	1.0 ± 0.01	1.6 ± 0.5
Osteopathy	1.5 ± 0.5	1.1 ± 0.3	1.7 ± 1.0	1.5 ± 0.5

All figures are mean ± standard deviation. Responses according to a four-point scale of 1 = very important, 2 = somewhat important, 3 = not important.
CAM, complementary and alternative medicine.

homeopathy, hypnotherapy, massage therapy, naturopathy, nutritional therapy, osteopathy, and yoga. Table 3 shows the agreement (mean < 2.0) across geographic regions for the practitioner-based CAM core list. There was agreement across all geographic regions for the inclusion of acupuncture, Ayurvedic medicine, TCM, chiropractic care, herbal medicine (also described as herbalism or phytotherapy), homeopathy, massage therapy, naturopathy, and osteopathy in the core CAM list. Respondents from the U.S., U.K., and Canada were more likely to rank nutritional therapy as an important practitioner-based CAM (Table 4). Respondents from Western European countries ranked anthroposophical medicine as an important CAM, and this differed from its ranking by respondents from all other geographic regions.

Self-administered CAM

Self-administered CAM therapies that were considered important overall (mean < 2.0) for the core list include Ayurvedic medicine, TCM products, guided imagery/relaxation therapy, herbal supplements, homeopathic products, meditation, naturopathic products, nutritional products, *qigong*, *t'ai chi*, and yoga. There was agreement (mean < 2.0) across geographical regions regarding the importance of TCM products, homeopathy products, herbal supplements, naturopathic products, and nutritional products (Table 5). Respondents from the U.S. and U.K. were more likely to agree about the importance of guided imagery/relaxation, *qigong*, and yoga (Table 6). *T'ai chi* was considered important by U.K. respondents and Western European respondents, while respondents from Canada and Europe were more likely to agree about the importance of Ayurvedic medicine.

Comments from respondents

Respondents took advantage of the opportunity to submit comments and suggestions which indicated the importance of geographic area in determining the importance of CAM therapies. For example, chiropractic therapies, anthroposophical medicine, and osteopathy are considered CAM in some regions, but mainstream medicine in others. There is a need for the core list to include the opportunity for geographic-specific therapies and researcher-specific therapies that are disease-specific.

Many respondents commented on the inclusion of any systems of medicine in the self-administered core list, due to the concern that individuals could not use systems of medicine without a practitioner. The presence of a practitioner was considered by many respondents to be essential to the use of systems of medicine and modalities of CAM, although most agreed that using products associated with systems of medicine (such as Chinese herbs) without a practitioner may be considered a self-administered CAM practice. There was further debate about what might be included in a system of medicine used in a core list of CAM. Does TCM include *qi gong* and *t'ai chi*, and how is this classified on the practitioner list versus the self-administered core list?

Discussion

The results of the Delphi process showed more agreement overall and across geographic regions for practitioner-based CAM compared with self-administered CAM. Respondent comments pointed to the difficulties involved in classifying self-administered aspects of CAM that may not be possible without the advice of a practitioner.

Table 4. Practitioner-Based CAM Disagreement by Region in Round 2

Practitioner-based CAM	*United States* (n = 10)	*United Kingdom* (n = 14)	*Canada* (n = 7)	*Western Europe* (n = 8)
Acupressure	2.2 ± 0.08	2.0 ± 0.8	1.7 ± 0.05	1.8 ± 0.05
Anthroposophical medicine	2.1 ± 0.6	2.2 ± 0.8	2.2 ± 0.8	1.1 ± 0.4
Aromatherapy	2.2 ± 0.7	1.6 ± 0.6	1.7 ± 0.08	2.1 ± 0.6
Guided imagery/relaxation	1.5 ± 0.7	1.8 ± 0.08	2.3 ± 0.08	2.0 ± 0.5
Hypnotherapy	1.8 ± 0.8	1.6 ± 0.7	2.3 ± 1.0	2.3 ± 0.5
Nutritional therapy	1.2 ± 0.6	1.4 ± 0.7	1.4 ± 0.08	2.0 ± 0.8
Yoga	1.9 ± 0.0	1.8 ± 0.6	2.4 ± 0.5	1.9 ± 0.6

All figures are mean ± standard deviation. Responses according to a four-point scale of 1 = very important, 2 = somewhat important, 3 = not important.
CAM, complementary and alternative medicine.

Table 5. Self-Administered CAM Agreement by Region in Round 2

Self-administered CAM	*United States* (n = 10)	*United Kingdom* (n = 14)	*Canada* (n = 7)	*Western Europe* (n = 8)
TCM products	1.8 ± 1.0	1.5 ± 0.5	1.3 ± 0.5	1.2 ± 0.4
Homeopathy products	1.6 ± 0.07	1.3 ± 0.5	1.2 ± 0.4	1.3 ± 0.5
Herbal supplements	1.6 ± 0.9	1.3 ± 0.7	1.2 ± 0.4	1.8 ± 0.4
Naturopathic products	1.9 ± 1.0	1.5 ± 0.7	1.2 ± 0.4	1.7 ± 0.5
Nutritional products	1.6 ± 0.7	1.5 ± 0.8	1.5 ± 0.7	1.7 ± 0.8

All figures are mean ± standard deviation. Responses according to a four-point scale of 1 = very important, 2 = somewhat important, 3 = not important.
CAM, complementary and alternative medicine; TCM, Traditional Chinese Medicine.

Table 6. Self-Administered CAM Disagreement by Region in Round 2

Self-administered CAM	*United States* (n = 10)	*United Kingdom* (n = 14)	*Canada* (n = 7)	*Western Europe* (n = 8)
Ayurvedic medicine	2.0 ± 1.0	1.8 ± 0.9	1.4 ± 0.6	1.5 ± 0.8
Guided imagery/relaxation	1.6 ± 0.7	1.8 ± 0.7	2.5 ± 0.6	1.8 ± 0.8
Meditation	1.6 ± 0.9	1.5 ± 0.5	2.2 ± 1.0	1.8 ± 0.8
Qigong	1.9 ± 0.6	1.8 ± 0.6	2.3 ± 0.5	1.7 ± 0.8
T'ai chi	2.1 ± 0.6	1.7 ± 0.5	2.3 ± 0.5	1.7 ± 0.8
Yoga	1.6 ± 0.7	1.6 ± 0.5	2.3 ± 0.8	1.7 ± 0.8

All figures are mean ± standard deviation. Responses according to a four-point scale of 1 = very important, 2 = somewhat important, 3 = not important.
CAM, complementary and alternative medicine.

Difficulties arose in classifying certain therapies, such as herbal medicine, nutritional therapy, and massage therapy. These therapies include a broad range of components that may have different meanings and interpretations overall and across geographical areas. The controversy about self-use of systems of medicine needs further discussion: The question is whether or not an individual can use a system of medicine without a practitioner. For the most part, individuals probably do not use whole systems of CAM without a practitioner, but instead use components or products, such as acupressure, herbal medicine, or Ayurvedic cooking.

Questions remain regarding whether or not systems of CAM should be separated from their methods or practices within the practitioner list. Most respondents agreed that they should be listed separately. A few respondents also debated the meaning of "practitioner" within CAM. For example, is it important to differentiate according to level of knowledge or try to measure skill in some way? Does it matter for prevalence measures if the practitioner is skilled? How do we differentiate between a well-educated consumer and an unskilled practitioner? CAM is not static; therapies currently considered to be CAM may become a part of mainstream medicine over time. For example, should herbal medicine, phytotherapy, osteopathy, or nutritional therapy be considered CAM or mainstream? Individual therapies can also be a part of more than one system—herbs are part of naturopathy, TCM, and Ayurvedic medicine.

There are limitations to this Delphi process. The compiled lists for practice-based and self-administered CAM are not representative of all English-speaking countries. New Zealand and Australia are not represented. Although opinions reflect the expertise of members of the ISCMR, not all members participated in the process. Further, the opinions of the respondents from ISCMR are not necessarily generalizable to all CAM researchers.

Guidelines exist for constructing surveys to measure the prevalence of CAM. This Delphi process, in accord with the existing literature, has demonstrated that:

(1) separate lists are required to measure practitioner-based and self-administered CAM;
(2) timeframes should include both ever use and recent use and include consideration of recall bias issues;
(3) researchers should measure and report prevalence estimates for each individual therapy so that direct comparisons can be made across studies, time, and populations;
(4) the list of CAM therapies should include a core list and, additionally, those therapies appropriate to the geographic region, population, and the specific research questions addressed (individual researchers may decide it is important to collect information on all therapies being used by the individual, irrespective of the classification);
(5) the intended populations and samples studied should be defined by the researcher so that the generalizability of findings can be assessed.

Ultimately, it is important to find out what CAM people are using and if they are being helped.

Conclusions

We have presented the initial development of an international core list of CAM that can be used across Western countries to measure prevalence of use. The next steps involve continued dialogue among CAM practitioners, researchers, and users to further define a usable list using these guidelines and then validating the resulting definitions in differing populations.

Acknowledgment

The authors thank the members of the ISCMR who participated in this Delphi study.

Disclosure Statement

No competing financial interests exist.

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