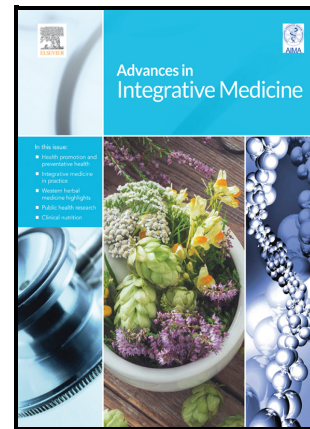


Evaluating the Barriers to the Utilization of Complementary and Alternative Medicine (CAM) in the United States: An Exploratory Study

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**Evaluating the Barriers to the Utilization of Complementary and Alternative Medicine (CAM) in the United States: An Exploratory Study**

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**Abstract**

Introduction

The utilization of certain forms of complementary and alternative medicine (CAM) is prevalent among adults in the United States. While researchers have extensively studied the factors influencing CAM use in Western countries, significant barriers to its adoption remain. This paper draws attention to the obstacles faced by individuals in their journey to using CAM.

Methods

Qualitative interviews were conducted with 21 patients who had turned to CAM for managing a chronic illness/condition. These in-depth, face-to-face interviews occurred in Miami, USA, during 2014-15. The sampling, data collection, and analysis processes of this study adhered to the principles outlined in Charmaz's constructivist grounded theory approach.

Results

From the data, three central barriers to CAM utilization in the US emerged: 1) Financial barriers: A significant portion of CAM treatments is not covered by insurance, making them cost-prohibitive for many. 2) Skepticism and discouragement: Both conventional medical practitioners and a segment of the public exhibited a noticeable trend towards discouraging CAM use. 3) Evaluation challenges: Patients expressed difficulty in assessing the efficacy and benefits of various CAM treatments compared to their costs.

## Discussion

Despite the widespread interest in and use of CAM in the US, numerous barriers hinder its broader integration into mainstream healthcare. These obstacles not only restrict healthcare choices for the general public but also appear to favor a select demographic, potentially based on income and availability of information..

### **What is already known about the topic**

- The high prevalence of CAM use by patients suffering from chronic ailments in the US
- Estimates of high out-of-pocket spending amongst CAM users in the US
- Conventional medical practitioner's varied attitudes towards CAM treatments and their use
- Disparate methods used to measure the efficacy of CAM treatments
- Few qualitative studies exploring the major barriers to CAM use in the US

### **What this paper adds**

- Use of grounded theory methods to understand the barriers to CAM use in the US
- In-depth qualitative analysis of the challenges faced by chronically ill patients in utilizing CAM treatments
- Exploratory findings extending research on the primary barriers to CAM utilization

### **1. Introduction**

Complementary and Alternative Medicine (CAM) is a term frequently used in Western countries (like the US, UK, Australia, and others) to refer to a broad range of health care systems, techniques, and products. Many health care systems and techniques, regarded as CAM in Western nations and typically practiced outside the mainstream healthcare in most countries, are in fact fundamental aspects of the traditional or integrated health care from which they originate. Governments in many nations have actively popularized traditional or indigenous health care systems, and practitioners undergo commensurate training, licensing, and regulation [1,2,3].

In the United States, CAM has navigated phases of development and reassessment [4]. State-wise licensing of various CAM practices reveals a lack of uniformity and limited insurance coverage [5]. Barriers such as lack of understanding, credibility within mainstream medicine, and challenges to research and evidence-based practice in CAM persist. Despite these obstacles, there have been efforts by the National Institute of Health to bring conventional medicine and CAM together in a regulated way through the National Center for Complementary and Integrative Health (NCCIH).

The establishment of NCCAM in 1998 (now NCCIH) augmented national interest and research into various forms of healing, a trend persisting today [6,7]. Amidst wide-ranging research on CAM's prevalence, safety, efficacy, and utilization, this paper focuses on the barriers to CAM use. To better understand the obstacles, this paper revisits previously collected data that used grounded theory to understand the meaning and experience of using CAM amongst chronically ill individuals. This data is contextualized to highlight the ongoing divide rather than the integration of different health practices. This division reaffirms the urgency of addressing the multifaceted barriers to CAM use, despite its growing popularity. There remains an essential need for collaboration and ensuring equal value and status alongside conventional medicine.

## **2. Methods**

The collection and analysis of data for this project was done in Miami/USA from 2014-2015, with ethical approval from the University of Miami Institutional Review Board obtained on July 30th, 2014. Participants were 18 years or older and had used CAM for a self-reported chronic ailment such as breast cancer, multiple sclerosis, chronic cardiac problems, cervical cancer, diabetes mellitus, multiple myeloma, osteoarthritis, chronic back pain, thrombotic thrombocytopenic purpura (TTP), Parkinson's disease, hyperthyroidism, ulcerative colitis, and a chronic migraine condition.

Utilizing the theoretical sampling approach inherent in grounded theory, the research seamlessly integrated data collection and analysis. Initially, purposive sampling began by contacting personal connections in Miami. After analyzing the first few interviews, categories for data collection were shaped. Subsequent participants were recruited through a snowball sampling strategy, where they

were referred by prior participants. To ensure a comprehensive understanding of the data, diversity in factors such as gender, age, and ethnicity was actively introduced. The process continued with the aim of achieving theoretical saturation, which is the point where categories are so thoroughly explored that no new insights or dimensions arise from additional data.

The interviews, which ranged in duration from 25 minutes to 3 hours and 30 minutes, were audio-recorded and took place either at the participants' residences or locations they chose. The researcher personally conducted all the interviews. Before each session, participants provided informed consent. The researcher took field notes during the interviews and transcribed them later. To ensure comprehensive coverage, an interview guide was used.

Following grounded theory guidelines, concurrent data collection and analysis was pursued. The interviews were guided by a semi-structured format, asking respondents to reflect on the meaning and experiences with CAM. This approach allowed participants to freely discuss and elaborate on the topic. After transcribing the first interview, the researcher undertook initial processing of the data, organizing and categorizing the textual information in Microsoft Word for clarity and accuracy. The researcher was solely responsible for coding all the data. Data analysis involved multiple stages, starting with initial coding, followed by the constant comparative method [8]. This initial coding produced action codes that influenced further data collection. These codes then led to the generation of focused codes, advancing to the development of conceptual categories [8].

Throughout the data collection and analysis phase, the researcher engaged in memo-writing; maintained reflective logs; and held monthly consultations with a senior researcher to review and refine the research process. These steps were crucial for identifying potential biases and ensuring the results' trustworthiness. Furthermore, memo-writing aided in streamlining analysis and pinpointing the project's main focus [9]. For confidentiality, pseudonyms were employed in all transcripts and resulting outputs.

Some major themes emerged from the data analysis process. One significant theme was the barriers that participants confront in using or desiring to use CAM therapies and practices. The researcher

determined that saturation for this theme was achieved since it was persistently probed in all interviews once it stood out as a focused category of significance.

### **3. Results**

A total of 21 in-depth interviews were conducted with an ethnically diverse cohort ranging in age from 32 to 77 years. Of the participants, 5 were male and 16 were female. Their employment status varied, with some working full-time, others being self-employed, and some retired. The study identified barriers to the pursuit of CAM. This theme was subdivided into three main aspects: the cost of CAM as a deterring factor, discouragement from both mainstream medical professionals and social circles/acquaintances, and the difficulties with evaluating the benefits of various types of CAM.

#### **3.1 Cost as a deterring factor**

In this study, participants indicated that the cost of CAM was an impediment to its use. In the US, commonly utilized CAM practices like acupuncture or chiropractic care can be quite expensive without insurance. Furthermore, CAM therapies like yoga or meditation can also be relatively costly due to the way they are marketed in Western countries [10]. Participants noted the significant financial burden of procuring CAM products and services. Many participants also suggested having foregone certain CAM treatments owing to monetary concerns. Though participants in the study expressed a desire and willingness to use other healing strategies beyond conventional medicine, the price of these therapies posed a challenge to their utilization. For example, a participant Lucy pointed out,

‘I don’t have the option of saying ok I am going to try naturoveda, I am going to try a doctor of alternative medicine, I don’t have the money to do it. I can’t afford to pay for every treatment or the entire series of treatments.’

Another participant, Amy provided a breakdown of her treatment expenses, shedding light on the monetary investment required of people intent on using CAM practices.

‘Reiki is like \$85 a week, if I wanted to go every week, every session is \$85 and with a massage, it’s \$105.... So, I cannot go every week, I cannot afford it. The only thing I can go to every week is the acupuncture because she is giving me a really good deal. She calls it her family discount and I spend about \$350 a month on acupuncture and it’s not insurance, it’s out of pocket. The Shaman treatment I have one more treatment that I am holding on to. And those are like \$150 a session. A session is about 2 ½ hour so it’s not very expensive if you consider how long it is, but it is expensive if you consider all the other treatments. And nothing is covered by insurance.’

Taken together, Amy was spending almost \$585 a month on CAM therapies. Since CAM therapies often require out-of-pocket payments, they place significant pressure on those with fixed monthly incomes. Here, Amy later suggested that she was considering tutoring to earn some extra money to pay for the health care choices she had made.

Another participant Mahdi affirmed that she had taken out a loan to cover the expenses for a CAM therapy she had used. She stated,

‘The cranial sacral plating, I actually took out a loan to see if it would help me which I then repaid. At that moment in time, it was the right thing for me to do, I am not sorry that I did that.’

Some participants explained that though the cost of treatment with CAM therapies was high, in the long haul they were the beneficiary as it enabled them to have a healthier body.

Interestingly, despite these financial challenges, none of the participants in this study were from socioeconomically deprived backgrounds. And yet, quite a few of the participants expressed having been affected by the cost of CAM therapies.

### **3.2 Discouragement from the mainstream**

The support for CAM varies amongst conventional medical practitioners (CMPs) who are trained in the biomedical sciences [11, 12]. Patients divulging details of their CAM use to CMPs might be

exposed to a range of reactions. Participants in this study revealed that typically CMPs did not encourage their patient's use of CAM.

Participants noted how CMPs rarely talked about the importance of strengthening the immune system. Lisa pointed out that after her cancer diagnosis in the 1990s, CMPs discouraged her from continuing with CAM practices, arguing it would be of no benefit. Recalling her experience, Lisa said,

‘So medical people were telling me oh it doesn't matter what you do. Don't do yoga, you'll hurt yourself. I mean just all sorts of things and I knew they weren't on the correct path ...I chose to do more of what I was doing and to stick with my programme.’

Similarly, another participant, Kelly, highlighted the prevalent skepticism in conventional medicine. She noted how her CMP was indifferent to CAM, even though the CMP was upfront about the lack of a cure in conventional medicine.

‘...The lady doctor said, yeah you could try it, but they don't have proof or training that anything else could work but drugs. And the drugs don't cure it, it just temporarily relieves the symptoms. So, my husband was insistent to go and try, so she said ok go, and when you come back come and see me and she had the pills ready so that was about it.’

While Kelly chose to explore CAM, others might not share her resolve. Several participants weren't always honest about their CAM use with their CMP's, fearing a derisive response or a lack of recognition and understanding of what CAM entails. A participant, Miranda, indicated she'd never admit to her CMP that she engaged in holistic healing.

‘I probably will not tell my regular doctor, I mean not that there is anything wrong with it, it's just that sometimes I don't think they appreciate it. They never talk about diet and yet that's so important what you put in your body and yet you don't hear them say anything....’

Many participants were cautious discussing their CAM usage with friends and acquaintances, being afraid of judgment or ridicule. One participant said she might disclose use of some CAM practices while withholding the use of others, expecting scrutiny.



‘I think I share; the energy work I don’t share too much because even my friends are like (really?)!’

While some participants felt comfortable confiding in their CMPs about their CAM use or sought out CMPs who were more supportive, only a few encountered practitioners who were entirely supportive of CAM therapies and practices.

Despite evolving research and practices, rigid views on CAM persist among conventional medical practitioners in the US. This ethos remains, even with advancements in CAM and the establishment of integrative medicine centers nationwide.

### **3.3 Difficulty evaluating benefits**

While there is ongoing debate about the efficacy of CAM, many individuals base their opinions on personal anecdotes or their direct experiences. However, the expectation for immediate results can lead to impatience and dissatisfaction. In this study, a few participants highlighted this concern, while others emphasized the long-term benefits of CAM. For instance, Kelly shared that she didn’t have adequate opportunity to evaluate the acupuncture treatment she underwent in Hong Kong, as she had to return to the US due to time and money constraints

‘.. he started doing treatments every day, acupuncture, and a lot of massage at the base of my skull and it’s amazing how much it hurt, rubbing deep down and stretching. He was a master in chi-gong so he did mental healing also and I couldn’t have stayed longer, he said I should’ve stayed longer up to 3 months...’

Similarly, another participant Larissa also touched upon the theme of patience and the need for continued sessions to truly gauge the benefits of CAM. She mentioned,

‘Like you know my friend, she is an acupuncturist, and she says people come in for 1 treatment and they feel better. But really you should maintain it so that there is sort of like a reversal. This is the difficulty, because they are paying out of pocket and they are not paying

through insurance, so for them to come for more than 1 session when they are not getting relief ...’

The cost factor also understandably drives the evaluation of CAM therapies. When individuals pay out of pocket, they expect to get prompt results and value for their money. This consumer behavior can be rooted in the broader societal expectation of receiving immediate returns on any investment. This sentiment was palpable among the study's participants, who frequently associated their perceptions of CAM therapies with the expenses they shouldered. Matt's perspective serves as an example. He expressed reservations about the value of CAM treatments, voicing concerns about the potential futility of such expenditures if no discernible benefits were observed.

‘Cost is also a factor and that’s been a factor with me ... the Chinese medicine doctor, every time I went to see her it would be like \$250..They want you to come every week or twice a week and if you see that’s a lot of money. And I had saved a lot and I’ll say that I had gone there for a month, and I spent \$2000, and I am not sure if I got anything out of it. It made me think like should I really be doing this? And is this a good decision?..’

It is probably not unusual for people to abandon certain strategies for healing in the absence of instant results. However, given the expenses incurred in availing of CAM, people are likely to be more demanding of CAM practitioners and products. In the intricate balance of cost, expectation, and perceived efficacy, the acceptance and continued use of CAM therapies remain deeply influenced by both individual experiences and broader societal norms.

#### **4. Discussion**

The sustained use of any treatment requires that people can evaluate the gains accrued from that healing strategy. Very often, individuals rely on the outcomes of evidence-based research for the use of conventional medicine. However, the dearth of research on CAM based on the metrics of biomedical sciences is often the reason why they are written off by CMP’s as quackery or dangerous [13]. The appropriateness of using randomized controlled trials (RCTs) to evaluate CAM has been

questioned. Since RCTs are geared towards assessing the efficacy of conventional medicine, they may not be the most appropriate method of evaluation for other healing techniques [14, 15].

This research uniquely illuminates the broader challenges CAM users encounter. It emphasizes the financial constraints due to the lack of insurance support and the societal hurdles stemming from the fear of ridicule. There exists a distinct difference in the therapeutic philosophies between conventional medicine and CAM. This difference complicates the evaluation of CAM benefits within the frameworks typical for mainstream treatments.

Among the challenges highlighted, cost emerges as a significant concern for CAM users. Since these expenses are often borne out-of-pocket, even if CAM treatments aren't always pricier, the lack of insurance support shifts the financial weight entirely onto the user [16,17]. This limitation not only restricts healthcare choices but also makes many CAM therapies inaccessible to those with limited economic means [18,19]. Interestingly, some nations harness indigenous healthcare practices to address health concerns in marginalized communities or disadvantaged areas [20, 21]. But, without the same leverage as conventional medicine in the US, CAM remains underrepresented in discussions about public health and isn't equally advocated for in insurance contexts.

This research also noted a tendency among CAM users to withhold their usage details, suggesting that CAM still faces skepticism and potential discouragement from the mainstream. Such behavior may arise from fears of mockery or embarrassment. However, previous studies have noted mixed attitudes towards CAM among CMPs, with some expressing support for CAM [22, 23].

Lastly, participants expressed unease when they didn't perceive quick health improvements from CAM use. Whilst, conventional medicine generally focuses on symptom management and curing diseases, CAM takes a holistic approach, emphasizing the interconnectedness of mind, body, and spirit [24, 25]. Unlike the immediate effects of many conventional treatments, CAM results might require more time [26, 27, 28]. It's worth noting that clinical trials assessing the effectiveness of CAM, particularly in areas like acupuncture or homeopathy, do exist [29, 30]. Yet, their findings aren't widely disseminated in Western mass media. More attention should be paid to the metrics by

which we evaluate CAM. Evaluating CAM purely against conventional medicine might overlook its unique benefits.

This study had some inherent limitations. The sample, while chosen based on theoretical sampling to achieve theoretical saturation, was both small and self-selected. This limits the broad applicability of the findings. Moreover, individuals from lower socio-economic backgrounds were not represented in the sample, which may have overlooked important perspectives on affordable CAM options. The sample did not offer a detailed exploration of CAM perceptions across diverse demographic categories, such as social class or ethnicity. It's also essential to highlight that this research was conducted exclusively in Miami, a city with a significant population of ethnic minorities in the US. This demographic context could have uniquely influenced the feedback from CAM users.

Given the observations and the identified limitations, there is a pressing need for further research in this area. Expanding the study to incorporate a more diverse demographic, especially across different socio-economic backgrounds and regions, would provide a more comprehensive understanding of CAM perceptions and usage. Furthermore, research exploring the integration of CAM with conventional medical practices, and how such combined treatments can optimize patient outcomes, is paramount. This holistic approach to understanding healthcare choices could be instrumental in framing better public health policies and insurance contexts that respect and incorporate the value of both CAM and conventional treatments.

## References

- [1] Park HL, Lee HS, Shin BC, Liu JP, Shang Q, Yamashita H and Lim B (2012) Traditional medicine in China, Korea, and Japan: A brief introduction and comparison. *Evidence-based complementary and alternative medicine*, 2012: 429103
- [2] Kang YM, Komakech R, Karigar CS, and Saqib A (2017) Traditional Indian medicine (TIM) and traditional Korean medicine (TKM): a constitutional-based concept and comparison. *Integrative medicine research* 6(2):105-113.
- [3] Katoch D, Sharma JS, Banerjee S, Biswas R, Das B, Goswami D, Harwansh RK, Katiyar CK, and Mukherjee PK (2017) Government policies and initiatives for the development of Ayurveda. *Journal of Ethnopharmacology* 197:25-31.
- [4] Foote-Ardah CE (2004) Sociocultural barriers to the use of complementary and alternative medicine for HIV. *Qualitative Health Research* 14(5): 593-611.

- [5] Cohen MH and Nelson H (2011) Licensure of complementary and alternative practitioners. *AMA Journal of Ethics* 13(6):374-378.
- [6] Hopp C (2015) Past and future research at National Center for Complementary and Integrative Health with respect to botanicals. *HerbalGram* 107: 44-51.
- [7] Kuszak AJ, Hopp DC, Williamson JS, Betz JM and Sorkin BC (2016) Approaches by the US National Institutes of Health to support rigorous scientific research on dietary supplements and natural products. *Drug Testing and Analysis* 8(3-4): 413-417.
- [8] Charmaz K (2006) *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. London: Sage Publications.
- [9] Charmaz K and Belgrave L (2012) Qualitative Interviewing and Grounded Theory Analysis. In: Gubrium JF, Holstein J, Marvasti AB and McKinney KD (eds) *The Sage Handbook of Interview Research: the Complexity of the Craft*. Thousand Oaks, CA: Sage Publications, pp. 247- 265.
- [10] Gokcen CB and Ertimur B (2015) Creating Hybridity: the Case of American Yoga. In: Kristin D and Yoon C (eds) *NA- Advances in Consumer Research Volume 43*. Duluth, MN: Association for Consumer Research, pp. 494-497.
- [11] Huston P and MacGuigan D (2021) What do academic physicians think of Tai Chi? A qualitative study. *The Journal of Alternative and Complementary Medicine* 27(5): 434-441.
- [12] Stussman BJ, Nahin RL, Barnes PM, Scott R, Feinberg T and Ward BW (2022) Reasons Office-Based Physicians in the United States Recommend Common Complementary Health Approaches to Patients: An Exploratory Study Using a National Survey. *Journal of Integrative and Complementary Medicine*. Epub ahead of print May 12, 2022. doi: 10.1089/jicm.2022.0493.
- [13] Beyerstein BL (2001) Alternative medicine and common errors of reasoning. *Academic Medicine* 76(3): 230-237.
- [14] Furnham A and Forey J (1994) The attitudes, behaviors, and beliefs of patients of conventional vs. complementary (alternative) medicine. *Journal of Clinical Psychology* 50(3): 458-469.
- [15] Singh RH (2010) Exploring issues in the development of Ayurvedic research methodology. *Journal of Ayurveda and Integrative Medicine* 1(2): 91-95.
- [16] Nahin RL, Stussman BJ and Herman PM (2015) Out-of-pocket expenditures on complementary health approaches associated with painful health conditions in a nationally representative adult sample. *The Journal of Pain* 16(11): 1147-1162.
- [17] John GM, Hershman DL, Falci L, Shi Z, Tsai WY and Greenlee H (2016) Complementary and alternative medicine use among US cancer survivors. *Journal of Cancer Survivorship* 10: 850-864.
- [18] Bishop FL and Lewith GT 2010 Who uses CAM? A narrative review of demographic characteristics and health factors associated with CAM use. *Evidence-Based Complementary and Alternative Medicine* 7: 11-28.
- [19] Chan YM, Huang H and Mei H (2012) Socioeconomic status, attitudes on use of health information, preventive behaviors, and complementary and alternative medical therapies: Using a US national representative sample. *Academic Research International* 3(2):15.
- [20] Samal J (2015) Role of AYUSH workforce, therapeutics, and principles in health care delivery with special reference to National Rural Health Mission. *Ayu* 36(1): 5-8.

- [21] Samal J and Dehury RK (2018) Can the AYUSH system be instrumental in achieving universal health coverage in India? *Indian Journal of Medical Ethics* 3(1): 61-65.
- [22] Frank E, Ratanawongsa N and Carrera J (2010) American medical students' beliefs in the effectiveness of alternative medicine. *International Journal of Collaborative Research on Internal Medicine & Public Health* 2(9): 292-305.
- [23] Lie DA and Boker J (2006) Comparative survey of Complementary and Alternative Medicine (CAM) attitudes, use, and information-seeking behavior among medical students, residents & faculty. *BMC Medical Education* 6(1): 1-6.
- [24] Barrett B, Marchand L, Scheder J, Appelbaum D, Chapman M, Jacobs C, Westergaard R and Clair NS (2000) Bridging the gap between conventional and alternative medicine. *Journal of Family Practice* 49(3): 234-234.
- [25] Barrett B, Marchand L, Scheder J, Appelbaum D, Plane MB, Blustein J, Maberry R and Capperino C (2004) What complementary and alternative medicine practitioners say about health and health care. *The Annals of Family Medicine* 2(3): 253-259.
- [26] Upchurch DM and Rainisch BKW (2013) A sociobehavioral model of use of complementary and alternative medicine providers, products, and practices: findings from the 2007 national health interview survey. *Journal of Evidence-Based Complementary & Alternative Medicine* 18(2):100-107.
- [27] Eaves ER, Sherman KJ, Ritenbaugh C, Hsu C, Nichter M, Turner JA and Cherkin DC (2015) A qualitative study of changes in expectations over time among patients with chronic low back pain seeking four CAM therapies. *BMC complementary and alternative medicine* 15(1):1-10.
- [28] Committee on Children with Disabilities (2001) Counseling families who choose complementary and alternative medicine for their child with chronic illness or disability. *Pediatrics* 107(3): 598-601.
- [29] Ratcliffe J, Thomas KJ, MacPherson H and Brazier J (2006) A randomized controlled trial of acupuncture care for persistent low back pain: a cost-effectiveness analysis. *BMJ* 333(7569): 626.
- [30] Nuhn T, Lüdtke R and Geraedts M (2010) Placebo effect sizes in homeopathic compared to conventional drugs—a systematic review of randomized controlled trials. *Homeopathy* 99(01): 76-82.

#### Author Statement

I, Anwesa Chatterjee, hereby declare that I am the sole author of this manuscript titled “Evaluating the Barriers to the Utilization of Complementary and Alternative Medicine (CAM) in the United States: An Exploratory Study”. I confirm that I have completed the research and writing of this paper, as detailed below:

**Conception and Design:** I was solely responsible for conceptualizing the study and designing its methodology.

**Acquisition, Analysis, and Interpretation of Data:** I independently collected all data and was solely responsible for its analysis and interpretation.

**Drafting and Revising the Article:** The article was drafted, written, and critically revised by me.

**Final Approval:** I have reviewed this final version of the manuscript and approve it for submission to *Advances in Integrative Medicine*

No conflicts of interest exist in relation to this research and its publication.

#### **Declaration of interests**

- The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.
- The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

#### **Ethics Statement**

I affirm that all participants involved in this study were approached with utmost respect. Prior to their involvement, every interviewee was provided with a clear and comprehensive explanation of the study's objectives, methodology, potential benefits, and any associated risks. Only after I provided them with the details of the research, did each interviewee provide their informed consent to participate.

Moreover, the ethical integrity and methodological approach of this study was reviewed and approved by the Institutional Review Board (IRB) of the University of Miami. The official approval for this research was granted on July 30th, 2014. All practices and procedures in this study were aligned with the standards set forth by the IRB, ensuring that the rights, wellbeing, and confidentiality of the participants were safeguarded at all times.