



THE LEMON TASTING CALCIUM AND VITAMIN D SUPPLEMENT

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BMJ 1999;319:693-696 (11 September)

Clinical review

ABC of complementary medicine

What is complementary medicine?

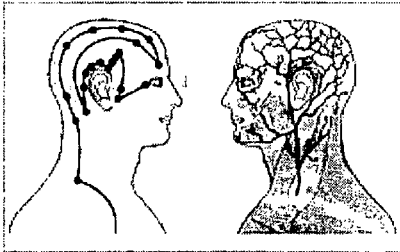
Catherine Zollman, Andrew Vickers.

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Complementary medicine refers to a group of therapeutic and diagnostic disciplines that exist largely outside the institutions where conventional health care is taught and provided. Complementary medicine is an increasing feature of healthcare practice, but considerable confusion remains about what exactly it is and what position the disciplines included under this term should hold in relation to conventional medicine

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In the 1970s and 1980s these disciplines were mainly provided as an alternative to conventional health care and hence became known collectively as "alternative medicine." The name "complementary medicine" developed as the two systems began to be used alongside (to "complement") each other. Over the years, "complementary" has changed from describing this relation between unconventional healthcare disciplines and conventional care to defining the group of

disciplines itself. Some authorities use the term "unconventional medicine" synonymously. This changing and overlapping terminology may explain some of the confusion that surrounds the subject.

Common complementary therapies

- | | | |
|---------------------------|--------------------------|---------------------------------|
| • Acupressure | • Chiropractic* | • Naturopathy |
| • Acupuncture* | • Cranial osteopathy | • Nutritional therapy* |
| • Alexander technique | • Environmental medicine | • Osteopathy* |
| • Applied kinesiology | • Healing | • Reflexology* |
| • Anthroposophic medicine | • Herbal medicine* | • Reiki |
| • Aromatherapy* | • Homoeopathy* | • Relaxation and visualisation* |
| • Autogenic training | • Hypnosis* | • Shiatsu |
| • Ayurveda | • Massage* | • Therapeutic touch |
| | • Meditation* | • Yoga* |
- *Considered in detail in later articles

Definition of complementary medicine adopted by Cochrane Collaboration

"Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within CAM and between the CAM domain and that of the dominant system are not always sharp or fixed."

We use the term complementary medicine to describe healthcare practices such as those listed in the box. We use it synonymously with the terms "complementary therapies" and "complementary and alternative medicine" found in other texts, according to the definition used by the Cochrane Collaboration.

Which disciplines are complementary?

Our list is not exhaustive, and new branches of established disciplines are continually being developed. Also, what is thought to be conventional varies between countries and changes over time. The boundary between complementary and conventional medicine is therefore blurred and constantly shifting. For example, although osteopathy and chiropractic are still generally considered complementary therapies in Britain, they are included as part of standard care in guidelines from conventional bodies such as the Royal College of General Practitioners.

Unhelpful assumptions about complementary medicine

"Non-statutory—~~not provided by the NHS~~"

- Complementary medicine is increasingly available on the NHS

- 39% of general practices provide access to complementary medicine for NHS patients

"Unregulated—~~therapists not regulated by state legislation~~"

- Osteopaths and chiropractors are now state registered and regulated, and other disciplines will probably soon follow

- Substantial amount of complementary medicine is delivered by conventional health professionals

"Unconventional—~~not taught in medical schools~~"

- Disciplines such as physiotherapy and chiropody are also not taught in medical schools

- Some medical schools have a complementary medicine component as part of the curriculum

"Natural"

- Good conventional medicine also involves rehabilitation with, say, rest, exercise, or diet

- Complementary medicine may involve unnatural practices such as injecting mistletoe or inserting needles into the skin

"Holistic—~~treats the whole person~~"

- Many conventional healthcare professionals work in a holistic manner

- Complementary therapists can be narrow and reductionist in their approach

- Holism relates more to outlook of practitioner than to the type of medicine practised

"Alternative"

- Implies use instead of conventional treatment

- Most users of complementary medicine seem not to have abandoned conventional medicine

"Unproved"

- There is a growing body of evidence that certain complementary therapies are effective in certain clinical conditions

- Many conventional healthcare practices are not supported by the results of controlled clinical trials

"Irrational—~~no scientific basis~~"

- Scientific research is starting to uncover the mechanisms of some complementary therapies, such as acupuncture and hypnosis

"Harmless"

- There are reports of serious adverse effects associated with using complementary medicine

The wide range of disciplines classified as complementary medicine makes it difficult to find defining criteria that are common to all. Many of the assumptions made about complementary medicine are oversimplistic generalisations.

Historical development

Since the inception of the NHS, the public sector has supported training, regulation, research, and practice in conventional health care. The recent development of complementary medicine has taken place largely in the private sector. Until recently, most complementary practitioners trained in small, privately funded colleges and then worked independently in relative isolation from other practitioners.

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Factors limiting research in complementary medicine

Lack of funding—In 1995 only 0.08% of NHS research funds were spent on complementary medicine. Many funding bodies have been reluctant to give grants for research in complementary medicine. Pharmaceutical companies have little commercial interest in researching complementary medicine.

Lack of research skills—Complementary practitioners usually have no training in critical evaluation of existing research or practical research skills.

Lack of an academic infrastructure—This means limited access to computer and library facilities, statistical support, academic supervision, and university research grants.

Insufficient patient numbers—Individual list sizes are small, and most practitioners have no disease "specialty" and therefore see very small numbers of patients with the same clinical condition. Recruiting patients into studies is difficult in private practice.

Difficulty undertaking and interpreting systematic reviews—Many poor quality studies make interpretation of results difficult. Many publications in complementary medicine are not on standard databases such as Medline. Many different types of treatment exist within each complementary discipline (for example, formula, individualised, electro, laser, and auricular acupuncture).

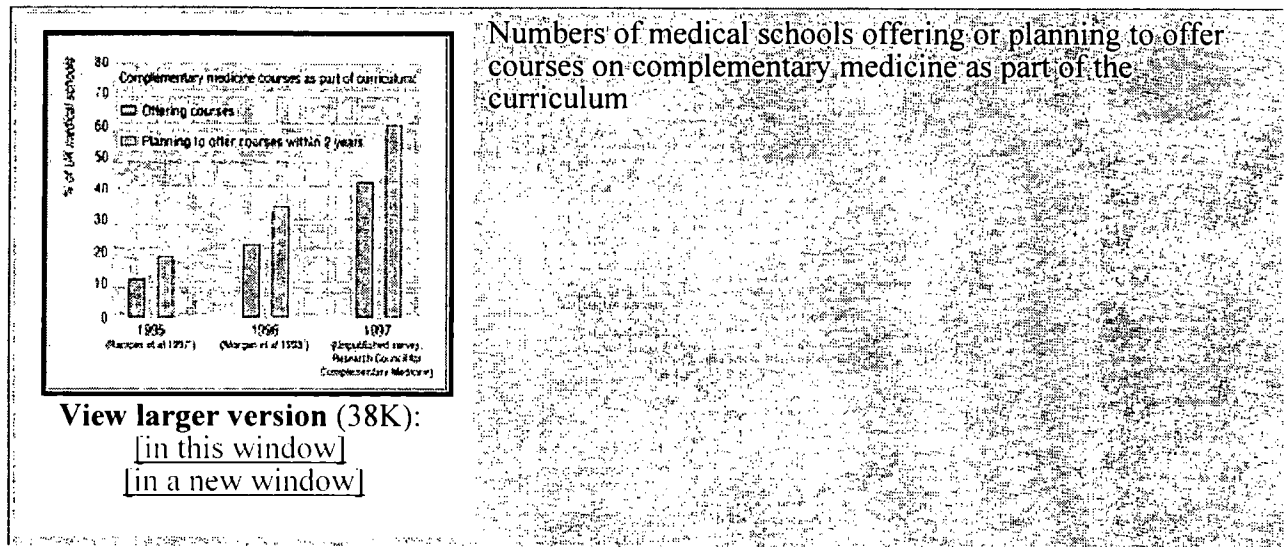
Methodological issues—Responses to treatment are unpredictable and individual, and treatment is usually not standardised. Designing appropriate controls for some complementary therapies (such as acupuncture, manipulation) is difficult, as is blinding patients to treatment allocation. Allowing for the role of the therapeutic relationship also creates problems.

Research

More complementary medical research exists than is commonly recognised—the *Cochrane Library* lists over 4000 randomised trials—but the field is still poorly researched compared with conventional medicine. There are several reasons for this, some of which also apply to conventional disciplines like occupational and speech therapy. However, complementary practitioners are increasingly aware of the value of research, and many complementary training courses now include research skills. Conventional sources of funding, such as the NHS research and development programme and major cancer charities, have become more open to complementary researchers.

Training

Although complementary practitioners (other than osteopaths and chiropractors) can legally practise without any training whatsoever, most have completed some further education in their chosen discipline.

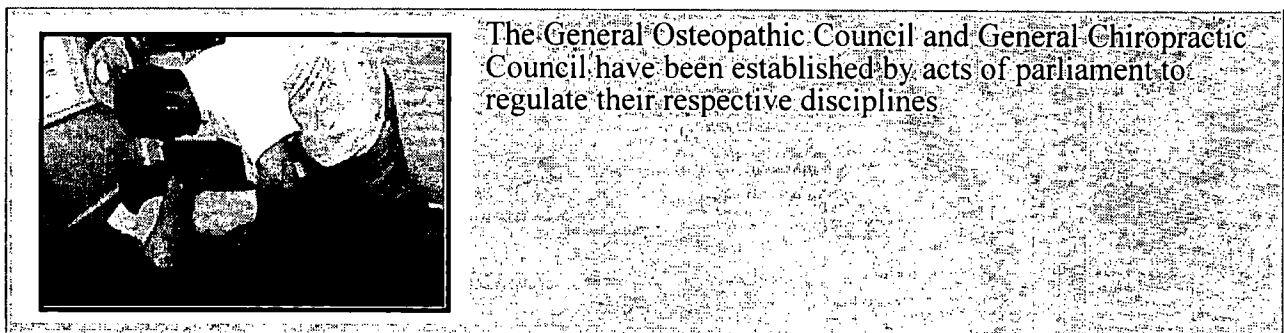


There is great variation in the many training institutions. For the major therapies—osteopathy, chiropractic, acupuncture, herbal medicine, and homoeopathy—these tend to be highly developed, some with university affiliation, degree level exams, and external assessment. Others, particularly those teaching less invasive therapies such as reflexology and aromatherapy, tend to be small and isolated, determine curricula internally, and have idiosyncratic assessment procedures. In some courses direct clinical contact is limited. Some are not recognised by the main registering bodies in the relevant discipline. Most complementary practitioners finance their training without state support, and many train part time over several years.

Conventional healthcare practitioners such as nurses and doctors often have their own separate training courses in complementary medicine.

Regulation

Apart from osteopaths and chiropractors, complementary practitioners are not obliged to join any official register before setting up in practice. However, many practitioners are now members of appropriate registering or accrediting bodies. There are between 150 and 300 such organisations, with varying membership size and professional standards. Some complementary disciplines have as many as 50 registering organisations, all with different criteria and standards.



Recognising that this situation is unsatisfactory, many disciplines are taking steps to become unified under one regulatory body per discipline. Such bodies should, as a minimum, have published criteria for entry, established codes of conduct, complaints procedures, and disciplinary sanctions and should require members to be fully insured.

The General Osteopathic Council and General Chiropractic Council have been established by acts of parliament and have statutory self regulatory status and similar powers and functions to those of the General Medical Council. A small number of other disciplines—such as acupuncture, herbal medicine, and homoeopathy—have a single main regulatory body and are working towards statutory self regulation.

Efficient regulation of the "less invasive" complementary therapies such as massage or relaxation therapies is equally important. However, statutory regulation, with its requirements for parliamentary legislation and expensive bureaucratic procedures, may not be feasible. Legal and ethics experts argue that unified and efficient voluntary self regulatory bodies that fulfil the minimum standards listed above should be sufficient to safeguard patients. It will be some years before even this is achieved across the board.

There are multiple levels of disease and, therefore, multiple levels at which therapeutic interventions can be made

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The approaches used by different complementary practitioners have some common features. Although they are not shared by all complementary disciplines, and some apply to conventional disciplines as well, understanding them may help to make sense of patients' experiences of complementary medicine.

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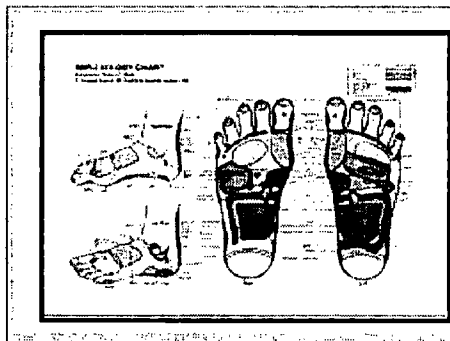
The holistic approach

Many, but not all, complementary practitioners have a multifactorial and multilevel view of human illness. Disease is thought to result from disturbances at a combination of physical, psychological, social, and spiritual levels. The body's capacity for self repair, given appropriate conditions, is emphasised.

Example of a holistic approach—Rudolph Steiner's central tenets of anthroposophy

- Each individual is unique
- Scientific, artistic, and spiritual insights may need to be applied together to restore health
- Life has meaning and purpose—the loss of this sense may lead to a deterioration in health
- Illness may provide opportunities for positive change and a new balance in our lives

According to most complementary practitioners, the purpose of therapeutic intervention is to restore balance and facilitate the body's own healing responses rather than to target individual disease processes or stop troublesome symptoms. They may therefore prescribe a package of care, which could include modification of lifestyle, dietary change, and exercise as well as a specific treatment. Thus, a medical herbalist may give counselling, an exercise regimen, guidance on breathing and relaxation, dietary advice, and a herbal prescription.



In reflexology areas of the foot are believed to correspond to the organs or structures of the body.

It should be stressed that this holistic approach is not unique to complementary practice. Good conventional general practice, for example, follows similar principles.

Use of unfamiliar terms and ideas

Complementary practitioners often use terms and ideas that are not easily translated into Western scientific language. For example, neither the reflex zones manipulated in reflexology nor the "Qi energy" fundamental to traditional Chinese medicine have any known anatomical or physiological correlates.



Acupuncturists may "take a patient's pulse," but they assess characteristics such as "wiriness" or "slipperiness."

Sometimes familiar terms are used but with a different meaning: acupuncturists may talk of "taking the pulse," but they will be assessing characteristics such as "wiriness" or "slipperiness," which have no Western equivalent. It is important not to interpret terms used in complementary medicine too literally and to understand that they are sometimes used metaphorically or as a shorthand for signs, symptoms, and syndromes that are not recognised in conventional medicine.

Different categorisation of illness

Complementary and conventional practitioners often have very different methods of assessing and diagnosing patients. Thus, a patient's condition may be described as "deficient liver Qi" by a traditional acupuncturist, a "pulsatilla constitution" by a homoeopath, and "a peptic ulcer" by a conventional doctor. In each case the way the problem is diagnosed determines the treatment given.

Confusingly, there is little correlation between the different diagnostic systems: some patients with deficient liver Qi do not have ulcers, and some ulcer patients do not have deficient liver Qi but another traditional Chinese diagnosis. This causes problems when comparing complementary and conventional treatments in defined patient groups.

Sources of information on healing

National Federation of Spiritual Healers (NFSH)

Largest professional registering body

Old Manor Farm Studio, Church Street, Sunbury on Thames, Middlesex TW16 6RG Tel: 01932 783164 Fax: 01932 779648 URL: www.nfsh.org.uk

Confederation of Healing Organisations (CHO)

Umbrella organisation for registering bodies in healing

Suite J, Second Floor, The Red and White House, 113 High Street, Berkhamsted HP4 2DJ Tel: 01442 870660

Publications

- Benor D. *Healing research*. Vols 1-4. Deddington: Helix Editions, 1992
Review of collected research on healing
- Brown C. *Optimum healing*. London: Rider, 1998
Description of a general practitioner's experience and use of healing

It should be stressed that the lack of a shared world view is not necessarily a barrier to effective cooperation. For example, doctors work closely alongside hospital chaplains and social workers, each regarding the others as valued members of the healthcare team.

Approaches to learning and teaching

Complementary practitioners are not generally concerned with understanding the basic scientific mechanism of their particular therapy. Their knowledge base is often derived from a tradition of clinical observation and treatment decisions are usually empirical. Sometimes traditional teachings are handed down in a way that discourages questioning and evolution of practice, or encourages reliance on their own and others' individual anecdotal clinical and intuitive experience.

It is obvious from this discussion that complementary medicine is a heterogeneous subject. It is unlikely that all complementary disciplines will have an equal impact on UK health practices. The individual complementary therapies with the most immediate relevance to the medical profession are reviewed in detail in later articles, but some disciplines are inevitably beyond the scope of this series—most notably those related to healing—and interested

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readers should consult texts listed in the boxes.

Further reading

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The ABC of complementary medicine is edited and written by Catherine Zollman and Andrew Vickers. Catherine Zollman is a general practitioner in Bristol, and Andrew Vickers will shortly take up a post at Memorial Sloan-Kettering Cancer Center, New York. At the time of writing, both worked for the Research Council for Complementary Medicine, London. The series will be published as a book in Spring 2000.

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- Lewith, G T, Ernst, E, Mills, S., Fisher, P., Monckton, J., Reilly, D., Peters, D., Thomas, K. (2000). Complementary medicine must be research led and evidence based. *BMJ* 320: 188-188 [[Full text](#)]
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Complementary Therapies?

Peter Morrell, Lecturer in Science Stoke College; Hon. Research Associate History of Medicine
Staffordshire Uni. , *Stoke College, UK*
bmj.com, 3 Nov 1999 [[Response](#)]

Research issues in traditional Chinese medicine

K C Tang
bmj.com, 17 Jan 2000 [[Response](#)]

Related letters in BMJ:

Complementary medicine must be research led and evidence based

G T Lewith, E Ernst, Simon Mills, Peter Fisher, Jonathan Monckton, David Reilly, David Peters,
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The challenge of complementary and alternative medicine

Ronald A. Chez, MD,* and Wayne B. Jonas, MD^b

Tampa, Florida, and Bethesda, Maryland

Complementary and alternative medicine can be defined as those medical systems, practices, interventions, and applications that currently are not part of the dominant or conventional medical system. There are more than 300 different topics under the term *complementary and alternative medicine* that can be divided into seven major categories on the basis of philosophy, approach to the patient, and orientation. Most patients seeking care from complementary and alternative medicine providers do so for the relief of signs and symptoms related to chronic illness while they are under the care of a physician. Clinical data derived from appropriately conducted clinical trials support the use and value of complementary and alternative medicine for selected indications. The challenge for both conventional medicine and complementary and alternative medicine is to fulfill the role of patient advocate by engaging in reciprocal open communication, facilitating the patient's informed choice, avoiding harmful or useless practices, and implementing an integrated evidence-based care plan. (*Am J Obstet Gynecol* 1997;177:1156-61.)

Key words: Alternative medicine, complementary medicine

As reflected in the mass media and clinical journals, there is increasing societal and medical interest about complementary and alternative medicine. The frequently cited article by Eisenberg et al.¹ provided data collected in 1990 on the use of complementary and alternative medicine by >1500 subjects. Extrapolating to the entire United States population, the authors estimated there were 425 million alternative practitioner visits in 1 year. This was a total of 40 million more visits than were made to primary care physicians. Of the \$13.7 billion spent on this care, >\$10.3 billion was not reimbursed. The main types of therapy used were exercise, prayer, relaxation techniques, chiropractic, and massage. The mean number of visits per user in the past 12 months was 19.

It is probable that the number of persons who use complementary and alternative medicine and the number of visits to complementary and alternative medicine providers has increased over the past 7 years. At least half of the physicians surveyed in this and other developed countries both make referrals to complementary and alternative medicine providers and use these types of interventions in their practice.^{2,3} The percentages of patients seeking complementary and alternative medical interventions in diseases such as acquired immunodeficiency syndrome and cancer range from 36% to 61% and from 6% to 61%, respectively.^{4,5}

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Because patients in our Preventive Prevention Clinic are treated with knowledge of their ultrasonographic findings, we have the clear choice to focus on the use of complementary and alternative medicine. The challenge for both conventional medicine and complementary and alternative medicine is to fulfill the role of patient advocate by engaging in reciprocal open communication, facilitating the patient's informed choice, avoiding harmful or useless practices, and implementing an integrated evidence-based care plan. (*Am J Obstet Gynecol* 1997;177:1156-61.)

As is true for conventional medicine, the physician who extends his or her usual system of practice to include complementary and alternative medicine must apply critical appraisal skills to analyze published clinical articles supporting these therapies, the appropriateness of an intervention for a specific patient, and the potential for harm from inappropriate and misplaced therapies.

The purposes of this article are to provide an overview of complementary and alternative medicine, to provide a selection of references in which such treatment was associated with clinical effectiveness, and to encourage the obstetrician-gynecologist to consider its potential role in the comprehensive care of women.

Complementary and alternative medicine versus Western biomedicine

Complementary and alternative medicine can be defined as those medical systems, professions, practices, interventions, modalities, therapies, applications, theories, or claims that are currently not part of the dominant (conventional) medical system. Over time, a specific alternative practice or treatment may be reclassified as conventional medicine in association with the emergence of supporting scientific data, clinical experience with its use, and a change in prevailing societal attitudes.⁶

Most complementary and alternative medical interventions have common philosophies and themes that are said to differentiate them from conventional medicine. These often include an emphasis on wholeness, the relationships between the mind, body, and spirit, and the person's interaction with the environment. The focus may be on determining the internal and external causes

of a problem rather than treating the patient's signs and symptoms. As a result, the specific goal of therapy can be to enhance the body's innate capacity for wellness and self-healing by creating or restoring balance between the person's physiologic and psychologic characteristics and bodily functions. In alternative medical terminology this is described as balance in the person's energy fields or life force.

Distinctions are also made between disease and illness, the person's response to disease, and between pain and the human experience of pain, which is suffering.⁷ Although they are interdependent, a distinction also is made between healing and curing. A cure is an externally applied medical intervention that removes all evidence of the diagnosed disease. Healing is an internal process of recovery that takes place on the physical, emotional, mental, or spiritual level and results in the person's having a sense of being complete, in balance or in harmony with self and surroundings. Because the two need not and may not occur together, it is possible for a patient to feel healed even when a cure is no longer possible and to be cured but not healed.⁷

Classification of complementary and alternative medicine

There are >300 different treatments, techniques, and modalities that can be placed under the umbrella term *complementary and alternative medicine*. This large, heterogeneous group can be divided into the seven major categories listed in Table I.⁶

Mind-body interventions. These techniques and therapies are based on the connectiveness between mind and body and its relationship to the person's maintenance of health and ability to withstand disease. This category includes biofeedback, meditation, the various forms of yoga, t'ai chi, relaxation response therapies, hypnosis, dance, art and music therapy, prayer, and mental healing and imagery.

Conditions for which some of these techniques have demonstrated clinical effectiveness include relaxation response and hypnosis for the relief of chronic pain and insomnia,⁸ intercessory prayer on the outcome of patients admitted to a coronary care unit,⁹ and psychosocial support group sessions for extending the survival time of patients with metastatic breast cancer.¹⁰

Alternative systems of medical practices. Frequently ancient in origin, these are professionalized health care systems that provide complete and comprehensive approaches to diagnosis and treatment. This category includes Indian, Ayurveda, Traditional Chinese Medicine, Tibetan medicine, homeopathy, anthroposophically extended medicine, naturopathy, and Unani Tibb.

Traditional Chinese Medicine incorporates herbal medicine, acupuncture, nutrition, acupressure, massage, and qigong. Acupuncture has demonstrated clinical efficacy in a variety of conditions such as the treatment of

Table I. Major categories of complementary and alternative medicine

Mind-body interventions
Alternative systems of medical practice
Manual healing methods
Pharmacologic and biologic treatments
Bioelectromagnetic applications
Herbal medicine
Diet and nutrition

chronic and recurrent pain including dysmenorrhea,¹¹⁻¹³ nausea and vomiting,¹⁴ alcoholism,¹⁵ and substance use and abuse,¹⁶ but not in patients with asthma.¹⁷

Homeopathy is based on the "law of similars; let likes be cured by likes." A naturally occurring substance is chosen that, when given in measurable quantities to healthy persons, matches the signs and symptoms of the patient's illness. However, the amount of the medicine that is prescribed is so dilute it often cannot be measured in molecular amounts. Nevertheless, systematic reviews of appropriately conducted clinical research studies provide evidence of efficacy for the treatment of pollinosis, influenza, postoperative ileus, and pain from trauma.¹⁸

Many indigenous populations throughout the world prefer or only have access to nonprofessionalized community-based health care. Individual providers in this category may be called medicine men or women, healers, shamans, traditional midwives, sponsors, and herbalists. The systems in which they practice include curanderismo in Hispanic communities and Alcoholics Anonymous in urban communities.

Manual healing methods. Physical therapy, massage, and chiropractic and osteopathic manipulation techniques are in this category. The subcategory referred to as biofield includes practices such as therapeutic touch, Reiki, polarity therapy, reflexology, and external qigong. In some of these the practitioners' hands touch or are in close proximity to the body but do not manipulate.

Chiropractic has been shown to be effective for the relief of acute low back pain¹⁹ and the short-term relief of tension headache and acute neck pain.²⁰ Massage of low-birth-weight newborns is associated with more rapid increases in weight and development.²¹

Pharmacologic and biologic treatments. This category is very large and diverse. It includes the use of both conventional medicines in an off-label manner and products not found in most conventional formularies. Some substances emanate from folk medicine; some have been formerly used and are now out of favor; and some are new entities developed for a specific patient. Most are controversial. Examples include antineoplastons, proteolytic enzymes, Coley's toxin, mistletoe lectins, and shark cartilage for the treatment of cancers, ozone as an antiviral therapy, and ethylenediaminetetraacetic acid chelation therapy in patients with obstructive artery disease.

Bioelectromagnetic applications. Living organisms interact with exogenous electromagnetic fields and also possess electrical currents that produce magnetic fields. Thermal applications of the low-frequency range include diathermy and radiofrequency surgery. The nonthermal uses of nonionizing electromagnetic fields include transcutaneous electrical nerve stimulation for the relief of dysmenorrhea,²² transcranial electrostimulation for the treatment of anxiety disorders,²³ and the application of pulsed electric and electromagnetic fields to facilitate the healing of nonunion bone fractures²⁴ and fresh tibial fractures.²⁵ Other investigations include the effects of exogenous natural and man-made electromagnetic fields (associated with power lines and strong ionizing electromagnetic radiation) on the body's endogenous electromagnetic fields.

Herbal medicine. The use of plant materials in medicines and food for therapeutic purposes has a long history. Single plant substances with clinical efficacy include feverfew in migraine headaches,²⁶ ginkgo for circulatory disorders associated with dementia,²⁷ possibly garlic for hypercholesterolemia but not as an antihypertensive,^{28, 29} and St. John's wort for mild to moderately severe depressive disorders.³⁰ Other single plant remedies include peppermint for gastrointestinal distress, ginger for nausea and vomiting, echinacea as an immune system stimulant, saw palmetto for benign prostatic hypertrophy, and ginseng for a variety of conditions. Particularly in the Orient, combinations of up to ≥ 10 herbs are provided as teas, decoctions, infusions, capsules, and tinctures.

This category also includes aromatherapy, the therapeutic use of essential oils extracted from parts of plants. The scientific evidence supporting the value of these substances when ingested or applied externally is scant.

Diet and nutrition. There is increasing recognition that specific vitamin, mineral, and food supplements added to the usual Western diet can have both preventive and therapeutic effects. In some instances, the amount prescribed exceeds the recommended daily allowances. A prominent example of the latter is the megadose amounts of daily folic acid intake associated with the decreased recurrence of neural tube defects in the fetus.³¹ Folic acid supplementation for all adults may become a recommendation on the basis of the relationships between the vitamin, hyperhomocysteinemia, and cardiovascular disease.³² Other examples are the effectiveness of niacinamide in improving joint mobility and the severity of osteoarthritis,³³ the use of fasting and a gluten-free vegan diet to reduce disease activity in rheumatoid arthritis,³⁴ and the eating of soy protein to improve lipid metabolism.³⁵

This category includes food-elimination diets to modify hyperactivity disorders in children and the systemic symptoms associated with food allergies. Alternative diets

also can be a component of lifestyle programs to enhance wellness and minimize illness. Some of the more prominent examples are vegetarianism, macrobiotics, and regimens espoused by Ornish et al.³⁶ and others.^{6, 7}

Comment.

Challenges for conventional medicine. It is imperative to acknowledge and affirm the essential role of conventional medicine with its capability to respond competently in the care of acute disease and trauma, its technical innovations in diagnosis and treatment, and the escalating clinical applications of basic science discoveries. However, it is in the areas of comprehensive care and the management of chronic disease conditions that the more reductionistic, mechanistic, and organ-specific approach of conventional medicine can be lacking.

Most patients who use complementary and alternative medicines in this country, Great Britain, and Europe do so in combination with the care they receive from their physicians.^{1, 4} Also, most patients access complementary and alternative medicines for relief of symptoms of chronic conditions such as back problems, allergies, arthritis, insomnia, headache, hypertension, digestive problems, anxiety, and depression; that is, conditions for which conventional medicine may not have a cure at the present time and prescribed treatment regimens can be associated with adverse side effects.

Therefore complementary and alternative medicine exists because it fills patients' needs. However, the gaps in communication between conventional medicine, complementary and alternative medicine providers, and scientists result in the patient's having to create her own care plan. An environment of mutual hostility, prejudice, dogmatism, confrontation, and denunciation results in the health professional's abrogating the ethical role of seeking to promote the patient's well-being and protect her from harm.

There is a finiteness to the scope of practice of both physicians and complementary and alternative medicine providers; few providers can be all things to all patients. Both groups have reciprocal obligations to adhere to the ethical principle of autonomy. The patient is the final arbitrator as to whether her needs are being met, and she has the right to choose between options. However, to do so she also has the right to be fully informed by her provider as to the goals and limits of the recommended therapy and a time/course of response. The ethical principle of beneficence is invoked when the provider fulfills the role of patient advocate by facilitating informed choice through discussing his or her own experience and knowledge, identifying authoritative sources, or seeking consultation, or all of these.³⁷

Similarly, complementary and alternative medicine and conventional medicine share a mutual responsibility

to apply evidence-based medicine to the other refer appropriate, open proof for avoid harm.

A fundamental recommendation defines the barrier to complementary to explain of biomedic mechanism consonant this rational intervention therapies have not whose clinical can required action of is, a direct that apply genetic regulation been made designs, implemented with standards is believers examples reviewed.

To further complement progress, legislation create a purpose research this time extramural and research specific complementary rigorously Responder, organizational reimbursement for interpretation of have all There

to apply evidence-based practices, to learn how to evaluate the other's potential value for the patient, and to refer appropriately. There is a need for bilateral curiosity, openness, and willingness to seek scientific empirical proof for a planned intervention and an obligation to avoid harmful or useless practices.³⁷

A fundamental tenet in patient care is that therapeutic recommendations be based on adequate evidence that defines the benefit/risk ratio and clinical efficacy. One barrier cited by conventional medicine in accepting complementary and alternative medicine is the inability to explain modes of action within the existing construct of biomedical science. For example, explanations for the mechanism of action and efficacy of homeopathy are not consonant with our current scientific dogma. However, this rationale for denying the role of various alternative interventions is belied by the repeated examples of therapies currently used in conventional medicine that have not met the same tests of explanatory criteria and whose clinical efficacy is not evidence based.^{38,39}

It can be posited that new scientific methods are required to evaluate and explain the mechanisms of action of complementary and alternative medicines; that is, a directed expansion of science to investigate the laws that apply to the natural universe including the bioenergetic regulation of cell activity. However, arguments have been made that the existing panoply of clinical research designs, including the randomized controlled trial, coupled with the highest level of scientific research standards is sufficient to provide answers to skeptics and believers alike.^{40,41} The references used in this article are examples of such clinical research published in peer-reviewed journals.

To further the application of scientific research to complementary and alternative medicines, in 1992 Congress legislated that the National Institutes of Health create an Office of Alternative Medicine. A primary purpose of this office is to coordinate and conduct research in complementary and alternative medicine. At this time funds have been distributed to support 52 extramural competitive research grants in complementary and alternative medicine and to create clinical research centers at 10 academic institutions for the specific purpose of establishing mechanisms to research complementary and alternative medicines in a scientifically rigorous manner.

Responding to the demands of purchasers and subscribers, some insurance companies and managed care organizations have created special health care plans that reimburse for certain alternative practices.⁴² Reimbursement for a specific alternative intervention can be falsely interpreted as an imprimatur that appropriate indications for its use, safety, efficacy, and cost-effectiveness have all been satisfied for that therapy.

There are also important implications for what society

defines legally as a health profession. The prototype applied to physicians includes regulatory protection and statutory authorization relative to training, licensure, certification, scope of practice, audit, professional liability, and disciplinary actions. Not all of these components are in place for many categoric providers of complementary and alternative medicine.⁴³

There are other areas of potential conflict, resistance, and controversy for both conventional medicine and complementary and alternative medicine groups. In addition to the impact of these reimbursement plans on the division of the health care dollar, these include the unfulfilled expectation that the salaried physician will work in tandem with alternative medicine practitioners in designing an integrated care plan for a patient and mutual referrals of patients will take place.⁴²

Challenges for the individual physician. The doctor-patient partnership rests on a foundation of trust. This trust speaks to the patient's comfort in complete disclosure and the patient's acceptance of the physician's knowledge, skills, understanding, and clinical experience.

However, physicians may project a negative, dismissive, and sometimes angry attitude when asked about alternative medicine. In the study of Eisenberg et al., 89% of patients were self-referred to an alternative practitioner and 72% did not tell their physicians they were using alternative treatments. Not only does this result in a medical record that lacks important information but also it denies an opportunity for the physician to better understand the patient's needs and to learn about the practice of alternative medicine in the community.

Patients are constantly being exposed to mass media articles and programs, as well as to best-selling books and articles on complementary and alternative medicine written by physicians and others. One result is that the patient may be more knowledgeable about some aspects of complementary and alternative medicines than her physician. Moreover, the patient may want information from her physician about the safety of, need for, and efficacy of an alternative treatment she is using or wishes to use.

It is not realistic that a physician be well informed about the wide range of alternative medicines and treatments while often struggling to remain current in the continual stream of advances in conventional medicine.

Although we know of at least 50 American medical schools that are currently offering courses in alternative medicine to their medical students, most practicing physicians were not exposed to such courses while in training. Therefore the physician will need to make a decision on establishing a knowledge base at some level about the more common complementary and alternative medical practices encountered in the local community.

One way is through self-study. The reading list at the end of this article contains some suggestions for a personal reference library. A search of electronic databases and

various alternative medicine-related web sites will also be productive. It may also be necessary to identify competent alternative medicine practitioners for the purpose of referral. The physician can ask the patient to provide her sources of information on the area of alternative treatment in which she is interested and the qualifications of the practitioner whom she is seeing. A referral network of alternative medical practitioners can be created the same way a list of referral physicians is, namely, by differentiating colleagues with ability and skill from those less capable through direct follow-up with the patient after a referral, informal discussions with colleagues, and the clinical outcome from the care provided.

In some instances the physician will be attracted to a specific alternative system or technique and will invest the time to study and become adept at its use. One such example is the increasing numbers of physicians who are learning and applying acupuncture in their practices.⁴⁴

Summary points

- Complementary and alternative medicine can be defined as those medical systems, professions, practices, interventions, modalities, therapies, applications, theories, or claims that are not currently part of the dominant or conventional medical system.
- Over time, a specific complementary or alternative practice or treatment may be reclassified to conventional medicine.
- Many alternative interventions share an emphasis on balance in the person's physiologic and psychologic characteristics and bodily function, the relationships between the mind, body, and spirit, and the person's interaction with the environment.
- It is possible to distinguish between terms such as healing and curing, pain and suffering, and disease and illness.
- Complementary and alternative medicine and conventional medicine share a mutual responsibility to apply evidence-based practices and to seek scientific empiric proof for a planned intervention and an obligation to avoid harmful or useless practices.
- Complementary and alternative medicine exists because conventional medicine can be limited in its ability to provide relief and fill patients' needs.
- The use of complementary and alternative medicine by the public and by physicians will continue to increase in the immediate future.
- On the basis of the needs of patients in the practice, the individual physician should decide the value of establishing a knowledge base at some level about the more common complementary and alternative practices encountered in the local community.
- The motivation for the physician to ask and learn about selected aspects of alternative medicine is the

possibility that some intervention will preserve or enhance the overall quality of life for the patient. Eventually, the other adjectives used to describe complementary and alternative medicine and conventional medicine will evolve into the single term *integrated medicine*.

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Addendum

Shown here is a list of material for a selected complementary and alternative reference library.

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Subject: RE: From J. Weeks: Regarding Design Principles of Healthcare Rene wal

Date: Fri, 10 Aug 2001 13:03:50 -0400

From: "Chang, Michele (WHCCAMP)" <changm@mail.nih.gov>

To: "Pihcp@aol.com" <Pihcp@aol.com>

CC: len.wisneski@onemedicine.com, PSNIDER@bastyr.edu,
"Jim Swyers (E-mail)" <jpswyers@starpower.net>

Thank you! I have forwarded this document and e-mail to the staff lead for the Commissioner Work Group working on this issue.

Michele M. Chang, MPH, CMT
Executive Secretary
White House Commission on
Complementary and Alternative Medicine Policy
tel: 301-435-6232
fax: 301-480-1691
website: whccamp.hhs.gov

-----Original Message-----

From: Pihcp@aol.com [mailto:Pihcp@aol.com]
Sent: Wednesday, August 08, 2001 7:26 PM
To: Chang, Michele (WHCCAMP)
Cc: len.wisneski@onemedicine.com; PSNIDER@bastyr.edu
Subject: From J. Weeks: Regarding Design Principles of Healthcare
Renewal

Hello Michelle --

I just spoke to Pam Snider who'd spoken with Candace ... and I understand there is interest there around the whole idea of Principles. I told Pam that

I'd e-mail you the document which we used at Summit 2001. The core document

is a DRAFT which was developed by a group which grew out of Summit 2000 and which is now co-chaired by Pam and Len Wisneski, who you may know. He's Maryland-based. Below is a description, from my June newsletter, of some of the process and thinking which went into developing this document. Attached

are some 3 dozen statements of principles from other groups in health care -- hospitals, IOM, CAM professional groups, employee benefits firms, health systems, integrative clinics, etc -- which Pam and I pulled together as back-up and resources in developing the DRAFT. I expect you'll find these instructive.

Pam's number is 425-602-3143 and Len's is 301-460-4350.

Hope this is useful and that you've had some time for pleasure this summer, despite your rush to deliver as document.

John

Your Input Sought on Practical, "Design Principles of Healthcare Renewal"

The value in clarifying and articulating fundamental principles which shape integrative or holistic approaches to health care is increasingly recognized

by leaders of diverse organizations who are promoting new paradigms of service delivery.

• Sylver Quevedo, MD, integrative medicine leader for Catholic Healthcare West, heads a group which developed a set of principles which are used to shape provider interactions in a sponsored, multi-practitioner integrative clinic at O'Connor Hospital.

• A holistic approach to employee benefit design called the Individual Health

Advocacy Program, successfully developed by Lee Murphy, of Chicago-based Benefit Performance Associates for such clients as Elgin, Illinois-based Sherman Health System is credited with underpinning a dramatic savings in employee benefit costs for the self-insured system.

• A two year process leading to promulgation of a set of cohesive principles

is presented by Pamela Snider, ND, as a critical step in the re-birth of American Association of Naturopathic Physicians as the national organization

for the modern naturopathic medical profession, and as a force in fashioning

both the basic sciences and clinical components of naturopathic medical education at Bastyr University.

• Integration leaders for Catholic Health Initiatives, Milt Hammerly, MD, and

for the Program in Integrative Medicine at the University of Arizona School of Medicine, Victoria Maizes, MD, each shared how successfully linking integrative care with the principle of patient-centered care opens the eyes and ears of conventional physicians who are instinctively wary of "alternative medicine."

• A two day retreat among diverse practitioners of acupuncture leading to a Seattle Statement of principles has helped clarify issues between groups with

disparate agendas on acupuncture regulation, according to Peter Martin, LAc,

board chair for Oregon College of Oriental Medicine.

• Corrine Bayley, with St. Joseph Healthcare, described how holistic principles her group developed positively energized trustee-level discussions

in her multi-hospital system.

These reflections grounded a consideration of a draft set of Design Principles of Healthcare for Accelerating Personal and Health System Renewal

which were used to provide a reflective backdrop for the practical issues explored at Integrative Medicine Industry Leadership Summit 2001. One participant observed, post-Summit, that the principles were "like an acupuncture treatment which opens up the energy and allows the collaborative

work to get done." (See related story, page 1.)

Below (or "On page X" is a set of "Design Principles" which were developed

as an outgrowth of Summit 2000 through an ad hoc Vision Group.¹ The group's original germination was in a belief that the integrative medicine industry "must articulate where it wants to go or it's never going to get there," according to Gary Sandman, of D.C.-based Integrative Medicine, Inc. On Sandman's early initiative, the group began to meet regularly in the fall of

2000. The group's focus quickly shifted from describing an optimally integrated healthcare future to developing the "design principles" which would shape that future.

Their draft product is offered here to INTEGRATOR readers for two reasons. First, these principles may be useful tools for stimulating reflection on the

practical role of principles in the integration environment. Second, the group is now reorganizing and taking in new ideas and "looking for new blood," says Len Wisneski, MD, who co-chairs the group with Snider. A

steering committee also includes Clement Bezold, PhD, of the DC-based Institute for Alternative Future and John Weeks.

1 The initial participants in the Vision Group were Gary Sandman, Clement Bezold, PhD, Roger Jahnke, OMD, Len Wisneski, MD, Pam Snider, ND, Alan Dumoff, MSW, JD, John Weeks, Terry Schmidt, PhD (Cand.), Jerry Whitworth, RN, CCP, and House Government Reform staff member Beth Clay.

(Note to layout: It would be nice to fit this, below, on to one page as it will be easier to make edits and fax back if it is.)

For Your Edits: DRAFT Design Principles of Healthcare
for Accelerating Personal and Health System Renewal

Preamble

Core principles drive the way healthcare operates and is experienced. Times of change and disturbance call us to examine, clarify and commit to renew our individual and community practices. The following set of principles emphasizes the integrative nature of optimal healthcare. Such care seeks to create health by engaging new and old approaches to health for the individual, system, community and environment. Integrative care is grounded in relationships, seeks sustainability, is energized by the unknown and crafted through continuous exploration of strategies for uniting the best of the world's evolving practices, outcomes and traditions.

These principles, based on the missions and visions of diverse stakeholders, are an initial expression of an effort to create a unifying view of a renewed system for healthcare delivery and payment. These principles are meant not as ideals, but as working tools of design, application, evaluation and alignment. They are offered here for community review, revision and amendment by the ad hoc Task Force on the Principles of Healthcare Renewal which grew out of the Vision Group of the Integrative Medicine Industry Leadership Summit 2000. Spring 2001

The design principles for accelerating health and well-being in individuals and in the health system are:

1. Honor wholeness and interconnectedness in all actions.

Body, mind, spirit, community, and environment are an integral whole that cannot be separated into isolated parts. All are involved in healing. Healthcare interventions, regardless of their focus, affect the whole.

2. Enhance the capacity for self-repair and healing.

The innate capacity for healing and the individual's personal empowerment in supporting these natural processes are fundamental considerations in all healthcare decisions.

3. Prioritize care in accordance with a hierarchy of treatment.

Care, and the leveraging of resources to affect care, are prioritized along diagnostic and therapeutic hierarchies which begin with education and empowerment in healthy choices, then move to the least invasive approaches

and escalate, as necessary, to approaches linked to increased likelihood of adverse effects or higher costs. The starting point for intervention is established through clarifying, with the individual receiving care, the risks

associated with foregoing, and with undertaking, more invasive approaches. Chronology and cause are fundamental aspects of this healing order.

4. Improve care through continuously expanding the evidence base.

Healthcare is a combined art and science in which personal practices and clinical choices and services are continuously evaluated and improved, by practitioners, users and organizations, based on diverse evidence. Included are the desires, perceptions and outcomes experienced by the individuals at the center of care, the clinical experience and understandings of all members

of a provider team, and particularly, systematically gathered evidence of experience and outcomes. More stringent evidentiary standards are associated

with higher risk or more costly interventions.

5. Embrace the fullness of diverse health care systems.

Conventional, traditional, indigenous, complementary and alternative models of care, and their bodies of knowledge, have contributions to make to the healthcare which is culturally most appropriate and effective for individuals

and communities. Best practices are discovered through exploring diverse structures for integration, including parallel, collaborative and assimilative models.

6. Partner with patients, their families and other practitioners.

Caregivers profoundly enhance healing and strengthen shared accountability through supporting the informed decision-making of the individuals/families/loved ones they serve, and through inclusive, respectful partnerships with other practitioners with whom they collaborate in care provision.

7. Use illness and symptoms as opportunities for learning and growth.

Illness represents an opportunity in which healing and balance are always possible even when curing is not. Symptoms are guides to health.

8. Explore integration in one's own care.

Practitioners, administrators and individuals are most effective in understanding and delivering integrative healthcare, and in embracing these design principles, when they follow these principles in their own care choices.

9. Align resource investment with these healthcare principles.

The renewal of our healthcare payment and delivery systems is fostered by aligning resource investment, in the personal, public, philanthropic and private sectors, with these principles. Humble willingness to work to resolve the tensions between one's personal and professional interests, and those shared interests expressed in these principles, is required of all participants. The renewed healthcare system is a partnership between an expanded commitment to the public health and a thriving industry of health creation.

10. Respect the time required for personal and health system change.

Interventions may be swift, but healing, habit change, and transformation take time and ongoing commitment.

NOTE: This is a DRAFT only. Neither the number nor the content of these design principles is fixed. Your ideas for changes, amendments, additional principles, better language, or a shift in emphasis, are actively solicited.

The end product may look nothing like this. This draft set of principles is a living document which will be altered, re-focused and refined through community response. Put your edits in CAPS, include other recommendations and send to

DRAFT Design Principles of Healthcare *for Accelerating Personal and Health System Renewal*

Provided by: Vision Group from Summit 2000
Context: All

Preamble

Core principles drive the way healthcare operates and is experienced. Times of change and disturbance call us to examine, clarify and commit to renew our individual and community practices. The following set of principles emphasizes the integrative nature of optimal healthcare. Such care seeks to create health by engaging new and old approaches to health for the individual, system, community and environment. Integrative care is grounded in relationships, seeks sustainability, is energized by the unknown and crafted through continuous exploration of strategies for uniting the best of the world's evolving practices, outcomes and traditions.

These principles, based on the missions and visions of diverse stakeholders, are an initial expression of an effort to create a unifying view of a renewed system for healthcare delivery and payment. These principles are meant not as ideals, but as working tools of design, application, evaluation and alignment. They are offered here for community review, revision and amendment by the ad hoc Task Force on the Principles of Healthcare which grew out of the Vision Group of the Integrative Medicine Industry Leadership Summit 2000.

Spring 2001

Draft Design Principles of Healthcare

for Accelerating Personal and Health System Renewal

The design principles for accelerating health and well-being in individuals, and in the health system, are:

1. Honor wholeness and interconnectedness in all actions.
 2. Enhance the capacity for self-repair and healing.
 3. Prioritize care in accordance with a hierarchy of treatment.
 4. Improve care through continuously expanding the evidence base.
 5. Embrace the fullness of diverse health care systems.
 6. Partner with patients, their families and other practitioners.
 7. Use illness and symptoms as opportunities for learning and growth.
 8. Explore integration in one's own care.
 9. Align resource investment with these healthcare principles.
 10. Respect the time required for personal and health system change.
-

Attachments

Immediately attached is the full version of the Draft Design Principles developed by the Vision Group. The additional documents were developed from a variety of sources as part of the Vision Group work to create this DRAFT set of *Design Principles of Healthcare*. In some instances, they were edited to fit the one page format by John Weeks or Pamela Snider, or both. These are meant for internal use in the Summit process. If one or more of these is of particular interest to you, please contact the individual who supplied the information, or Pamela (pamela.snider@bastyr.edu) or John Weeks (pihpc@aol.com)

Some Organizations Represented at Summit 2001

St. Joseph Health System: *Principles of Holistic Care*
Catholic Healthcare West/Center for Integrative Medicine at O'Connor Hospital
Catholic Healthcare Initiatives: View of Integrative Care
Sherman Health System/Benefit Performance Associates, LLC
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DRAFT Design Principles of Healthcare

for Accelerating Personal and Health System Renewal

provided by: Vision Group from Summit 2000

Context: All

Preamble

Core principles drive the way healthcare operates and is experienced. Times of change and disturbance call us to examine, clarify and commit to renew our individual and community practices. The following set of principles emphasizes the integrative nature of optimal healthcare. Such care seeks to create health by engaging new and old approaches to health for the individual, system, community and environment. Integrative care is grounded in relationships, seeks sustainability, is energized by the unknown and crafted through continuous exploration of strategies for uniting the best of the world's evolving practices, outcomes and traditions.

These principles, based on the missions and visions of diverse stakeholders, are an initial expression of an effort to create a unifying view of a renewed system for healthcare delivery and payment. These principles are meant not as ideals, but as working tools of design, application, evaluation and alignment. They are offered here for community review, revision and amendment by the ad hoc Task Force on the Principles of Healthcare which grew out of the Vision Group of the Integrative Medicine Industry Leadership Summit 2000.

Spring 2001

The design principles for accelerating health and well-being in individuals, and in the health system, are:

1. Honor wholeness and interconnectedness in all actions.

Body, mind, spirit, community, and environment are an integral whole that cannot be separated into isolated parts. All are involved in healing. Healthcare interventions, regardless of their focus, affect the whole.

2. Enhance the capacity for self-repair and healing.

The innate capacity for healing and the individual's personal empowerment in supporting these natural processes are fundamental considerations in all healthcare decisions.

3. Prioritize care in accordance with a hierarchy of treatment.

Care, and the leveraging of resources to affect care, are prioritized along diagnostic and therapeutic hierarchies which begin with education and empowerment in healthy choices, then move to the least invasive approaches and escalate, as necessary, to approaches linked to increased likelihood of adverse effects or higher costs. The starting point for intervention is established through clarifying, with the individual receiving care, the risks associated with foregoing, and with undertaking, more invasive approaches. Chronology and cause are fundamental aspects of this healing order.

4. Improve care through continuously expanding the evidence base.

Healthcare is a combined art and science in which personal practices and clinical choices and services are continuously evaluated and improved, by practitioners, users and organizations, based on diverse evidence. Included are the desires, perceptions and outcomes experienced by the individuals at the center of care, the clinical experience and understandings of all members of a provider team, and particularly, systematically gathered evidence of experience and outcomes. More stringent evidentiary standards are associated with higher risk or more costly interventions.

5. Embrace the fullness of diverse health care systems.

Conventional, traditional, indigenous, complementary and alternative models of care, and their bodies of knowledge, have contributions to make to the healthcare which is culturally most appropriate and effective for individuals and communities. Best practices are discovered through exploring diverse structures for integration, including parallel, collaborative and assimilative models. (.... more on next page ...)

6. *Partner with patients, their families and other practitioners.*

Caregivers profoundly enhance healing and strengthen shared accountability through supporting the informed decision-making of the individuals/families/loved ones they serve, and through inclusive, respectful partnerships with other practitioners with whom they collaborate in care provision.

7. *Use illness and symptoms as opportunities for learning and growth.*

Illness represents an opportunity in which healing and balance are always possible even when curing is not. Symptoms are guides to health.

8. *Explore integration in one's own care.*

Practitioners, administrators and individuals are most effective in understanding and delivering integrative healthcare, and in embracing these design principles, when they follow these principles in their own care choices.

9. *Align resource investment with these healthcare principles.*

The renewal of our healthcare payment and delivery systems is fostered by aligning resource investment, in the personal, public, philanthropic and private sectors, with these principles. Humble willingness to work to resolve the tensions between one's personal and professional interests, and those shared interests expressed in these principles, is required of all participants. The renewed healthcare system is a partnership between an expanded commitment to the public health and a thriving industry of health creation.

10. *Respect the time required for personal and health system change.*

Interventions may be swift, but healing, habit change, and transformation take time and ongoing commitment.

NOTE: This is a DRAFT only. Neither the number nor the content of these design principles is fixed. Your ideas for changes, amendments, additional principles, better language, or a shift in emphasis, are actively solicited. The end product may look nothing like this. This draft set of principles is a living document which will be altered, re-focused and refined through community response. Put your edits in CAPS, include other recommendations and send to Beth.Clay@mail.house.gov or fax to 202-226-1274.

St. Joseph Health System: *Principles of Holistic Care*

Orange, California

Provided by Corrine Bayley

Context: Health system

1. Body, mind and spirit are an integral whole that cannot be separated into isolated parts.
2. Every intervention or interaction is holistic in its *impact* – it affects the whole person.
3. The human person has an innate capacity for self-repair and healing.
4. Relationships –among caregivers and between caregivers and patients/family/loved ones – have a profound effect on healing.
5. Patients and families/loved ones play a critical role on the healthcare team.
6. Healing is always possible, even when curing is not.
7. Staff and physicians will be effective in providing holistic care to the extent that they embrace these principles are themselves treated holistically.

Catholic Healthcare West/Center for Integrative Medicine at O'Connor Hospital

Principles of Practices

Catholic Healthcare West; San Jose, California

Provided by Sylver Quevedo, MD, and Deborah Quevedo, RN

Context: Health system/integrative Clinic

The members of the Center for Integrative Medicine shall endeavor to practice the following principles of holistic health care:

1. In the practice of holistic healthcare, the goal is healing the whole person, body, mind and spirit.
2. The practice of self-care and personal development is integral to holistic health care and is a continuous process. The effort to balance what one gives to self and to others is essential to achieve and maintain wholeness.
3. Professional staff shall approach health care practice with a sense of sacredness about their work. In so doing, they create and enhance the healing environment. They make it conducive to wholeness by bringing a spiritual perspective that conveys meaning and purpose in life.
4. Catholic Healthcare West core values: Dignity, Collaboration, Justice, Stewardship and Excellence shall be practiced in the Center.
5. Recognizing the uniqueness of each individual patient, the professional staff shall endeavor to render care that is consistent with the patient's preferences, interests, culture and beliefs, family background, and hopes and dreams.
6. Professional staff will practice interventions grounded in the theory of Integrative Medicine based on research and evidence where available and with a commitment to developing new knowledge, approaches, and evidence. They will use conventional scientific approaches, while simultaneously exploring new methodologies necessary to elucidate a broader paradigm of health and healing.
7. Professional staff will encourage and allow patients to take responsibility for their own self-care, providing support, education and resources to the patient. They shall be willing to give up control of information and "knowing what is best" in order to minimize co-dependence and encourage autonomy of the patient.
8. Holistic Healthcare regards both intellectual and empirical knowledge and intuitive and empathic knowledge to be important in the care of patients.
9. Professional staff is committed to the study and acceptance of other healing traditions.

Text by Deborah Quevedo, R.N.

Catholic Healthcare Initiatives: View of Integrative Care

Denver, Colorado

Provided by Milt Hammerly, MD

Context: Health system

Philosophical basis

The philosophical basis of integrative healthcare is comprehensive in scope, collaborative by necessity and personalized by design, drawing on the resources, skills and perspectives of a wide variety of disciplines, specialties and therapies, including complementary therapies when clinically appropriate.

- *Comprehensive*

Assesses and responds to a patient's body/mind/spirit needs.

- *Collaborative*

Recognizing the danger of operating in silos and the limitations of any one practitioner, technique, specialty or discipline, care is provided by a multidisciplinary team.

- *Personalized*

Treatments are tailored to each patient.

Other identified factors

- *Patient/community empowerment and responsibility*

Integrative healthcare recognizes the important role patients play in their own health and attempts to engage patients and communities, wherever possible, to be an active part of health promotion and the healing process.

- *Rational and judicious selection of therapies*

Choices of therapeutic recommendations are made from among a continuum of interventions and guided by risk stratification as well as evidence of therapeutic safety and efficacy.

- *Not about promoting CAM*

Integrative healthcare is first and foremost about patient advocacy and not about therapy advocacy.

Sherman Health System/Benefit Performance Associates, LLC

Elgin, Illinois

Provided by James Novak, vice president human resources

Context: Employee Benefits

Statement of Philosophy

A philosophy of personal responsibility partnership between Sherman and its employees for the attainment of their personal financial security. A shift from the entitlement philosophy of the traditional employee benefits plan design

The restructured employee benefits of SHS seeks to:

- Provide an attractive, competitive program of benefits enabling SHS to recruit and retain employees while allowing employees flexibility in their choice of benefits to fit their lifestyle needs
- Recognize that lifestyle and personal choices are major determinants of one's future financial security
- Heighten employee's understanding of benefits and make them aware of the value of their lifestyle and behavioral choices on the cost of their benefits and their personal financial plan
- Encourage participants to enhance their financial security through good health and financial choices, planning and education
- Offer a basic level of protection to prevent staff members and their families from incurring economic hardship due to serious injury and illness, premature death, disability or old age.
- Redistribute the unallocated benefit dollar expenditures so that more employees have the opportunity to share in these monies.
- Reallocate benefits dollars from illness and disability, to wellness and productivity.

Integrated Health Advocacy Program: Core Principles

Benefit Performance Associates, Naperville Illinois

Provided by Lee Murphy, Partner

Context: Employee Benefits

Advocacy

An empowerment approach to health benefit participants, providers, and payors, incorporating the principles of wholism, accountability and responsibility in optimizing resource utilization for the individual and common welfare.

Wholism

A necessary, working balance in which the physical, social, intellectual, psychological, spiritual, financial and environmental components of health are optimally integrated.

Accountability

The owning of consequences based on informed choices and ongoing actions.

Responsibility

An interdependent, shared expectation for appropriate productive responses, according to an individual's, group's or organization's ability to do so.

Empowerment

Education, training, and decision support based upon reliable measurements of process efficiency, efficacy and sustainable positive outcome change.

Acupuncture and Oriental Medicine Principles: The Seattle Statement

Seattle, Washington

Source: Acupuncture and Oriental Medicine Alliance

Context: Health care discipline/collaboration

Declaration of principles for people and organizations who use Acupuncture and Oriental Medicine principles in their work or lives. We believe that Acupuncture and Oriental Medicine best serves society when practiced with the following principles:

- Respect the broad diversity of Acupuncture and Oriental Medicine;
- Encourage collaboration between Acupuncture and Oriental Medicine and other individuals and groups within and outside of organized health care systems;
- Honor the legacy of Acupuncture and Oriental Medicine, its masters, artisans, and others who created and nurtured that legacy, and contemporary colleagues, collaborators and peers who carry on the legacy;
- Recognize the energetic basis and respect the dynamic, evolving nature of Acupuncture and Oriental Medicine;
- Place the healing relationship and the well-being of the individual consumer at the center of Acupuncture and Oriental Medicine practice;
- Recognize that the social, cultural, and physical environment, including race, gender, age, socioeconomic status and sexual orientation, affect the health and healing of the individual;

Provide tools and guidance for individuals to reach their own capacity for informed choice, self healing and living fully, in the presence of health, illness or in the process of dying;

- Maintain independence of practice based on appropriate standards of education, certification and care;
- Recognize that maximum accessibility to health care is essential to individual and social well-being;
- Promote public awareness of the facets and traditions of Acupuncture and Oriental Medicine and their integration into personal, social and cultural life;
- Recognize the need for continual expansion of human understanding through research, analysis and practical experience focused on the interactions among body, mind, spirit, emotions and faith of the individual, society and nature as a whole.

Northwest Integrated Healthcare 2010: Principles for CAM Policy Integration

Seattle, Washington

Source: NWIHC 2010 Steering Committee

Context: Multi-stakeholder regional public-private partnership based in King County, WA

Mission

To improve the health of the people of the Pacific Northwest beginning with King County, Washington State by creating an integrated system utilizing conventional and alternative health care services. This will be accomplished by engaging key stakeholders in the development and implementation of a strategic plan to promote the cost effective integration of complementary and alternative health care into health services delivery and payment systems.

Principles for Complementary and Alternative Medicine Policy Integration

- CAM is about systems of healing, not isolated therapies. These systems change the way we think about and provide health care.
- This integration movement is not only about integrating CAM. It is about mutual collaboration to create a true health care system.
- Facilitate collaboration: mandate the “deeply round” table for government advisory, staffing and decision making positions, agencies and processes. Deeply engage CAM professionals at all levels.
- Research outcomes first, not isolated therapies. Redirect CAM research to 90% outcomes, field, research, and training CAM in office, clinical researchers.

Level the playing field. Balance disparities between CAM and CM federal funding for education, services, and research.

- Strengthen accountability and standards critical for public protection by supporting activities that communicate, respect and further develop standards in emerging professions.
- There is a critical need for an appropriate nationwide regulatory environment.
- Help the CAM professions mature.
- True integration & collaboration requires joint training programs and clinical experiences. Practitioners who train together, practice together.
- Include underserved and special-needs populations.
- Reimbursement system needs careful reconsideration.
- There is a critical need for accurate information for public and professionals.
- There is a critical need for natural product quality assurance, either private or public.

Developed by NWIHC 2010 White House Commission on CAM Task Force September 2000, presented as testimony at the White House Commission on CAM Town Hall Meeting, Seattle, Washington, October 30-31, 2000 by Joseph E. Pizzorno, N.D., President Emeritus, Bastyr University.

University of Arizona: Program in Integrative Medicine

Tucson, Arizona

Source: University of Arizona, Program in Integrative Medicine website: www.arizona.edu

Context: Academic medicine

Basic Principles of Integrative Medicine

- A partnership between patient & practitioner in the healing process.
- Appropriate use of conventional & alternative methods to facilitate the body's innate healing response.
- Consideration of all factors that influence health, wellness & disease, including mind, spirit & community as well as body.
- A philosophy that neither rejects conventional medicine nor accepts alternative medicine uncritically.
- Recognition that good medicine should be based in good science, inquiry driven & open to new paradigms.
- Use of natural, less invasive interventions whenever possible.
- The broader concepts of promotion of health & the prevention of illness as well as the treatment of disease.
- Practitioners as models of health & healing, committed to the process of self-exploration & self-development.

San Diego Children's Hospital: Center for CAM Integration

Context: Hospital

Mission

To promote the development of a program for integrated pediatric care, education and research encompassing all therapies utilizing the principles of scientific evidence-based medicine, safety and quality, and to provide these services to further restore, maintain and enhance the growth and development of our patients, their families, our staff, and our community.

Vision

The evolution of a program that sets the standards for excellence in the establishment of a health care institution that is in harmony with the community, providing a healing, learning and nurturing environment for our patients, their families, our staff and the community.

Values

- Quality of care and safety
- Scientific evidence-based medicine
- Measurable outcomes
- Compassion
- Education
- Quality of life
- Mind/body/soul wellness

Center for Integrative Health, Medicine and Research

Santa Monica, CA

Provided by Lucy Gonda, founder

Vision

- To provide superior integrative care in a compassionate caring environment.
- To serve as a learning environment which generates important research findings towards the advancement of alternative health care.

Purpose

Create an environment that

- integrates healing philosophies
- provides continuing care and council for people with a variety of conditions
- educates and empowers people around the world
- creates a dynamic, functioning model of inspiration for health care providers worldwide.

Mission

- Foster approaches to health that incorporate innovative and integrative styles of healing.
- Improve health by providing integrative, comprehensive and innovative healthcare that is compassionate, affordable and accessible.
- Conduct research demonstrating the effectiveness of integrative approaches to health.
- Educate the public and health professionals about these integrative approaches and therapies.

American Association of Naturopathic Physicians: Principles of Practice

McLean, Virginia

Source: AANP Definition of Naturopathic Medicine Consensus Position Paper

Context: Health care discipline

Definition

Naturopathic medicine is a distinct system of primary health care – an art, science, philosophy and practice of diagnosis, treatment and prevention of illness. Naturopathic medicine is distinguished by the principles upon which its practice is based. These principles are continually reexamined in the light of scientific advances. The techniques of naturopathic medicine include modern and traditional, scientific and empirical methods. The following principles are the foundation of naturopathic medical practice:

Principles

- *The Healing Power of Nature (Vis Medicatrix Naturae)*

Naturopathic medicine recognizes an inherent self-healing process in the person which is ordered and intelligent. Naturopathic physicians act to identify and remove obstacles to healing and recovery, and to facilitate and augment this inherent self-healing process.

- *Identify and Treat the Causes (Tolle Causam)*

The naturopathic physician seeks to identify and remove the underlying causes of illness, rather than to merely eliminate or suppress symptoms.

- *First Do No Harm (Primum Non Nocere)*

Naturopathic physicians follow three guidelines to avoid harming the patient: utilize methods and medicinal substances which minimize the risk of harmful side effects, using the least force necessary to diagnose and treat; avoid when possible the harmful suppression of symptoms; acknowledge, respect and work with the individual's self-healing process.

- *Doctor As Teacher (Docere)*

Naturopathic physicians educate their patients and encourage self-responsibility for health. They also recognize and employ the therapeutic potential of the doctor-patient relationship.

- *Treat the Whole Person*

Naturopathic physicians treat each patient by taking into account individual physical, mental, emotional, genetic, environmental, social and other factors. Since total health also includes spiritual health, naturopathic physicians encourage individuals to pursue their personal spiritual development.

- *Prevention*

Naturopathic physicians emphasize the prevention of disease – assessing risk factors, heredity and susceptibility to disease and making appropriate interventions in partnership with their patients to prevent illness. Naturopathic medicine is committed to the creation of a healthy world in which humanity may thrive.

Methods: Naturopathic medicine is defined by its principles. Methods and modalities are selected and applied based upon these principles in relationship to the individual needs of each patient. Diagnostic and therapeutic methods are selected from various sources and systems, and will continue to evolve with the progress of knowledge.

Summary of the Principles of Tibetan Medicine

Provided by: Eliot Tokar, for further detail see: www.tibetanmedicine.com

Context: Health Care Discipline: Practice

Esoteric basis

- The state of our mind/consciousness is the basis of the actions we take in our life, and is therefore the central determinant of the extent of the suffering (e.g. illnesses) we experience.
- A lack of perception [fundamental ignorance] of the basic nature of both spiritual and material is the primary cause of suffering.
- Proceeding from fundamental ignorance, our tendencies toward materialism, aggression, and nescience are the major bases of the suffering and illness we experience in our lives.
- All illnesses, although clearly significant in a material sense, are transient events that should not be confused with our basic [pure spiritual and healthy] nature as beings with consciousness.
- All suffering in our lives can be positively affected by spiritual study and practice which allows us to inquire into the basic nature of our mind and its perception of reality, and liberate ourselves from fundamental ignorance.

Scientific basis of Tibetan medicine

- Physics of the Elements

Early Tibetan medical research found that the basic forces manifest in nature were the same as those that influence the functioning of the human organism. Tibetans developed a system of physics to define the basic qualities of the natural world. According to Tibetan medical theory, all of the material that makes up our universe is derived from the qualities of 5 basic elements. These 5 elements are named for their most identifiable manifestations in nature: earth, water, fire, wind and space. The characteristics and the nature of all matter result from the qualities of these elements individually or in combination.

- Three Basic Principles of Physical Function

It is essential in Tibetan medicine to understand the functions of the body's organs and systems. However, it is the underlying physiological principles that create and maintain those functions that are of primary importance.

- Tibetan medicine defines 3 Principle Systems that give rise to and then control all the body's processes.
 - Lüng - provides the principal of circulation (circulation of blood, nervous system impulses, food throughout our digestive tract, thoughts in our mind).
 - Tripa - provides the principal of heat, (thermoregulation, metabolism, liver function, vision, capacity for discriminating intellect).
 - Bädken - provides the principal of cold (functions such as thermoregulation, allows energy to create function, provide our body structure, maintains its fluids, creates the will and capacity for memory).
- A disturbance in one or a combination of these 3 Principle Systems disrupts the proper functioning of the body and thereby its organs, systems (e.g. nervous system, digestive system, excretory system, etc.) and/or substances (e.g. blood, fat, flesh, bone, marrow, etc.) and can lead to the onset of illness.

THE INTEGRATOR *for the Business of Alternative Medicine*

Seattle, WA, and Newton, MA

Source: John Weeks (from the *Viewpoint* in the inaugural October 1998 INTEGRATOR)

Context: Publishing

Mission

Shaping an industry/creating health.

Goals

- Identify emerging structures, clarify areas of common interest which provides competitive intelligence and industry cohesion.
- Keep present the more sublime goal -- embraced by progressive leaders of health plans, insurance companies, and academic medicine, as well as by the CAM community -- of health creation in the individuals and populations served.
- Advocate for appropriate CAM integration through useful, balanced information.
- Serve as a means of interactive exchange among stakeholders.
- Focus on all the leading stakeholders vested in the practical business of delivering, integrating and covering CAM: providers, health systems, HMOs, suppliers, employers, CASM professions, government, academicians and venture capital.

Planetree Principles of Humanistic Patient-Centered Care

42 member hospitals

Provided by: website (planetree.org)

Context: Hospital and health system

Mission To serve as a catalyst in the development and implementation of new models of health care which: cultivate the healing of mind, body and spirit; are patient-centered (rather than provider-focused), value-based and holistic, and integrate the best of western scientific medicine with time-honored healing practices

Planetree believes that the principles of human caring, when integrated with contemporary scientific medicine, can enhance the process of healing within the healthcare setting.

1. We recognize that patients have many facets: physical, emotional, intellectual and spiritual and they are not isolated units but members of families, communities and cultures.
2. We acknowledge patients as individuals with rights, responsibilities and free choice regarding their own health and life. Personalized healthcare increases the patients awareness of choices and encourages them to become more active in the decision-making process – while at all times respecting their level of readiness and desire to participate.
3. It is the right of patients to have access to all information about all aspects of their illness and hospitalization. One importance source of information is the medical record. We believe that the accessibility of medical information creates an environment of trust and provides a valuable educational resource.
4. Open and honest communication is the key to collegial, equal relationships among all members of the healthcare team, including the patients and their families. We encourage direct, person-to-person communication in a warm, caring environment.
5. All people involved in patient care, including the patient, play an important role in the healthcare team. When all points of view are equally valued, an environment is created that powers everyone and enables each person to perform at a higher level.
6. A nurturing environment, one that that is supportive, friendly and caring is an essential component of quality healthcare delivery.
7. The physical environment is vital to the healing process and should be designed to promote healing, learning and patient and family participation.
8. The experience of illness and interaction with the healthcare system has the potential of being a time of personal growth for patients. It can be used to reevaluate like goals and values, to clarify priorities, and to tap inner strengths.

Deaconess Hospital

Evansville, Indiana

Provided by Mary Beth Davis, RN, Holistic Coordinator, March 2001

Context: Hospital/health system

Mission

In keeping with its Christian Heritage and tradition of service, the mission of Deaconess Hospital is to provide quality health care services with a compassionate and caring spirit to persons, families and communities of the Tri-State.

Values

Our values are based on our commitment to Quality. We define Quality as the continuous improvement of services to meet the needs and exceed the expectations of the customers we serve. Our values are:

- Quality in everything we do.
- Respect for all people
- Efficiency and effectiveness in the use of resources.
- Innovation toward continuous systems improvement
- Partnership with those we serve and with suppliers
- Education for continuous growth and knowledge
- Pride in workmanship

University of Maryland Program in Complementary Medicine: Core Principles

Source: Brian Berman, MD

Context: Academic medicine

Core Principles

Our program is firmly grounded in the following principles:

- Recognition of the crucial importance of non-physical factors in health
- Belief in the fundamental importance of the relationship between the patients and practitioner
- Development of evidence-based approaches to treatment and prevention of illness
- Emphasis on facilitating patients in becoming less reliant on the health care system and becoming more skilled in self-care
- Belief in the need for practitioners to attend to their own health and well-being if they are to be truly of service to others.

National Academy of Sciences: Institute of Medicine

From the recommendations in:
"Crossing the Quality Chasm: A New Health System for the 21st Century"
March 1, 2001

Context: Health system transformation

Healthcare processes shall be designed to reflect:

- continuous healing relationships
- customization based on patient needs and values
- the patient as the source of control
- shared knowledge and the free flow of information
- evidence-based decision making
- safety as a system of property
- transparency
- anticipation of needs
- continuous decrease in waste, and
cooperation among clinicians.

Pew Commission: Twenty-one Competencies for the Twenty-first Century

Source: Recreating Health Professional Practice for a New Century, Pew Health Professions Commission, December 1998, p. vii.

Context: Pew Health Professions Commission Task Force Recommendations

- *Embrace a personal ethic of social responsibility and service.*
- *Exhibit ethical behavior in all professional activities.*
- *Provide evidence-based, clinically competent care.*
- *Incorporate the multiple determinants of health in clinical care.*
- *Apply knowledge of the new sciences.*
- *Demonstrate critical thinking, reflection, and problem-solving skills.*
- *Understand the role of primary care.*
- *Rigorously practice preventive health care.*
- *Integrate population-based care and services into practice.*
- *Improve access to health care for those with unmet health needs.*
- *Practice relationship-centered care with individuals and families.*
- *Provide culturally sensitive care to a diverse society.*
- *Partner with communities in health care decisions.*
- *Use communication and information technology effectively and appropriately.*
- *Work in interdisciplinary teams.*
- *Ensure care that balances individual, professional, system and societal needs.*
- *Practice leadership.*
- *Take responsibility for quality of care and health outcomes at all levels.*
- *Contribute to continuous improvement of the health care system.*
- *Advocate for public policy that promotes and protects the health of the public.*
- *Continue to learn and help others learn.*

American Holistic Medical Association

Source (Direct Source): <http://www.holisticmedicine.org>; 3/2001

Context: Health Care Discipline: Practice

Mission

To support practitioners in their evolving personal and professional development as healers and to educate physicians about holistic medicine.

Vision

To transform health care so that it addresses physical, environmental, mental, emotional, spiritual and social health, thereby contributing to the healing of the planet. As holistic physicians, we are committed to the health of all whom we serve including ourselves. The essence of our vision is unconditional love.

Principles of Holistic Medical Practice

- *Holistic physicians embrace a variety of safe, effective options* in the diagnosis and treatment, including: education for lifestyle changes and self-care, complementary alternatives, conventional drugs and surgery
- *Searching for the underlying causes of disease is preferable* to treating symptoms alone.
- *Holistic physicians expend as much effort in establishing what kind of patient has a disease* as they do in establishing what kind of disease a patient has.
- *Prevention is preferable to treatment* and is usually more cost-effective. The most cost-effective approach evokes the patient's own innate healing capabilities.
- *Illness is viewed as a manifestation of a dysfunction of the whole person*, not as an isolated event.
- *A major determinant of healing outcomes* is the quality of the relationship established between physician and patient, in which patient autonomy is encouraged.
- *The ideal physician-patient relationship* considers the needs, desires, awareness and insight of the patient as well as those of the physician.
- *Physicians significantly influence patients* by their example.
- *Illness, pain, and the dying process can be learning opportunities* for patients and physicians.
- *Holistic physicians encourage patients to evoke the healing power* of love, hope, humor and enthusiasm, and to release the toxic consequences of hostility, shame, greed, depression, and prolonged fear, anger, and grief.
- *Unconditional love is life's most powerful medicine*. Physicians strive to adopt an attitude of unconditional love for patients, themselves, and other practitioners.
- *Optimal health is much more than the absence of sickness*. It is the conscious pursuit of the highest qualities of the physical, environmental, mental, emotional, spiritual, and social aspects of the human experience.

American Holistic Nurses Association: Mission and Philosophy

Taken from website www.ahna.org

Context: Professional organization

Mission

Unite nurses in healing

Philosophy

We believe:

1. Nursing is an art/science with the primary purpose to nurture others toward the wholeness inherent within them.
2. Nurses have a unique opportunity to provide services that facilitate wholeness.
3. Holistic nurses demonstrate expertise in a variety of roles and activities.
4. Holistic nursing assists people to assume personal responsibility for their healthcare.
5. Clients, families, and communities have the right to health care that honors the body, mind, and spirit.
6. Disease and distress are viewed as an opportunity for increased awareness of the interconnectedness of body, mind, and spirit.

Holistic modalities and therapies provide support and options in healing.

8. The American Holistic Nursing Association serves as a foundation and dynamic force for nursing practice. We are committed to unity and healing of self, the nursing profession, and the planet.

Developed December 1999 and revised January 17, 2000.

American Association of Naturopathic Medical Colleges: The Integration Project

Seattle, Washington

Source: American Association of Naturopathic Medical Colleges: Deans Council

Context: Academic medicine/health care practice

Goal

The systematic, intensified integration of naturopathic theory, principles of practice, and paradigm throughout naturopathic medical college curricula.

- Integration will be defined through recommended changes in courses, course competencies, outcomes assessment, clinical training, research, and learning environment (the methods used in education and the environment in which learning occurs).
- This integration will be built on the science-based educational structure already in existence in naturopathic medical colleges.
- The principles of naturopathic medicine outline in the AANP Definition of Naturopathic Medicine document represent professional consensus on the defining framework for naturopathic clinical theory.
- These accepted principles of practice will also provide the reference point and defining structure for the Integration Project.

Fundamentals of Ayur-Vedic Medicine

Natural Medicine Clinic: Seattle, Washington

Provided by: Dr. Vivek Shanbhag, ND, AYA

Context: Health care discipline

Principles of Practice

- Ayur-Veda means “science of life.” Each individual has a unique psycho-physiological constitution. Therapeutic plans are highly personalized and comprehensive.
- Vata represents biological Air and Space; Pitta represents biological Fire & Water; Kapha represents biological Earth & Water.
- Every person has all the three – Vata, Pitta & Kapha: One or two may be predominant, health means dynamic balance of all the three. Disease is caused by the imbalance of one or more of the three.

Definition of Health

Health is a participatory, ongoing process of achieving and maintaining a dynamic balance in all the aspects of life through the means of comprehensive natural therapies customized to suit the individual's psychosomatic constitution and the current imbalance, if any. The goal of this process is not only to heal disease and to reestablish balance, but also to prevent disease and to promote positive health.

- Health is a process not a state. This process is ongoing not a one-time attempt. This process is participatory, the person must take the responsibility for his or her health – not depend on an expert to fix it
- Health is dynamic balance – not stationary balance. The dynamic balance needs to be achieved in all the aspects of this person's life, physical, biochemical, intellectual, emotional, behavioral, spiritual, familial, social, environmental and universal – not narrowed down to only physical or biochemical aspects
- Therapies need to be comprehensive, considering all aspects of life like nutrition, natural medicines, exercise, rest, emotions and lifestyle – not limited to drugs and surgery
- Therapies need to be natural – not synthetic
- Therapies need to be customized to suit the individual – not standardized for imaginary “average person”
- Therapies need to address the complete physical, biochemical, intellectual, emotional, behavioral, spiritual, familial, social picture – not just the physical symptoms
- The goal is to heal diseases, reestablish balance, prevent disease, and promote positive health – not just to suppress symptoms or “quick-fix the problem”

Midwives Alliance of North America

Lilburn, Georgia

Provided by JoAnne Myers-Ciecko, MPH, Executive Director, Seattle Midwifery School

Source: Foundation documents (current pamphlet)

Context: Health care discipline

Guiding Principles

- Midwives work in partnership with women and their chosen support community throughout the care-giving relationship.
- Midwives respect the dignity, rights, and the ability of the women they serve to act responsibly throughout the care-giving relationship.
- Midwives work as autonomous practitioners, collaborating with other health care and social service providers when necessary.
- Midwives understand that physical, emotional, psycho-social and spiritual factors synergistically comprise the health of individuals and affect the childbearing process.
- Midwives understand that female physiology and childbearing are normal processes, and work to optimize the well-being of mothers and their developing babies as the foundation of care-giving.
- Midwives understand that the childbearing experience is primarily a personal, social and community event.

Midwives recognize that a woman is the only direct care provider for herself and her unborn baby; thus the most important determinant of health pregnancy is the mother herself.

- Midwives recognize the empowerment inherent in the childbearing experience and strive to support women to make informed decisions and take responsibility for their own well-being.
- Midwives strive to insure vaginal birth and provide guidance and support when appropriate to facilitate the spontaneous process of pregnancy, labor, and birth, utilizing medical intervention only as necessary.
- Midwives synthesize clinical observations, theoretical knowledge, intuitive assessment and spiritual awareness as components of a competent decision making process.
- Midwives value continuity of care throughout the childbearing cycle and strive to maintain continuous care within realistic limits.
- Midwives understand that the parameters of “normal” vary widely and recognize that each pregnancy and birth is unique.

Theory and Practice of Chinese Medicine

Provided by: Paul Karsten, LAc, Seattle Institute of Oriental Medicine, Director; Bastyr University, Faculty

Context: Health Care Discipline: Practice

- *Yin and Yang*

Differentiating conditions according to yin and yang and returning individual to a balance and harmony of yin and yang.

- *Five Phase (Element) Theory*

Identifying the phase in alarm or out of balance according to the recognized patterns of signs and symptoms associated with each phase. Treatment is oriented towards rebalancing the particular element.

- *Qi-Blood-Body Fluid Differentiation*

Identification of primarily internal conditions according to the primary vital substance involved. Deficiency, obstruction and other imbalances of the vital substances are identified and appropriate treatment recommended.

- *Zang-fu Theory*

Identifying the organ/function that is depleted, obstructed or "excess" and applying appropriate therapies to return the organs to harmony

- *Channel Theory*

Identification of the energetic channel involved with the complaints with treatment to strengthen or activate the affected flow. Often used for musculoskeletal pain, trauma and external conditions. There is also a subset of using the 8 extra channels as a method for balancing the energetics of the body.

- *Eight Principles*

A cluster of binary attributes by which the practitioner can organize symptoms in order to develop a treatment plan. Yin/yang, cold/hot, internal/external, and deficiency/excess provide a method to identify the locale and quality of the condition of concern.

- *Six Stage Theory*

Usually used for invasive or infectious disease as a method to identify the level of the disease and provide treatment based on the recognition of the pattern of symptoms associated with the depth of entry of the pathogen.

- *Four Level Theory*

Used primarily for invasive pathogenic influences by identifying the level to which the pathogen has transmitted along with appropriate therapy for its exit.

American Osteopathic Association: Principles of Osteopathic Medicine

Chicago, Illinois

Provided by: Penelope S. Evans, Administrator, Division of Predoctoral Education

Source: American Osteopathic Association's Yearbook and Directory of Osteopathic Physicians

Context: Health care discipline

Osteopathy is a system of medical care

... with a philosophy that combines the needs of the patient with current practice of medicine, surgery and obstetrics, and emphasis on the interrelationships between structure and function, and an appreciation of the body's ability to heal itself.

Osteopathic medicine is a philosophy of health care

... and a distinctive art, supported by expanding scientific knowledge; its philosophy embraces the concept of the unity of the living organism's structure (anatomy) and function (physiology). Its art is the application of the philosophy in the practice of medicine and surgery in all its branches and specialties. Its science includes behavioral, chemical, physical, spiritual and biological knowledge related to the establishment and maintenance of health as well as the prevention and alleviation of disease. Osteopathic concepts emphasize the following principles:

- The human being is a dynamic unit of function.
- The body possesses self-regulatory mechanisms which are self-healing in nature.

Structure and function are interrelated at all levels.

- Rational treatment is based on these principles.

Association of Chiropractic Colleges (ACC) Chiropractic Paradigm

Source: website (www.chirocolleges.org)

Context: Health care discipline

Chiropractic is a health care discipline which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery. The practice of chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. In addition, Doctors of Chiropractic recognize the value and responsibility of working in cooperation with other health care practitioners when in the best interest of the patient. The Association of Chiropractic Colleges continues to foster a unique, distinct chiropractic profession that serves as a health care discipline for all. The ACC advocates a profession that generates, develops, and utilizes the highest level of evidence possible in the provision of effective, prudent, and cost-conscious patient evaluation and care.

- *Purpose*

The purpose of chiropractic is to optimize health.

- *Principle*

The body's innate recuperative power is affected by and integrated through the nervous system.

- *Practice*

The practice of chiropractic includes: establishing a diagnosis, facilitating neurological and biomechanical integrity through appropriate chiropractic case management, and promoting health.

- *Foundation*

The foundation of chiropractic includes philosophy, science, art, knowledge, and clinical experience.

- *Impacts*

The chiropractic paradigm directly influences the following: education, research, health care policy and leadership; relationships with other health care providers; professional stature; public awareness and perceptions; and patient health through quality care.

- *Subluxation*

Chiropractic is concerned with the preservation and restoration of health, and focuses particular attention on the subluxation. **A subluxation** is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health. **A subluxation** is evaluated, diagnosed, and managed through the use of chiropractic procedures based on the best available rational and empirical evidence.

American Medical Association

Chicago, IL

Source: website (<http://www.ama-assn.org/ama/pub/category/1855.html>)

Context: Health care discipline: Practice

Vision

The vision reflects a shared desire by the Board of Trustees and Senior Management that the AMA approach the new millennium with renewed vigor based on a solid understanding of purpose, values, and envisioned future.

Core Purpose

To promote the science and art of medicine and the betterment of public health.

Core Values

- Leadership: the stewards of medicine, caring advocates for patients and the profession.
- Excellence in all we do: the highest quality service, products and information.
- Integrity and ethical behavior: the basis for trust in all our relationships and actions.

Envisioned Future

The AMA will be an essential part of the professional life of every physician and an essential force for progress in improving the nation's health.

Objectives

AMA will pursue being:

- The world's leader in obtaining, synthesizing, integrating, and disseminating information on health and medical practice;
- The acknowledged leader in setting standards for medical ethics, practice and education;
- The most authoritative voice and influential advocate for patients and physicians; and
- A sound organization that provides value to members, federation organizations, and employees.

Last updated: Mar 08, 2001

Oath of Hippocrates

Source: From HIPPOCRATIC WRITINGS, translated by J. Chadwick and W. N. Mann, Penguin Books, 1950.
<http://www.med.umich.edu/irbmed/ethics/hippocratic/hippocratic.html>

Context: Medical practice

I swear by Apollo the healer, by Aesculapius, by Hygeia (health) and all the powers of healing, and call to witness all the gods and goddesses that I may keep this Oath, and promise to the best of my ability and judgment:

I will pay the same respect to my master in the science (arts) as I do to my parents, and share my life with him and pay all my debts to him. I will regard his sons as my brothers and teach them the science, if they desire to learn it, without fee or contract. I will hand on precepts, lectures, and all other learning to my sons, to those of my master, and to those pupils duly apprenticed and sworn, and to none other.

I will use my power to help the sick to the best of my ability and judgment; I will abstain from harming or wrongdoing any man by it..

I will not give a fatal draught (drugs) to anyone if I am asked, nor will I suggest any such thing. Neither will I give a woman means to procure an abortion.

I will be chaste and religious in my life and in my practice.

I will not cut, even for the stone, but I will leave such procedures to the practitioners of that craft.

Whenever I go into a house, I will go to help the sick, and never with the intention of doing harm or injury. I will not abuse my position to indulge in sexual contacts with the bodies of women or of men, whether they be freemen or slaves.

Whatever I see or hear, professionally or privately, which ought not to be divulged, I will keep secret and tell no one.

If, therefore, I observe this Oath and do not violate it, may I prosper both in my life and in my profession, earning good repute among all men for all time. If I transgress and forswear this Oath, may my lot be otherwise.

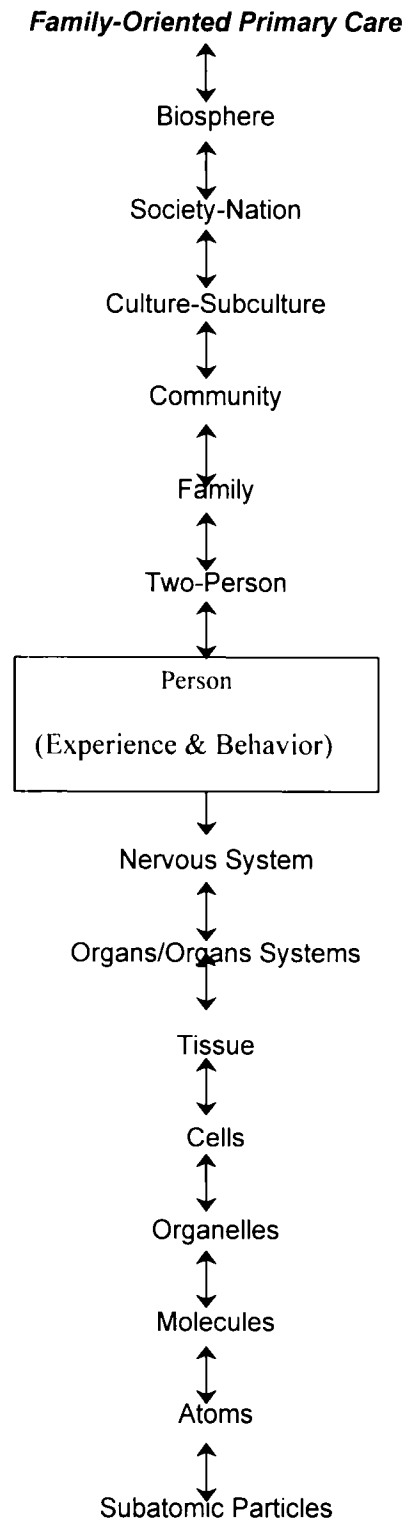
The remaining statements were include content which informs the DRAFT principle relative to a “therapeutic hierarchy.”

Prioritize care in accordance with a hierarchy of treatment

Care, and the leveraging of resources to affect care, are prioritized along diagnostic and therapeutic hierarchies which begin with education and empowerment in healthy choices, then move to the least invasive approaches and escalate, as necessary, to approaches linked to increased likelihood of adverse effects or higher costs. The starting point for intervention is established through clarifying, with the individual receiving care, the risks associated with foregoing, and with undertaking, more invasive approaches. Chronology and cause are fundamental aspects of this healing order.”

Family Medicine: Biopsychosocial Systems Hierarchy

Context: Health care discipline



Systems Hierarchy. Engel, GL. May 1980. The Clinical Application of the Biopsychosocial Model. *American Journal of Psychiatry*. May 1980. The American Psychiatry Association

Tibetan Medical Theory

Provided by: Eliot Tokar, for further detail see: www.tibetanmedicine.com

Context: Health care discipline

Diagnosis: *A Concise Summary of the Causes of the Onset of Illness:*

The disturbance can come mainly from 4 factors whose qualities, based on their constituent elements, act to disturb the qualities of any of the 3 Principle Systems. The 4 factors are behavior, diet, environment and superphysical influences.

- **Behavior:** full range of the habits and actions we might take, such as those concerning our sleep, eating, exercise, social habits, psychology, culture, health, etc.
- **Diet:** Foods have qualities based on the 5 elements. Qualities are analyzed in a detailed system that classifies their resultant effects.
- **Environment:** Climatic conditions have qualities based on the 5 elements. Environmental conditions, therefore, affect the relative balance or imbalance of the 3 Principle Systems.
- **Super-Physical influences:** Tibetans believe that non-material characteristics of certain types of environments and/or manifestations of spiritual activity can sometimes influence health.

The necessary qualities of a doctor: Meditative practices regarding the Buddha of Medicine focuses physicians on the highest possible view of themselves as a compassionate healer and on their patients as not merely defined by their illness. Such practices also help focus and quiet the doctor's mind in a manner that facilitates their ability to practice proper diagnosis and treatment. Although the Tibetan Buddhist and Tibetan medical systems are separate and distinct, they are so in a manner, His Holiness the Dalai Lama described, as like the way in which the "fingers are separate from the hand."

Making a Diagnosis:

- First, differentiate illnesses by hot or cold nature of condition.
- Next, determine nature of illness relative to 3 Principle Systems of Physiological function.
- Determine the localization of the illness, the specific nature of the illness, organs or systems involved, chronicity of illness, etc.
- In complex or chronic illness, take into account stages of cure.
- Change treatment, and re-diagnose as layers of illness reveal their nature.

Treatment of Illness

- **Behavior/Lifestyle:** The first level of treatment should be for the patient to adopt their behavior and lifestyle approaches appropriate to their condition.
- **Diet:** If behavior/lifestyle changes are not sufficient, the next stage of treatment should be dietary change.
- **Herbal Compounds:** If behavior/lifestyle changes and dietary change are not sufficient, the next stage of treatment should be herbal compounds. Tibetan herbal medicines are not used as patent remedies or as a stand-alone therapy.
- **Physical Therapies:** If behavior/lifestyle changes, dietary change and herbal remedies are not sufficient, the next stage of treatment should be physical therapies, including: Massage, Tibetan Acupuncture, Inhalation Therapy, and Hydrotherapy.

Naturopathic Medicine: Clinical Theory

Provided by: Pamela Snider, ND; Jared Zeff, ND

Context: The Integration Project: American Association of Naturopathic Medical Colleges; Academic Institution/Health Care Practice

The Therapeutic Order

Re-establish The Basis for Health:

Remove obstacles to cure by addressing the Determinants of Health

Stimulate the Vis Medicatrix Naturae

(Healing Power of Nature):

All systems and modalities have methods which stimulate the inherent self healing processes: Examples are botanical, homeopathic, nutritional, hydrotherapy, psychological-spiritual medicine, Ayurvedic, Tibetan, Traditional Chinese Medicine, acupuncture

Tonify Weakened Systems:

All systems and modalities have system specific strategies (botanical, homeopathic, nutritional, hydrotherapy, psychological-spiritual medicine, Ayurvedic, Tibetan, Traditional Chinese Medicine, acupuncture and others).
Examples of seven systems: •strengthen the immune system •decrease toxicity •normalize inflammatory function
•optimize metabolic function •balance regulatory systems •enhance regeneration •harmonize with your life force

Correct Structural Integrity:

Use therapeutic exercise, manipulation, massage, and other structural approaches.

Prescribe Specific Natural Substances,
modalities or interventions for pathology.

Prescribe Specific Pharmacological or Synthetic Substances
modalities or interventions for pathology.

Use Higher Force Interventions:

Examples are surgery, suppressive drugs, radiation, chemotherapy and other approaches.

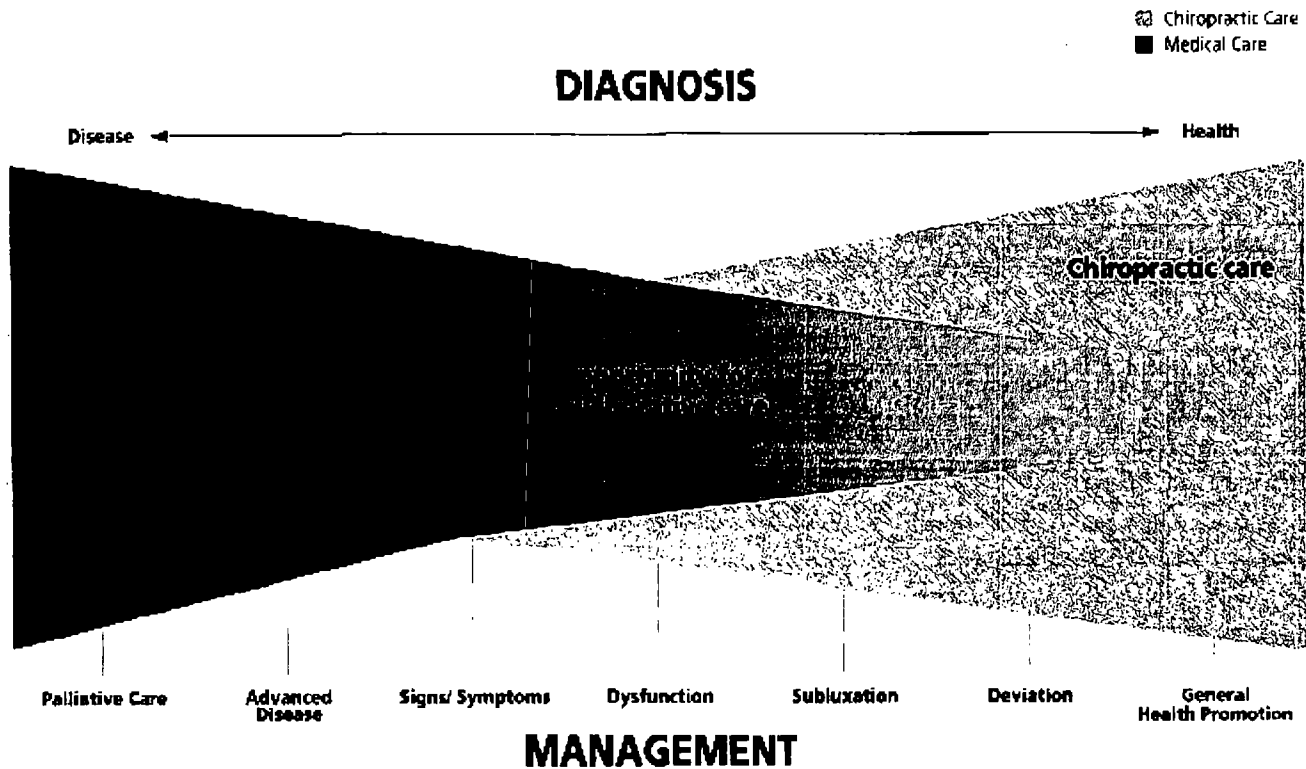


"The Patient":

***The actual Therapeutic Order may change,
depending on the individual patient's needs
for safe, effective care.***

Sources: Jared Zeff, ND, The Process of Healing: A Unifying Theory of Naturopathic Medicine, The Journal of Naturopathic Medicine, Vol.7, No.1, 1997
Marc Micozzi, MD, PhD. Fundamentals of Complementary and Alternative Medicine. Pizzorno, J, Jr. and Snider, P, ND . "Naturopathic Medicine" .
Churchill Livingston: New York. 2001

ACC CHIROPRACTIC SCOPE AND PRACTICE



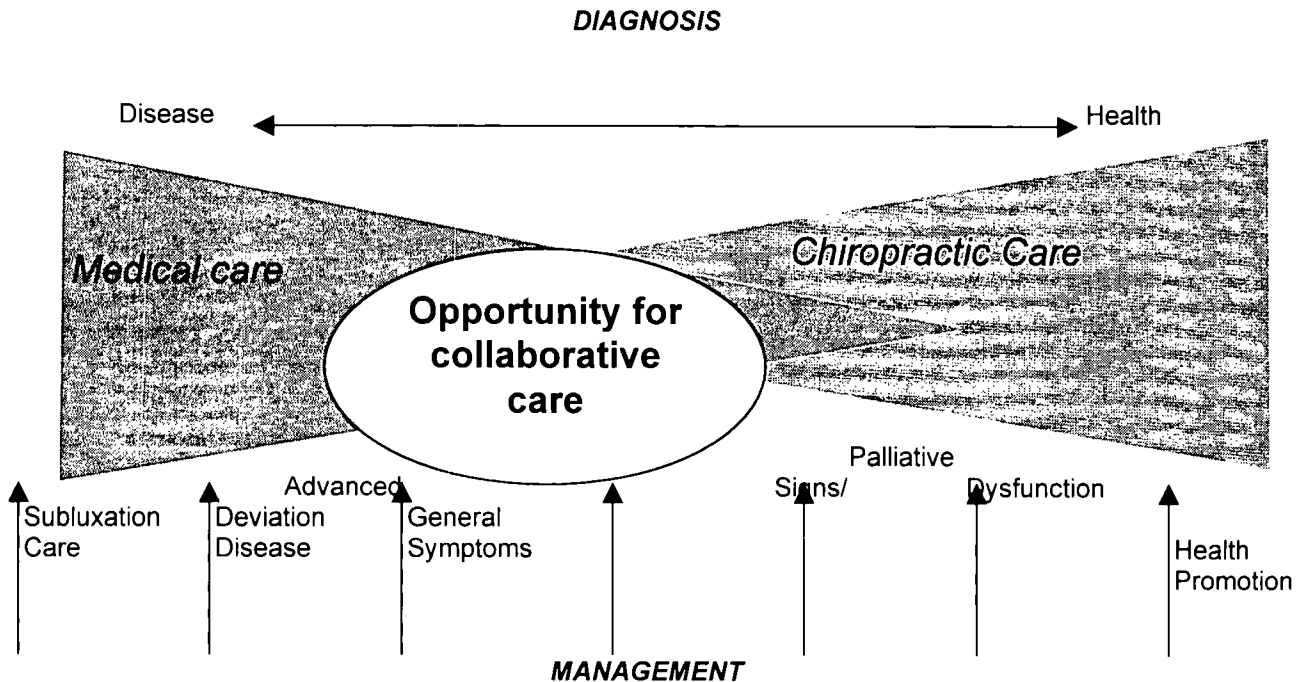
- **Diagnostic:** Doctors of Chiropractic, as primary contact health care providers, employ the education, knowledge, diagnostic skill, and clinical judgment necessary to determine appropriate chiropractic care and management. Doctors of Chiropractic have access to diagnostic procedures and /or referral resources as required.
- **Case Management:** Doctors of Chiropractic establish a doctor/patient relationship and utilize adjustive and other clinical procedures unique to the chiropractic discipline. Doctors of Chiropractic may also use other conservative patient care procedures, and, when appropriate, collaborate with and/or refer to other health care providers.
- **Health Promotion:** Doctors of Chiropractic advise and educate patients and communities in structural and spinal hygiene and healthful living practices.

Association of Chiropractic Colleges (ACC) Chiropractic Scope and Practice

Provided by: Gerry Clum, President, LifeWest Chiropractic College

Source: website (www.chirocolleges.org)

Context: Chiropractic Health Care: Theory



- **Diagnostic:** Doctors of Chiropractic, as primary contact health care providers, employ the education, knowledge, diagnostic skill, and clinical judgment necessary to determine appropriate chiropractic care and management. Doctors of Chiropractic have access to diagnostic procedures and /or referral resources as required.
- **Case Management:** Doctors of Chiropractic establish a doctor/patient relationship and utilize adjustive and other clinical procedures unique to the chiropractic discipline. Doctors of Chiropractic may also use other conservative patient care procedures, and, when appropriate, collaborate with and/or refer to other health care providers.
- **Health Promotion:** Doctors of Chiropractic advise and educate patients and communities in structural and spinal hygiene and healthful living practices.

State of Washington: Public Health Improvement Plan

Source: State of Washington/Department of Health

Context: Public health strategy

"Sets the strategic direction of the public health system relative to the greater health system in which it operates"

- *Public Health: Mission and Core Functions*

The mission of public health is to prevent disease, injury, disability, and premature death. This includes protecting our health from threats in the environment and promoting health through risk reduction and education. To carry out this mission, public health agencies perform three basic core functions.

- *Health assessment* to determine the nature and extent of health problems.
- *Policy development* to make decisions about what problems take priority and what should be done about them.
- *Assurance* that effective action gets taken.

- *Prevention: The Business of Public Health*

The first and foremost public health activity is prevention of disease, injury, disability, and premature death. Public health carries out prevention by influencing the environmental conditions and personal behaviors that create health risks. Prevention can be classified into three types: primary, secondary and tertiary.

- *Determinants of Health*

There are several major determinants of the general health of a population. Each can be influenced by the public health system. The major known determinants of our health are:

- *Socioeconomic conditions:* Poverty, unemployment, lack of education, and other indicators of low socioeconomic status are often associated with higher rates of health problems. Through data collection and analysis, the public health system helps identify and make known health problems that may be related to poor socioeconomic conditions.
- *Physical environment:* The public health system has a strong environmental health component with major responsibilities in the areas of water quality, food safety, radiation protection, and control of toxic substances.
- *Access to and quality of health care:* Public health monitors and improves the quality of health care by licensing and certifying health professionals, health services, and health care facilities. Public health influences access to health care by sometimes providing critical services to low income families and other vulnerable populations.
- *Behavioral risk and protective factors:* Health is to a great extent determined by personal behavior. The influence of public health on behavioral risks is twofold: One is through assessments that provide information on the nature and extent of risks. The other is through programs that promote healthy behavior or reduce unhealthy behaviors.
- *Genetics:* Genetics can play a part in a wide variety of health problems. They have far reaching effects on families and often create long term needs for health, educational, and social services. Public health influences the genetic component of health by supporting a wide variety of support services to assist individuals and families.



Groft, Stephen (WHCCAMP)

From: Jim Swyers [jpswyers@starpower.net]
Wednesday, September 12, 2001 3:46 PM
'Effie Chow (E-mail)'; 'Conchita Paz (E-mail)'; Veronica Gutierrez (E-mail); Tom Chappell (E-mail); 'Joe Pizzorno'; Jonas, Wayne; Jonas, Wayne
Cc: Axelrod, Corinne (WHCCAMP); Chang, Michele (WHCCAMP); Fisher, Ken (WHCCAMP); Groft, Stephen (WHCCAMP); Pollen, Geraldine (WHCCAMP); Miller, Maureen (WHCCAMP)
Subject: definition and guiding principles



Working Definition Summary of Work
of CAM and ... Group H conf c...

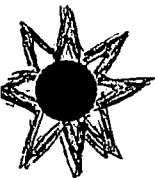
Dear Work Group H members,

I have attached two documents to this e-mail. One is the summary of our conference call last week. The other is a revised draft of the section on the definition and guiding principles. As we discussed, I have develop a summary definition, which incorporates the Cochrane/OAM definition but without some of the controversial language (e.g., politically dominant) as well as the other issues we discussed to date.

In addition to the summary definition, I added a category to the CAM differentiation section to encompass some of the concerns Wayne expressed. I'm sure this part will evolve significantly as we continue our discussions and receive feedback from the full Commission, who will help us decide where it will ultimately wind up in the report. I've also tried to fix the over-emphasis on "medicine" in the previous draft by substituting "health care" whenever appropriate.

Because of the tight deadline we are facing to get ready for the October meeting, I ask that you review the draft and send me your comments/edits no later than Friday afternoon (48 hours from now). I will then work on it over the weekend and have it ready to send out to the full Commission by no later than next Monday. Because we are still in the drafting stage, let us not be overly concerned with minor issues at this point, but focus instead on making sure we have addressed all of the major issues. As Wayne said in the conference call, what we have right now is "pretty good," and it will only get better after we present it to the rest of the Commission and incorporate their feedback.

I have to say, it has been a pleasure working with all of you on this part of the report. You have made my job much easier by being so positive and constructive with your comments. I look forward to your feedback on this latest draft and to seeing all of you again in October. Take care.



Staff Lead: Jim Swyers

**DEFINING COMPLEMENTARY AND ALTERNATIVE MEDICINE AND
ELABORATING GUIDING PRINCIPLES**

Appreciation
Veronica Gutierrez, Charlotte Kerr, Archibald, Joe Pagnano
Members: Tom Chappel and Wayne Jones (Facilitator)
The White House Commission on Complementary and Alternative Medicine

Policy (WHCCAMP) is charged with making specific legislative and administrative recommendations to maximize all of the potential benefits of CAM. Commissioners, therefore, expressed a strong desire to develop a better understanding for what is encompassed by CAM. CAM is such a diverse field that many Commission members believed it necessary to differentiate among the various types of CAM as well as to understand their underlying commonalities before they could develop final recommendations in any of the major topic areas. The Commission assigned a Work Group to make a detailed examination of the published literature and other relevant sources of information and develop a working definition of CAM to help guide its deliberations.

The Commissioners also believed that a set of "guiding principles" was needed to serve as guideposts for its deliberations. The Commission settled on a set of ten statements to serve as guiding principles, which were further refined by the Work Group on Definitions. This group also developed an early draft of a mission statement. All of these--the definition, guiding principles, and mission statement--were more fully developed by the full Commission.

DESCRIBING AND DEFINING CAM

Complementary and alternative medicine (CAM) is a diverse set of both ancient and modern health care systems and practices. These systems and practices, which are not usually available or supported in most western countries, focus on the support and stimulation of healing processes and on whole person care to prevent and treat illness.

The healthcare systems and practices in the U.S. that are generally recognized as being CAM are shown in Table 1:

Table 1: Common CAM Therapies and Systems of Medicine		
*Acupuncture	Chiropractic	Naturopathic Medicine
*Acupressure	(Sacral) Cranial Osteopathy	Nutritional Therapy
Alexander Technique	Environmental Medicine	*Qigong
Applied Kinesiology	*Herbal Medicine	Reflexology
Anthroposophic Medicine	Homeopathy	Relaxation and Visualization
Aromatherapy	Hypnosis	Shiatsu
Autogenic Training	Imagery	Spiritual Healing
Ayurvedic Medicine	Iridology	Therapeutic Touch
Bioelectromagnetics	Massage and Bodywork	Traditional Chinese Medicine
Energy Medicine	*Meditation	*Yoga
	Mexican-American curanderos	
*Many CAM therapies and practices are derived from complex systems of healthcare and healing and are typically delivered within the context of the overall care rather than as a stand-alone therapy, although they may be delivered as stand-alone treatments by those who are not trained in the particular system of medicine.		
Adapted from Zollman C, Vickers A. What is complementary medicine? BMJ 1999;319:693-696		

It should be emphasized that a number of CAM practices that are listed in Table 1 have gained or are increasingly gaining acceptance and recognition by mainstream health care. Often, however, the CAM system from which the practice is derived is only

marginally accepted and engaged in dialogue by mainstream medical and healthcare organizations (e.g, acupuncture and Traditional Chinese Medicine).

This marginalization results in the lack of formal recognition in health care education and research funding for most CAM systems. In some cases (Special Communications, 1988), the marginalization of CAM has resulted in the systematic and consistent suppression of CAM professions, institutions, and practitioners by mainstream health care professions through a variety of political, institutional, and economic means.

The exclusion of a detailed discussion of various CAM systems in mainstream medical education makes it difficult for conventional doctors to communicate with and refer to CAM practitioners. Lack of access to research funds, contributes further to this marginalization in that people researching CAM systems are not able to generate and publish the kinds of data that can convince insurance companies and third-party payers to reimburse for their services (Pelletier et al., 1997).

The marginalization of CAM systems has occurred for a variety of reasons, including:

- a) a lack of an understanding or acceptance of the explanatory model or models underlying the system (e.g., homeopathy, chiropractic) by mainstream science.

- b) The origin of the system from cultures outside of the U.S. or from indigenous cultures (e.g., Ayurvedic Medicine, Traditional Chinese Medicine, Native American Medicine). Because these systems often rely on low technology approaches (e.g., herbs), they may be seen as primitive and unscientific.
- c) the lack of sufficient data on safety, efficacy, or potential mechanism of action to support its use for treating specific illnesses (e.g., vitamin therapy).
- d) the inability to easily integrate the system into the mainstream healthcare model.
- e) the widespread belief that the healthcare or healing system is not practical or feasible for most people, even though there is scientific consensus that it is therapeutic (e.g. environmental medicine, therapeutic diets).

Another reason that many CAM systems have been marginalized is the difficulty of licensing and regulating their practitioners. Although some of these CAM systems lend themselves easily to certification, licensing, and regulation, others do not. Indeed, there is a great diversity of education, training, and standards of practice among CAM practitioners, ranging from highly educated and organized to self-taught and unregulated. There are at least six categories of CAM practitioners based on their education, training, and regulation. These include:

1. Professional CAM practitioners with a cohesive healing philosophy, defined practice standards, accredited education, state licensing, documented safety, and at least some research substantiation. Examples include chiropractors, naturopathic physicians, and Traditional Chinese Medicine practitioners.
2. Physicians who practice wholistic medicine (i.e., they practice mainstream medicine along with those therapies that are considered complementary to mainstream medicine) but do not consider themselves to be CAM practitioners per se.
3. Dually trained physicians who use conventionally accepted medical practices along with clearly "alternative" therapies and practices that are highly controversial or not widely accepted by mainstream healthcare practitioners and institutions.
4. Emerging professions consisting of lay and self-trained practitioners, such as lay homeopaths and herbalists. Some of these emerging professions are working to establish standards for minimum education and training.
5. Community healers who receive training through centuries-old traditions. They tend to practice solely within their community, which provides informal oversight and regulation. Examples include Native American healers and Mexican-American curanderos.

6. Self proclaimed or minimally educated healers who practice without apparent standards or community oversight.

These variations in education, training, and self-regulation impact access to and delivery of CAM systems by limiting the ability of their practitioners to practice lawfully and obtain malpractice insurance. Although practitioners of some CAM systems, such as chiropractic, are licensed in all 50 states, others are licensed in only a portion or a few states (see Section ?).

Common Characteristics of CAM Systems

Although the discussion so far has highlighted the heterogeneity among CAM systems, there are a number of similarities among the major CAM systems that point to a common origin. These similarities include a focus on:

- a) Clinical observation - Many of these practices have evolved out of clinical experience, from small groups who use the intervention (e.g. neural therapy, polarity) to widely used, elaborately detailed systems such as Traditional Chinese Medicine.
- b) Whole systems - CAM systems tend to emphasize a complete or combination systems approach that includes multiple simultaneous interventions with

individualization, or variation, of those interventions during the course of treatment. They often assume that the entire system is required as a package independent of the isolated effects of its individual components (e.g., the use of whole plant extracts rather than isolated active ingredients). For example, a chiropractor, in addition to providing a spinal adjustment, may also offer advice on diet and exercise, provide guidance on breathing and relaxation, and prescribe nutritional supplements.

- c) Stimulating Self-Healing Processes - CAM systems tend to emphasize the stimulation or support of natural healing processes, referred to as *vis medicatrix naturae* (the healing power of nature) and seek to enhance those processes in order to accelerate the natural course of recovery, rather than mask or suppress the symptoms of the disease. (e.g. nutritional & diet therapy for rheumatic diseases rather than immuno-suppressants.). Even CAM modalities that are not directly evolved from traditional systems of medicine, have adopted the philosophy that the body's self-healing mechanism can be speeded up, sometimes to an astonishing degree, by the proper stimuli. Thus, many CAM practitioners employ therapies designed to stimulate the patient's constitution to fight on its own behalf, on the assumption that this emphasis on enhancing the natural healing process is the most appropriate foundation of any medical therapy (House of Lords, 2000).
- d) Promoting Self Care - CAM systems tend to emphasize a practitioner-patient partnership in looking at options. There is also an emphasis on promoting self

responsibility and promoting interventions that incorporate quality of life, patient preferences, and patient satisfaction into the therapeutic and diagnostic decision-making processes.

- e) Vitalism - Many CAM systems emphasize the need to achieve balance of energy in order to promote a higher, or optimal, level of functioning above the mere absence of illness. Restoring harmony and promoting optimal functioning is a major focus of many CAM systems, including Ayurvedic Medicine, Native American Medicine, Homeopathic Medicine, Traditional Chinese Medicine, Naturopathic Medicine, and Chiropractic.
- f) Spiritualism - Most of the world's traditional healing systems—Traditional Chinese Medicine, Indian Ayurvedic Medicine, and Native American Medicine—are based on the assumption that humans are connected to one another, to the earth, and the spiritual world in many more ways than science has yet uncovered. Disease, in these systems of medicine, is an imbalance within our bodies as well as between the way we live and the natural, social, and spiritual world (Gordon, 1996).

These common characteristics of major CAM systems also are shared by some branches of mainstream healthcare. For example, conventional health care has long recognized the need for promoting a good, balanced diet as a means of maintaining health and warding off a host of nutrition-related illnesses, such as diabetes and cancer. Yet,

those who promote such ideas often go largely ignored by the major healthcare institutions.

For example, according to a recent report by the Nutrition Education Consortium (1997), despite strong scientific data, public interest, US government reports, society studies, and congressional mandates, the teaching of nutrition in medical schools and residency programs remains “woefully inadequate.” Most medical schools do not even have faculty trained specifically in nutrition (Cooksey et al, 2000), despite the fact that nutrition is one of the most significant contributors to good health.

There are a number of reasons why nutrition is not a central focus of mainstream health care education. However, the most significant barrier to revamping medical education to include such crucial information appears to be faculty resistance (Armstrong & Koffman, 1998). As Dr. Walter Willett, Professor of Epidemiology and Nutrition at the Harvard School of Public Health recently, stated before the Commission, “it is a sad reality that nutrition is not very much a part of mainstream medicine,” but is more representative of some of the CAM systems.

Other major elements of CAM systems, such as spirituality, have also begun to make their way into healthcare education reform. The American Association of Medical Colleges (AAMC), for example, recently called for the incorporation of knowledge about the link between spirituality and health into medical school curricula (AAMC, 1999). However, this effort faces significant opposition by those who believe it is inappropriate,

and perhaps unethical, for healthcare providers to be too inquisitive or supportive of patients' spiritual beliefs or practices (Sloan et al., 2000).

Thus, although there is a great diversity among the systems of healthcare, healing, and self-care that are typically classified as CAM, there is also a great deal of similarity among them. There also is significant overlap between what is traditionally thought of as CAM and a many aspects of what is commonly referred to as mainstream medicine. These commonalities suggest to the Commission that in the not-too-distant future, divisions between CAM and conventional medicine as well as between the various CAM systems will become further blurred and that integrative medicine will become more of the norm rather than the exception.

Summary Definition of CAM

In summary, complementary and alternative medicine (CAM)¹ is a heterogeneous group of medical, health care, and healing systems, modalities, and practices other than those intrinsic to mainstream healthcare in the U.S. CAM includes all such systems and practices and their accompanying theories, explanations, and worldviews that have to do

¹ For the purposes of this report we use the term "complementary and alternative medicine" (CAM) to designate practices that are not an integral part of mainstream, western biomedicine. The terms "mainstream" "conventional" and "orthodox" are used interchangeably in the report. "Traditional medicine" will be used only to refer to indigenous practices that are part of long-standing healing systems of traditional cultures. Except where noted, no distinction is implied between practices referred to by the terms "complementary" (when used to supplement conventional medicine), "alternative" (when used instead of conventional medicine), or "integrative" (when used in a coordinated fashion with conventional medicine). The reality is that any CAM practice may be used in any or all of these ways at different times and under different circumstances.

with preventing and treating illness and promoting health and well-being. Although heterogeneous, the major CAM systems have many common characteristics, including a major focus on individualizing treatments, treating whole people and systems, promoting self-care and self-healing, and supporting vitalism and spirituality. Many CAM systems have characteristics also commonly found in some branches of mainstream healthcare, such a focus on good nutrition and preventive medicine. Thus, boundaries between CAM and mainstream medicine as well as between CAM systems are often blurred and constantly shifting and evolving.

GUIDING PRINCIPLES OF THE COMMISSION

Based on its understanding of complexities and commonalities of CAM systems and practices and their relationship to mainstream medicine, the Commission endorsed 10 basic principles to both guide its process for making recommendations and the recommendations themselves. These Guiding Principles, include a commitment to promoting:

Evidence. The Commission it committed to promoting the use of science and the appropriate scientific methods to help identify safe and effective CAM services and products and generating the evidence that will enhance the development and delivery of these services and products.

Dissemination. Quality health care can be enhanced by promoting efforts that thoroughly and thoughtfully examine the current evidence base for CAM systems and practices and make this evidence base widely and easily available in a timely fashion. The Commission recognizes the need to enhance this evidence base by advocating for high-quality research.

Prevention. Good health care emphasizes the promotion of health in addition to the treatment of disease. There is overwhelming scientific evidence that it is significantly more humane and cost-effective to prevent illness and disease compared to treating people once they become ill.

Health and Healing. The body has a remarkable capacity for recovery and self-healing and a major focus of health care is to support and promote this capacity.

Wholeness. Health involves all aspects of life – mind, body, spirit, relationships and environment - and quality health care must support care of the whole person in this context.

Individuality. Every person is unique and has the right to have healthcare customized to that uniqueness, respecting their preferences and preserving their dignity.

Choice. People have the right to choose freely among safe and effective therapies and qualified practitioners who are responsive to their needs and accountable for their claims and actions.

Education and Empowerment. Education about prevention, healthy lifestyles, and the power of self-care and healing capacity should be made an integral part of curricula for both health care professionals and the public at all ages.

Public Involvement. Public and consumer views and participation must be included in all research and health care prioritizations and decisions.

Partnerships. Good health care requires collaborative teamwork between conventional and complementary practitioners, researchers, and patients committed to the creation and delivery of optimal healing environments. Any potential benefits of CAM for the public can best be maximized through promoting collaborations between conventional and CAM healthcare professionals and researchers. These collaborations can best be encouraged by the integrated delivery of CAM and conventional medicine, where CAM practitioners work side-by-side with conventional practitioners. Integrated delivery, however, does not mean the distillation of CAM services that are then offered by conventionally trained practitioners.

These 10 Guiding Principles are remarkably consistent with the core values of the National Academy of Sciences' Institute of Medicine report on ways to improve health

care in the 21st century. The IOM report, entitled *Crossing the Quality Chasm: A New Health System for the 21st Century*, list 10 core beliefs that healthcare processes should be designed to reflect:

- Continuous healing relationships
- Customization based on patient needs and values
- The patient as a source of control
- Shared knowledge and the free flow of information
- Evidence-based decision-making
- Safety as a system of property
- Transparency
- Anticipation of needs
- Continuous decrease in waste, and
- Cooperation among clinicians

Because of the significant overlap of its 10 Guiding Principles with the core beliefs of the IOM report, the Commission sees its mission as being complementary to such efforts. In particular, the Commission's recommendations will focus heavily on supporting efforts to make the nation's healthcare system more centered around and tailored to consumer preferences, particularly those with chronic, debilitating conditions.

Mission Statement

[To be discussed and drafted after the October Meeting]

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