Why are you doctors? The importance of care and compassion

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Integrated medicine is a practice of medicine that incorporates the best effective complementary and alternative medicine (CAM) treatment(s) alongside orthodox methods of diagnosis and treatment. The concept of integrative medicine is more commonly accepted and practised in the USA, and is aided by the development of the National Center for Complementary and Alternative Medicine (NCCAM). Integrative medicine is about treating the patient as a whole; encompassing the wider issues of health and well-being such as attention to individual's emotional needs, lifestyle and relationships, in addition to promoting self healing and encouraging individual responsibility for health. It is these areas that often provide the quality to life.

The recent (November 2000) report[1] from the House of Lords Select Committee on Science and Technology acknowledged that the use of CAM is increasing throughout Western industrialised nations, and highlighted the issue of integration. It suggests that three main areas within CAM should be addressed:

1. education, in particular familiarisation courses for health professionals
2. research into treatment effects
3. the future of regulation of the multitude of CAM modalities and practitioners.

The conference opened with a video link from HRH Prince Charles, founder and president of the Foundation for Integrative Medicine (FIM), commending the joint cooperation between NCCAM and the Royal College of Physicians that resulted in this conference. Prince Charles suggested that the challenge of integrative medicine for the whole community should be an attainable goal and, it is hoped, will become a reality if the Department of Health accepts the recommendations of the House of Lords to pump-prime centres of excellence.

The professional perception of CAM

The medical perception of CAM was addressed by Dr Lewith in a survey of the members and fellows of the RCP; the RCP has taken a lead in the medical development and understanding of CAM within the UK. Physicians were open to patients' wishes to use CAM, but perceived the use of CAM on the NHS to be too expensive. A significant minority (at least 1 in 10) of hospital-based doctors, however, do use CAM irrespective of whether it is provided through the NHS or privately. The use of CAM by physicians is largely localised to palliative care, pain control and rheumatology. Worryingly, of those physicians practising CAM or referring on to CAM practitioners, only 14% were trained to do so.

Dr Straus described the evolution of the National Center for Complementary and Alternative Medicine (NCCAM) at the National Institutes of Health. The USA and UK are similar in some respects. There has been a rapid change in the culture and structure of the health system over the last 70 years. The increased appeal and use of CAM is similar in both countries, although some CAM therapies are integrated (osteopathy and acupuncture in the UK) while others are marginalised. However, the differences in the health system in the USA (largely private practice, and CAM therapies' dependence on individual state legislation) show that politics and finance still dictate treatment decisions.

NCCAM was created as a result of political need because of the increased use of CAM therapies by patients and payments made by health insurers in respect of CAM therapies. Their mission statement is 'to explore complementary and alternative healing practices in the context of rigorous science; to educate and training CAM researchers; and to disseminate authoritative information to the public and professionals'. NCCAM has expanded and currently has 16 centres of excellence across different disciplines and illnesses. One hundred million US dollars was made available to NCCAM in the fiscal year 2000. The majority of funding is allocated to clinical trials, with the primary research aim being to define effectiveness. The key areas for research are cancer, degenerative disorders, arthritis and women's health, although many other areas are considered and funded.

What do patients want and why?

CAM use is not related to the level of satisfaction or belief in conventional medicine, nor is it related to the desire for personal control but instead to

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increased education levels and world views. Poor health seems to increase CAM use. Indeed, CAM users are often proactive about health and therefore likely to seek out the best conventional care.

The importance of values does seem to be an underlying predictor of CAM use. Paul Ray[2] identified the importance of subcultures in the USA:

- Cultural creatives who have belief and are committed to a range of moral values/ philosophical orientations
- Moderns, ie those who are happy to go with the dominant values of the cultural mainstream
- Heartlanders with traditionalist values

Cultural creatives were significantly more likely to use CAM. Those who had had a spiritual experience which had transformed the way they viewed the world were also more likely to use CAM. Therefore the types of patients who use CAM are the more educated, those with poorer health, those committed to values (cultural creatives) and those who have had a transforming life experience.

Education

Integration may be achieved through education, in particular through familiarisation with CAM in medical schools. Issues such as 'what is the most effective treatment', the safety of CAM, and the qualifications needed for professional practice need to be addressed. Currently many UK and US medical schools offer some training programmes but the approach is varied and limited, although this is changing[3]. After the NIH conference on education in CAM in 1995, 75% of US medical schools began to offer some education, and indeed NCCAM has recently initiated funding to support the development of CAM teaching. In the UK, CAM education needs more coherence, with a standard core curriculum offered throughout UK medical schools. At present CAM education is offered as an option within an already overstretched curriculum in both the UK and the majority of US medical schools.

Regulation and certification

Following the commissioned Department of Health report, 140 professional bodies were identified representing 50,000 practitioners who work in 30 CAM treatments within the UK[4]. The report did highlight that the majority of bodies are run professionally (a code of ethics, a register of members available to the general public, and professional indemnity insurance). The complaints procedure, however, was often poor even in established organisations.

CAM therapies are too disparate to come under one umbrella. In part to reflect this diversity, the House of Lords' report suggested three groups, and related many of its recommendations to their classification. The House of Lords recommended that statutory legislation should be essentially unitary, and similar to the Council of Professions Complementary to Medicine. This would result in each discipline setting its own standards for the formal regulatory process.

In the USA state registration is compulsory for the 'practice of medicine' and practitioners of CAM face prosecution for unauthorised practice. Only medical doctors can diagnose and treat disease; state law applies to the scope of individual practice and advises and licenses CAM practitioners. Each state has different schemes and different interpretations of this particular set of regulations. Registration allows

Conference programme

- **The public and professional perception of complementary medicine**
- **The medical perceptions of CAM in the UK**
- **The evolution of the NIH Centre – a response to public need**
- **What do patients want and why?**
- **The patient's perception of CAM**
- **What is clinical evidence?**
- **The Cochrane view of CAM research**
- **Can we trust in systematic reviews?**
- **St John's Wort prospective studies**
- **Research methodology for CAM**
- **How and when should you teach CAM?**
- **Integrated medical education in the UK**
- **CAM medical education in the USA**
- **The education debate: what should we teach our conventionally trained healthcare professionals about CAM?**
- **Regulation strategies in the United Kingdom**
- **Regulation and certification in the USA**
- **Development of osteopathy in the UK**
- **Delivery Mechanisms**
- **The problems and challenges in establishing and integrated medical programme**
- **An example in practice: integrated cancer care at the Hammersmith Hospitals NHS Trust**
- **Interprofessional relationships within an integrated medical service**
- **The Glasgow Experience: the integration of, practice and teaching in a medical school environment**
- **The science base for CAM: strategies and tactics**
- **Does complexity theory provide a new paradigm for understanding the mechanism underlying CAM?**
- **Research strategies: The House of Lord's Report**

the CAM therapist to practise safely and ethically, but not necessarily effectively. If a licensed practitioner exceeds this scope they face prosecution.

Delivery mechanisms

The challenges and issues concerning the changes integration will bring were addressed by both Dr Weil (USA) and Dr Speigel (USA). Issues applicable to both CAM and conventional medicine that hinder integration, such as innate prejudice, hypocrisy and poor science, were discussed as well as the role that education and high quality research will play in overcoming these problems. Indeed, these stumbling blocks have been successfully overcome and have shifted the culture of conventional medicine, in practice, in a number of UK NHS centres.

Lucy Bell from the Integrated Cancer Care unit at Hammersmith Hospital, London described the evolution of their unit. Established ten years ago, it is now a fully operational fulltime service with secured NHS funding for eight team members. Patients are offered a choice of four out of five CAM modalities (massage, aromatherapy, art therapy, relaxation and reflexology) alongside their conventional treatment. Significant reductions in anxiety and depression levels, and the control of side effects have been clearly demonstrated, in addition to the improved care and emotional support given to these vulnerable patients.

Dr David Reilly, director of Glasgow Homoeopathic Hospital (GHH) described this hospital as a 'place of beauty and healing within the NHS'. The GHH admits 3,600 patients a year. It has deep roots in primary, secondary and tertiary care. Integrated care is defined as 'care that makes greater coherence within a person or within their care plan'. The essence of the therapeutic relationship is highlighted at GHH, and focuses on the power of self-healing. Indeed the power of the homoeopathic consultation alone, prior to medication, has been shown to increase patients' coping skills[5]. Dr Reilly suggested that we should shift our attention to the factors that can facilitate the healing response. The process of fragmentation of self in chronic illness, and alienation of the body, lends itself to the philosophies of CAM; and it is here, where the emphasis is on care rather than cure, that CAM can play such a major role in helping the patients to heal themselves.

The patient's view

These sentiments were mirrored in the eloquent description by Jane Lapotaire of the impact of her health care experiences in both France and the UK after her subarachnoid haemorrhage. Describing herself as a cultural creative, Jane talked about issues that surround good medical care. She described how basic aspects of care were neglected; her experiences of not being asked how she was, not being told what was happening to her, and not being touched. She wants to 'put the care back into medicine… there is no budget for care… Don't treat the illness, treat the person. Try to find some meaning for that person'. She asked: 'Why are you doctors? Have you lost sight of the importance of care and compassion?'

What is clinical evidence, and the science base for CAM

Where is the research evidence to evaluate CAM? Professor Kleijnen described the Cochrane, NHS centre for reviews. The Cochrane centre prepares systematic reviews of the best available evidence to assess whether an intervention is effective. It contains other databases such as DARE and NHS EED which can be accessed through the website www.york.ac.uk/inst/crd. There are many reviews of CAM, and currently the centre is producing publications on acupuncture, homoeopathy and herbal medicine.

The usefulness of systematic reviews (SR) in CAM was addressed by Dr Linde. Currently the Cochrane complementary medicine field holds 58 reviews on herbal medicine, 39 on acupuncture and 18 on homoeopathy. Linde suggests that the SR is the best tool for obtaining an overview of the available scientific evidence on a defined topic, but counselled caution when interpreting these SRs as there is considerable discordance between the available reviews of the same subject. The detailed interpretation of the evidence in each review needs to be carefully considered. This should encompass factors such as the comprehensiveness of the search, the selection process – ie inclusion criteria, diagnostic criteria, design of the trial, randomisation and statistical methodology – as well as those factors defining methodological quality within each study. Therefore the results of systematic reviews should be interpreted with caution, particularly in CAM where few good quality primary studies exist.

Finally, Professor Hyland (UK) spoke of the need for integration of conceptual paradigms, and stated that integration of clinical skills alone is not adequate.

Assumptions in modern Western medicine are fundamentally different from those within CAM and are based on the reductionist, analytical view of illness as a sequential process, ie a specific cause results in pathology, and treating the cause will rectify health. CAM, on the other hand, is based on the assumption of distributed causes: ill health is defined as an imbalance which when treated using either single or multiple therapies will allow a return to a healthy state. Complexity theory is a model based on systems theory and encompasses the meta theoretical assumptions of CAM and conventional medicine. It suggests that two types of pathology can occur together:

- *Specific* pathology, ie sequential events result in symptoms, the analogy being a broken part that needs fixing
- *Network* pathology, ie parallel disturbances where many factors lead to an imbalance. The extended network (for example the psychoneuroimmunoendocrine network) is normally capable of self-regulation, but under specific circumstances may become dysregulated, resulting in a 'learning error' so that the system incorrectly adapts and results in ill health.

The emergence of complexity theory can explain some features of chronic illness, ie their intrinsic variability, multiple risk factors and inconsistent triggers. Consequently the integration of CAM and conventional medicine needs to be considered not just at the therapeutic level, but also theoretically.

In conclusion, we considered that this was a landmark conference of high academic quality. We hope it will encourage the development of an improved research and education agenda, and more cooperative ventures between the US and the UK.

References

1 House of Lords. Session 1999–2000. Sixth Report, Select Committee on Science and Technology. *Complementary and alternative medicine.* London: The Stationery Office, 2000.

2 Ray P, Anderson SR. T*he cultural creatives: how 50 million people are changing the world.* New York: Harmony Books, 2000.

3 Owen DK, Lewith G, Stephens CR. Can doctors respond to patients' increasing interest in complementary and alternative medicine? *Br Med J* 2001;322:154–8.

4 Mills S, Budd S. *Professional organisation of complementary and alternative medicine in the United Kingdom: a second report to the Department of Health.* Exeter: Centre for Complementary Health Studies, 2000.

5 Mercer SW, Reilly D, Watt G. *Empathy and enablement: a pilot study of consultations at the Glasgow Homoeopathic Hospital.* Scottish NHS Research Conference Proceedings, September 2000, in press.