Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

A Perspective on: Core Competencies in Integrative Medicine for Medical School Curricula: A Proposal; and Curriculum in Integrative Medicine: A Guide for Medical Educators

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The above-named documents,[1,2] released during the summer of 2004, contain information valuable beyond the boundaries of conventional academic medicine. While most health care provider groups may pay homage to portions of what is presented, I question whether any provider group embraces what is presented in totality. I share this perspective for all providers of health care to ponder.

The Consortium of Academic Health Centers for Integrative Medicine (CAHCIM) was formed in 1999 in response to the growing interest of the public in complementary and alternative medicine (CAM) and the growing dissatisfaction in the practice of medicine. The mission of CAHCIM is to "help transform healthcare through rigorous scientific studies, new models of clinical care, and innovative educational programs that integrate biomedicine, the complexity of human beings, the intrinsic nature of health, and the rich diversity of therapeutic systems." (*Guide*, pg. 10)

Integrative medicine is defined by CAHCIM as "an approach to the practice of medicine that makes use of the best-available evidence, taking into account the whole person (body, mind, and spirit), including all aspects of lifestyle. It emphasizes the therapeutic relationship and makes use of the rich diversity of therapeutic systems, incorporating both conventional and complementary/alternative approaches." (*Proposal*, pg. 522)

Competencies in Integrated Medicine

The CAHCIM Working Group on Education has emphasized "an expanded way of viewing the physician, the patient, and their work together." (*Proposal*, pg. 523) This is accomplished by reaffirming and re-emphasizing the humanistic values at the core of medicine in medical education. To accomplish this affirmation and emphasis an additional set of core competencies beyond the typical knowledge, attitude and skills has been put forth. This additional set of competencies is in the area of values.

"A graduating physician shall demonstrate an understanding of the following:

1. A physician is defined by a philosophy and perspective on health and illness as well as by a set of skills and techniques. This broad perspective will improve outcomes for patients, deepen fulfillment in collegial relationships, and enable the physician to find continuing meaning in his or her work.
2. A physician has a broad definition of professionalism, which allows the health care team to become a healing community that supports and develops wholeness in all relationships, those between colleagues as well as those between physician and patient.
3. A physician recognizes the relevance of feelings, beliefs, life experiences, meaning, and faith

to his/her professional behavior.This broadens the nature of physician-patient interaction and shifts the conventional boundaries of physician-patient relationships.
4. A physician is able to recognize the value of his or her own full human experience and to focus and dedicate it to the benefit of patients. Who the physician is as a person is transmitted through his or her work and 'presence' and has a substantive impact on the outcome of the doctor-patient relationship.
5. A physician believes that an ongoing commitment to personal growth is fundamental to the practice of medicine.
6. A physician is able to create a relationship of harmlessness, safety, nonjudgment, and acceptance that enables patients to access their own strengths and direct their own lives.
7. A physician recognizes the pursuit of meaning as fundamental to the process of healing and has the capacity to find meaning in daily work and daily relationships. This capacity allows the physician to accompany patients as they seek and find meaning in the events of their lives.
8. A physician recognizes the multivariate and sometimes unknown factors that influence health and healing.
9. A physician views health and illness as a part of human development that can evoke the potential for personal and social wholeness through the experience of illness and suffering." (*Proposal*, pp. 523-24)

Additional competencies related to knowledge, attitudes and skills can be found in both the proposal and the guide.

How appropriate it would be to replace the word "physician" with "health care provider" and have these competencies apply to all engaged in the healing process with patients. It could be argued that in the CAM provider community, many of these competencies are integral to how practice is conducted. In fact, isn't it these humanistic competencies that often distinguish the practice of a CAM provider from a traditional medical provider, and so often lead to high levels of patient satisfaction with CAM providers? It serves us to acknowledge that while the humanistic side of care is integral to CAM education, philosophies and practices, policy barriers to their systems of care and the economics of delivery in CAM sometimes cast a negative shadow over the espoused humanistic values. We may fail our own values.

While the CAHCIM Working Group recognized that humanistic values have always been an integral part of the practice of medicine from the days of Hippocrates, it felt a need to "re-emphasize" these "value competencies" for those seeking to integrate the practice of traditional medicine with "alternatives." The group also pointed out two major barriers to implementing the teaching of CAM in the medical curriculum: "the divergent nature of unconventional therapies and the varying levels of evidence that supports their use." (*Guide*, pg. 11) The resistance to sharing economic benefits and power of cultural authority with the CAM provider could also be considered a barrier not mentioned in the guide.

The first major barrier was the perceived inability of traditional instructional methods designed to teach new scientific facts to "achieve an effective understanding of the principles and practice of integrative medicine." (*Guide*, pg. 11) The second barrier was finding time to insert the teaching of "integrative medicine competencies into the conventional medical school curriculum" (*Guide*, pg. 11), an already overloaded curriculum.

Three key components for effectively teaching integrative medicine are recommended:

1. experiential approaches to facilitate an understanding of complementary and alternative therapies;
2. education of medical students in self-care and reflection; and

3. faculty development programs to produce educators who have both knowledge and skills in integrative medicine, and who recognize the importance of self-care and reflection in medical education and practice. (*Proposal*, pg. 525)

Paradigm Clash or Paradigm Absorption?

While the aspirations set forth by the CACHIM Working Group are laudatory, transition in medical education has been slow. Those academic medical centers that have incorporated CAM instructional components in their programs have done so as electives, introductory survey courses, site visits to CAM practitioners, selected literature reviews, and invited lectures in the classroom. If the additional instruction is to train physicians to "dabble" in the practice of CAM, I wonder what kind of response would be received if the academic CAM centers were to offer similar types of instruction so their graduates could "dabble" in the practice of surgery or prescription formulary.

It appears that, "given the divergent nature of CAM therapies and the varying levels of evidence that support their use" (*Proposal*, pg. 525), academic medicine has categorized the integration of CAM with traditional medicine as an option based on "soft science" relegated to a secondary role to address growing public acceptance and its impact on managing patient care. CAM concepts and philosophies such as life force, theories of spiritual causation, and therapeutics based on interconnectedness of healer and patient have been marginalized or excluded from the reductionistic biomedical paradigm.

The emergence of the biopsychosocial paradigm has opened the door for a more humanistic approach to the science of health care and has created opportunities for research beyond the narrow boundaries of reductionism. With the establishment of the CACHIM Working Group and the recommendations set forth, a race has begun. The race is between traditional medicine (in the Western sense) and CAM.

On the one hand, will medicine embrace integrative medicine (CAM) and subsume its values and practices under the umbrella of medicine? On the other hand, will CAM step up its research productivity and produce evidence that explains the mechanisms and predicts the potential outcomes that CAM provides in a scientifically substantive manner? Will CAM leaders deeply engage in the public policy and health care reform debate as industry, providers, patients and government attempt to move health care financing and policy toward a healthier nation? Or will CAM continue to reside in the comfortable confines of so-called "pre-scientific mysticism" that persists in portions of the CAM community?

I wonder who will win the race - or could it be that the two contestants form a team that makes all participants, especially patients, winners? Efforts within the CAM community to form an Academic Consortium for Complementary and Alternative Healthcare team are coming together concurrently to join with the leaders of CAHCIM'S conventional academic medical centers to hold a National Education Dialogue to Advance Integrated Health Care, scheduled for June 2005.

The curriculum is available at www.imconsortium.org/html/education.php; the Web site for the consortium of academic medical centers is www.imconsortium.org.

References

1. Kingler, et. al. Core competencies in integrative medicine for medical school curricula: a proposal. *Academic Medicine* June 2004;79(6):521-531.
2. Consortium of Academic Health Centers for Integrative Medicine. *Curriculum in Integrative Medicine: A Guide for Medical Educators*. May 2004, published by the CAHCIM Working

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