Distinguishing Between Complementary and Alternative Medicine and Integrative Medicine Delivery: The United Kingdom Joins World Leaders in Professional Integrative Medicine Education

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“Sixteen years as a general practitioner [GP] showed me that the prevailing biomedical reductionist model fails to address the complexity of human experience and psychosomatic illness that daily practice brings up, and for which I was not trained. Even at the purely physical level, there are huge gaps in conventional training with virtually no training in musculoskeletal medicine (a huge component of GP life) or nutritional medicine, without stepping outside conventional training to embrace, for example, nutritional therapy, acupuncture, or osteopathy courses.”

These are the words of one of the authors, Dr. David Morris, having chosen to embark on training in integrative medicine (IM).

The advent of professional IM education in the United Kingdom has lagged 15 years behind America and Australia substantially because of opposition based on lack of understanding about the difference between complementary and alternative medicine (CAM) and IM. CAM embraces a spectrum of traditional therapies and treatment approaches not generally used or taught within mainstream medicine, whereas IM refers to an overarching model of whole-person care that focuses primarily upon health rather than illness, and on the active engagement of individuals in achieving optimum health and well-being. IM embraces the “best of all worlds,” integrating approaches to treatment from the allopathic, complementary, alternative, psychologic, spiritual, environmental, nutritional, and self-help arenas. Another delaying factor has been the belief held by some proponents of IM that medicine should become integrated “from the inside out,” with efforts focussed on core modules of IM for medical undergraduates rather than professional training in IM.

In the United Kingdom, the British College of Integrative Medicine (BCIM) was established specifically to address the need for training and education in IM. This College’s first cohort of doctors and nurses will graduate with a diploma in the Study of Integrative Medicine (DipSIM) in March 2012—the first-ever British postgraduate degree qualification in IM. The BCIM view, upon which the 2-year part time Diploma syllabus was formed, is that IM integrates:

For patients:
- Understanding of, and care for, the physical, emotional, spiritual, social, and environmental factors in the etiology of illness and its treatment
- Their personal understanding of the cause and meaning of their illnesses
- Their own wisdom, commitment, and effort in the self-healing process and in achieving the best outcomes from therapeutic and medical interventions.

For diagnostics and treatment:
- Allopathic medical diagnostics and treatments
- Functional and environmental medicine diagnostics and treatments
- Evidence-based complementary and alternative therapies
- Psychologic therapy, support groups, self-help practices, and spiritual healing
- Nutritional therapy and healthy eating regimens.

For case management:
- A multidisciplinary person-centered approach with the client’s needs, values, and choices as the primary determinants in the type of help offered
- Focus on the support of carers to prevent burnout and stress-related illness.

For IM professionals:
- Reflective practice, auditing, and continuous learning
- Mutual respect and support

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• Ongoing professional supervision, personal and professional development, and health coaching to promote optimum self-care.

For society:
• Community and business involvement in the generation of health and well-being
• Work to identify and eliminate environmental toxicity
• Sustainable healthcare
• Green policies in all healthcare environments.

IM practitioners help patients to use the crisis of illness as a springboard for positive personal change and the development of the “fully engaged” scenario envisaged by Wanless,3 which he concludes is the only way to avoid health system collapse from potential cost savings made through primary and secondary prevention of illness.

However, most conventional biomedical education in the United Kingdom does not teach the models and skills required to effect and integrate change in the causal relationships among emotional, social, physical, environmental, and behavioral elements causing costly lifestyle-related illnesses. Nor are medical graduates taught the evidence-based interventions and self-help techniques that can prevent illness and be integrated safely and cost-effectively with orthodox biomolecular medicine to enhance health and well-being, facilitating learning and providing meaning in the face of life and health challenges. As a result, the training of medical IM professionals in the United Kingdom has hitherto been self-directed and, as a result, the public has been completely unclear about the depth, breadth, and reliability of the skills and knowledge of providers branding themselves IM practitioners. So, while CAM professionals have made great strides in the definition of their professional training and practice standards, IM practitioners in the United Kingdom have been without either a recognized professional body or formal training framework. This will change in March 2012 as the first DipSIM graduates are entered onto the new BCIM Register of Integrative Medicine Practitioners, signaling to the public and medical profession alike, the achievement of a well-rounded and academically rigorous study of the theory, science, art, and skills of IM and adherence to a code of professional IM practice.

Meanwhile, people served by health care professionals who are ignorant about current IM evidence for low-cost effective therapeutic and self-help approaches are deprived of their benefits, remaining dependent on a system that is unsustainable socially and economically. For example, between 1997 and 2010, in the United Kingdom alone, health service expenditure doubled from US$89 to US$172 billion. Definitive figures for the potential savings that could result from an integrative approach have yet to be demonstrated conclusively, but it is becoming evident that the professionalization of IM and its insertion into health care strategy globally must be encouraged. An integral component to this concerns the interactions between professionals and patients as described by Rollnick and Miller2 who draw attention to the catalyzing of sustainable changes in health-defining behaviors, especially in the face of widening health inequalities Marmot (2010).3

IM may be a significant part of the answer sought by both health economists and the general public who want sensitive holistic health care. In San Diego,4 researchers studying women with breast cancer who adopted a healthy diet and daily exercise program reported a doubling of survival at 14 years, which is better than for any current conventional treatment for breast cancer, with only negligible costs by comparison. The seminal work of Dean Ornish5,6 and other lifestyle researchers7 have similarly impressive results with the Omaha Mutual insurance company stating that cardiology patients on his program cost an average of $30,000 less per person. With the American Heart Association reporting an estimated incidence of 81,000,000 cases of cardiovascular disease in the United States in 2006,8 the cost-saving potential of this supported self-help intervention alone is clearly immense.

Crucially, however IM is not just about financial savings and efficiency. It is about practice and about meaning—for patient and practitioner alike.9 Having trained in acupuncture and homeopathy, Dr. Morris still felt the need to develop a deeper understanding of a truly integrative approach, to evaluate the evidence base for IM critically, and to study the subtler concepts of the nature of health and wellness and the meaning of illness. Crucially, he learned to apply IM theory to his own self-care. He asks: “If the providers of health care themselves are not supported compassionately, then how can they be expected to act compassionately?” Then he goes on to say:

Through the course’s health mentorship program, I have been supported to start a spiritual practice (meditation), which is profoundly beneficial to me, and to lose 10 kg of excess weight. Additionally through the course’s medical supervision process, I have been helped to integrate my learning into my professional practice. It has been particularly gratifying to rediscover the skill of critical thinking enabling me to better challenge the dominant, expensive, all pervasive drug culture, now deemed an urgent priority by Godlee and Loder10 in the recent British Medical Journal editorial with the subtitle “Urgent Action is Required to Restore the Integrity of the Medical Evidence Base.

In his practice, a motivational telephone mentoring initiative has reduced hospital admissions of the chronically ill by 20%, and this inspiring IM project has won the prestigious Heath Service Journal Award for Long Term Conditions Management in 2010.

As IM develops worldwide, the requirement for consensus among educational leaders on the terms, standards, and competencies necessary for the teaching and practice of IM in Australia, the United Kingdom, Europe, and the United Kingdom does not teach the models and skills required to effect and integrate change in the causal relationships among emotional, social, physical, environmental, and behavioral elements causing costly lifestyle-related illnesses. Nor are medical graduates taught the evidence-based interventions and self-help techniques that can prevent illness and be integrated safely and cost-effectively with orthodox biomolecular medicine to enhance health and well-being, facilitating learning and providing meaning in the face of life and health challenges. As a result, the training of medical IM professionals in the United Kingdom has hitherto been self-directed and, as a result, the public has been completely unclear about the depth, breadth, and reliability of the skills and knowledge of providers branding themselves IM practitioners. So, while CAM professionals have made great strides in the definition of their professional training and practice standards, IM practitioners in the United Kingdom have been without either a recognized professional body or formal training framework. This will change in March 2012 as the first DipSIM graduates are entered onto the new BCIM Register of Integrative Medicine Practitioners, signaling to the public and medical profession alike, the achievement of a well-rounded and academically rigorous study of the theory, science, art, and skills of IM and adherence to a code of professional IM practice.

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**Box 1: International Postgraduate Integrative Medicine Teaching Centers**

- The Arizona Center for Integrative Medicine, USA—Andrew Weil, MD
- The British College of Integrative Medicine, UK—Rosy Daniel, BSc, MBBCh
- The European University Viadrina, Germany—Harald Walach, PhD
- The National Institute of Integrative Medicine, Australia—Professor Avni Sali, MBBS, PhD, FRACS, FACS, FACNEM
States (see Box 1). The BCIM is calling for and suggesting the establishment of an international think tank, "Integrative Medicine International" (IMI), to establish an international dialogue focused on securing international agreement on professional training and standards. At this point the BCIM identifies and serves nine major educational and career-development pathways for people considering specialist careers in IM as follows:

1. Primary prevention of illness
2. Environmental medicine
3. Functional medicine
4. Study and specialization in application of IM by type of illness, stage of life, or gender
5. Advanced expertise in a specific CAM discipline
6. Psychosomatic mind–body medicine
7. Spiritual and end-of-life care
8. Research and teaching
9. Leadership and management.

Undoubtedly, today’s IM graduates will be the natural leaders of the transformation of health care from passive health management to much-needed proactive health creation. It is heartwarming to see that the first course in the United Kingdom has drawn international attendance from Thailand, Portugal, Scotland, Wales, and England. The second DipSIM goes forward from October 2011 in Bath, in the United Kingdom, and in line with the recommendations of the 2010 WHO Framework for action on interprofessional education and collaborative practice,11 will now be open to all medical graduates, providing the unique opportunity for psychologists, occupational therapists, dentists, pharmacologists, dieticians, physiotherapists, and others to study with doctors and nurses dedicated to creating the vital innovative IM services of the future.

References


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