# Teaching integrated care: CAM familiarisation courses

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## ABSTRACT

- As the use of CAM grows, CAM familiarisation offers educational opportunities for undergraduates to understand CAM, their attitudes to medical change and the process of evidence-based medicine.
- Such courses also offer the opportunity to integrate patient care and improve the relationship between medical and CAM practitioners.
- CAM familiarisation courses are available in many medical schools in the United States and the United Kingdom.
- The multiprofessional model which we have developed at the University of Southampton (UK) offers valuable experience to those thinking of establishing such courses.

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The growth of complementary and alternative medicine (CAM) raises many issues. Among the most important are efficacy, availability and disclosure of its use by patients (all of which may affect a patient's management), and professional relationships with CAM practitioners (particularly the non-medically qualified). It should also be acknowledged that "today's fringe practice may become tomorrow's mainstream",[1] and the current definition of CAM, which is based on therapies not normally taught in medical schools or offered in hospitals, will have to change as such therapies are increasingly integrated into practice.[1] Who, 30 years ago, would have thought that acupuncture would become an acceptable method of treating chronic pain?

## Why should conventionally trained and registered healthcare professionals learn about CAM?

There has been a steady increase in the number of people who use CAM throughout the Western industrialised nations. In the United States, out-of-pocket expenditure on CAM doubled in the 1990s, with 42% of people using some form of CAM each year.[2] To cope with this, professionals indicated that they would like to be more aware of their patients' expectations and use of CAM,[3] and professional organisations are suggesting various levels of knowledge and training with respect to CAM. Australian GPs seem to agree, with 93% of respondents to a survey in Victoria wanting some form of CAM familiarisation, while simultaneously underestimating the use of CAM by their patients.[4] Other studies suggest that up to 75% of patients who use CAM never disclose this to their medical doctor.[2]

It is possible that there may be two groups of patients who use CAM — those whose primary source of medical advice is their GP and those who use their CAM practitioner for this purpose. This further emphasises the need for CAM familiarisation among GPs as well as the importance of considering that some CAM practitioners should be thought of as professional colleagues. In one study, 84% of United Kingdom medical students reported that knowledge about CAM would be important to them as future physicians, although they became less interested as their training progressed, possibly because of exam pressures.[5] Those who have received some CAM familiarisation in their training are more positive towards the needs of patients who wish to discuss CAM with their family physician.[5]

Key issues in setting the learning goals are the different priorities of clinicians, students and patients; factors that influence efficacy and patients' safety; and exploring what patients and clinicians need to know so that both conventional and complementary medicine can be used appropriately.

As well as providing CAM familiarisation to medical students, there are challenges in providing information about CAM to established practitioners in diverse healthcare disciplines.[6] Practising doctors have very little opportunity to reflect on the changing relationship between CAM and conventional medicine. Doctors attending CAM courses, either to familiarise themselves with CAM or to learn a new therapeutic technique, give a variety of reasons for doing so, from understanding what patients are using to increasing the breadth of their skills. Doctors studying to be CAM therapists often call on different personality traits from those they use in conventional medicine, and report various benefits from training, including engaging their feelings, trusting their intuition and enjoying "therapeutic touch".[7]

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## The changing face of CAM education

Most medical schools in the UK now offer CAM familiarisation courses. This was predicted in the mid-1990s, even though a minority of UK medical schools had such courses in place at the time.[8] Similarly, in the United States, one study reported that 83% of primary care medical school faculties had some experience of offering one or more CAM therapies within primary care curricula,[9] and almost all US medical schools offer some CAM familiarisation. This reflects the fact that family doctors in the UK and America are increasingly referring patients to CAM practitioners.[10,11] Most of this evolution has occurred over the last 10 years, emphasising the changes in undergraduate education demanded by students on both sides of the Atlantic. Further impetus has been provided in the UK through the General Medical Council document *Tomorrow's doctors*, which emphasises the need for CAM familiarisation in UK medical schools,[1] a need supported by the recent House of Lords' Select Committee on CAM.[12]

It is vital to remember that, within CAM, there are a range of diverse philosophical and practical systems of healthcare, some of which (eg, nutritional and manipulative medicine) are more easily

taught and used in a complementary way than others. Homoeopathy, Ayurveda and Traditional Chinese Medicine require a different understanding of health to be delivered on an effective and individualised basis. Many doctors increasingly recognise the value of CAM treatments, especially where there is scientific evidence to support practices.

Evidence-based outcomes rely on a conventional research approach that involves randomised controlled trials (RCTs) and, subsequently, systematic reviews. These are expensive, and CAM research can find it difficult to attract funding.[13] RCTs lend themselves less comfortably to CAM practice, particularly as the therapies involve individualised treatments over prolonged periods. For instance, the use of placebos in CAM provides a level of complexity that is not apparent in conventional research: what sort of placebo is appropriate for acupuncture or manipulation?

Interestingly, acupuncture has become almost conventional and is now widely used in most UK pain clinics. This increase in popularity led to the proposal of an acupuncture endorphin hypothesis,[14] in spite of the limited clinical evidence for acupuncture in chronic pain.[15] This suggests that an understanding of acupuncture's possible mechanism has made it a more acceptable treatment, whereas homoeopathy may be unacceptable in some quarters because of its fundamental implausibility.

## The referral process

Professional relationships frequently centre on the process of patient referral. In the absence of clear legal guidelines, many doctors are reluctant to formally recommend CAM, and CAM practitioners may be equally reluctant to refer to conventional carers. Consequently, CAM may continue to be perceived by patients as alternative rather than complementary or integrated. However, if the relationship between CAM providers and conventional physicians can be improved through education and familiarisation, the process of referral and joint patient care between these two professional groups may become more integrated, benefiting both professionals and patients.

## CAM familiarisation modules

One place where all medical graduates can receive some familiarisation with CAM is medical school, where such courses may be optional, core, or a combination of both. Students' attitudes towards CAM can change with familiarisation courses,[5,16] and, as their knowledge base and confidence in dealing with patients using CAM increases, so does the perceived value of CAM interventions.

CAM teaching in different medical schools falls into several broad types:

- courses offering an introduction centred around the particular expertise of an interested member of the faculty:[17]
- courses run by CAM practitioners who may be outside the university;
- courses using CAM as an example to develop an understanding of evidence-based medicine and critical appraisal; and
- courses involving a number of teachers (CAM practitioners and conventional physicians).

A survey of 74 medical schools found that most US courses were taught by CAM practitioners and less than 20% emphasised a scientific or evidence-based approach to the evaluation of CAM.[18] However, we know little about the detailed structure of most CAM familiarisation courses and how they are sustained financially or technically. An advantage of having a single enthusiast teaching is that the students will usually get in-depth knowledge of one therapeutic approach; the disadvantage is that they may not perceive an appropriate "balance" within the world of CAM practice.

At the University of Southampton all medical students are offered a 1-hour lecture in first year, a half-day presentation in their second year, and a third-year special study unit over 10 half-days. The key features of this special study unit are that it uses learning objectives set by students and CAM lecturers; revisits basic assumptions about becoming a doctor (eg, what is health?); uses a reflective learning process; reviews the evidence base for CAM; employs a teaching team of local CAM practitioners (including medical practitioners, nurses and chiropractors); and includes clinical visits as well as seminars.

The little information that we have about the breadth of CAM familiarisation teaching suggests that the students in these courses regularly encounter specific themes which are much broader than just CAM. These involve patient choice, the nature of evidence and how it may be evaluated, individualised treatments versus more conventional treatment protocols, different beliefs about health and the role of the carer/physician, privately funded treatments versus state funding (in the UK), and out-of-pocket expenditure versus reimbursed expenditure (in the US). Further, the variability of "standards of care", the lack of statutory regulation within the CAM professions, the lack of communication between healthcare providers, and the training requirements both for CAM practitioners and for doctors using CAM in their practices are issues that are consistently raised. Providing appropriate patient-centred healthcare for minority groups is a vital issue — this includes ethnic groups with different "traditional" medical systems, such as traditional Chinese medicine and Aboriginal medicine.

In Southampton, students give consistent feedback that the teaching delivers the agreed learning objectives, as our course is the subject of continuous audit, appraisal and subsequent evolution.[19] Their confidence in their knowledge of specific therapies, and their willingness to give explanations and recommendations to their patients, increased dramatically.

## CAM familiarisation in Australia

The teaching of CAM varies widely between different Australian medical schools, but appears to be undergoing a process of change. While increasingly recognised as an important issue by Australian medical schools, there is no unifying requirement recommended by the Australian Medical Council that CAM should be communicated in any form to medical students. This is left up to individual medical schools.[13]

## The added value of a CAM familiarisation course

In our view, "thinking outside the box" of conventional medicine by being introduced to CAM is an invaluable educational opportunity for medical undergraduates. Not only does it provide an opportunity to look at conventional medicine from a different perspective, but it enables the development of critical appraisal and provides vital information about the practice of CAM. The main considerations in establishing a CAM familiarisation course are shown in the Box.

### Recommendations for establishing a complementary and alternative medicine (CAM) familiarisation course

- Nominate an individual within the faculty to initiate, develop and manage the course (this creates accountability and the appropriate networks).
- Provide adequate funding to develop resources and remunerate teachers who take time away from their private practices.
- Establish clear course aims and objectives in conjunction with both the teaching team and students.
- Set up a continual process of appraisal and audit to manage teaching quality and allow the course to evolve.
- Develop a working relationship with the university medical education department to provide assistance with teaching methods, course aims and objectives, and appropriate appraisal and audit.
- Develop a working relationship with CAM researchers locally and nationally to develop the evidence-based element of the course.
- Involve local CAM practitioners in course development (not only does this sustain the teaching network, but it also creates the potential for a CAM research network).
- Provide students with some form of clinical experience within the local CAM community.
- Create a Web-based resource for the course.
- Create a teaching team with regular yearly or twice-yearly meetings.

Integration can therefore centre around a common educational need. If at all possible, we would recommend that both medical and non-medically qualified individuals are involved as teachers and, furthermore, we believe that the course will be much richer if the audience is multiprofessional and involves, at the very least, nurses and doctors being taught together.

## Conclusion

While the use of CAM in Western industrialised nations continues to expand, patients are likely to benefit through effective CAM modalities becoming increasingly integrated with conventional medical management. In the future, doctors will require information about CAM to maintain a central role in patient care and relating to CAM professionals. There are broader educational opportunities in providing CAM familiarisation beyond the simple "gaining of knowledge". This could lead to a maturing relationship between conventional physicians and CAM practitioners, exploring the common ground between the professions and benefiting patients who wish to receive integrated care without conflict between professionals. In Australia, the same trends in growth and interest in CAM are apparent, but without an evident sustainable or coherent approach so far to CAM familiarisation in medical schools. If patients are to benefit from an integrated, patient-centred approach, the CAM and conventional medical communities will need to understand each other. What better place to start this process than as part of medical undergraduate education?

## Competing interests

None identified.

## References


1 General Medical Council. Tomorrow's doctors. Recommendations on undergraduate medical education. London: GMC, 1993.
2 Eisenberg DM, Davis RB, Ettner SL. Trends in alternative medicine use in the United States. *JAMA* 1998; 280: 246-252.
3 Konefal J. The challenge of educating physicians about complementary and alternative medicine. *Acad Med* 2002; 77: 847-850.
4 Pirotta MV, Cohen MM, Kotsirilos V, Farish SJ. Complementary therapies: have they become accepted in general practice? *Med J Aust* 2000; 172: 105-109.
5 Furnham A, McGill C. Medical student's attitudes about CAM. *J Altern Complement Med* 2003; 9: 275-284.
6 Hill FJ. Complementary and alternative medicine: the next generation of health promotion? *Health Promot Int* 2003; 18: 265-272.
7 Freeman R. Mentoring in general practice. Oxford: Butterworth Heinemann, 1998.
8 Rampes H, Sharples F, Maragh S, Fisher P. Introducing complementary medicine into the medical curriculum. *J R Soc Med* 1997; 90: 19-22.
9 Levine SM, Weber-Levine ML, Mayberry RM. Complementary and alternative medical practices: training, experience and attitudes of a primary care medical school faculty. *J Am Board Fam Pract* 2003; 16: 318-326.
10 Wharton R, Lewith GT. Complementary medicine and the general practitioner. *BMJ* 1986; 292: 1498-1500.
11 Borkan J, Neher JO, Soker B. Referrals for alternative therapies. *J Fam Pract* 1994; 39: 545-550.
12 House of Lords. Science and Technology — Sixth Report. Complementary and alternative medicine. London: House of Lords, 21 Nov, 2000. Available at: www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm (accessed Jul 2004).
13 Lewith GT, Ernst E, Mills S. Complementary medicine must be research led and evidence based [letter]. *BMJ* 2000; 320: 188.
14 Clement-Jones V, McLoughlin L, Lowry PJ, et al. Acupuncture and heroin addicts: changes in metenkephalin and beta-endorphin in blood and cerebrospinal fluid. *Lancet* 1979; 2: 380-382.
15 White A. Acupuncture research methodology. In: Lewith GT, Jonas WB, Walach H, editors. Clinical research in complementary therapies. Edinburgh: Churchill Livingstone, 2002.
16 Halliday J, Taylor M, Jenkins A, Reilly D. Medical students in complementary medicine. *Complement Ther Med* 1990; 1: 32-33.
17 Mills EJ, Hollyer T, Guyatt G, et al. Teaching evidence-based complementary and alternative medicine: I. A learning structure for clinical decision changes. *J Altern Complement Med* 2002; 8: 207-214.
18 Brokaw JJ, Tunnicliff G, Raess BU, Saxon DW. The teaching of complementary and alternative medicine in US medical schools: a survey of course directors. *Acad Med* 2002; 77: 876-881.
19 Owen D, Lewith GT, Stephens CR. Can doctors respond to patients' increasing interest in complementary and alternative medicine? *BMJ* 2001; 322: 154-157.


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