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## Perspective

## Integrative medicine is integral to providing patient-centered care

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## Introduction

The Institute of Medicine's (IOM) report *Crossing the Quality Chasm* details a roadmap to quality 21st health care for all Americans.<sup>1</sup> This health care system of the future would be built on 6 "best practice" principles, 1 of which is patient-centeredness. The IOM defines patient-centered care as "respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions."<sup>1</sup> In this model of care, patients and their families are invited into the decision-making process, and their preferences for care are given weight equal to the clinician's expertise. This model also contemplates that evidence-based decisions will use the best available research evidence (Fig 1).<sup>2</sup> Many believe that high-quality health care cannot be achieved without thusly incorporating the patient's experience. Improved clinical outcomes, enhanced patient satisfaction, and lower costs have been achieved across a wide variety of diseases and conditions using patient-centered approaches.<sup>3</sup>

First proposed in 1978, the Planetree model is identified as 1 of the 3 models most likely to accelerate the implementation of patient-centered care in ambulatory and acute care settings.<sup>4</sup> A main feature of the Planetree model is the use of integrative medicine (IM) as a method to achieve patient-centered care. IM is "healing-oriented, and embraces conventional and complementary therapies. ... Definitions abound but the commonalities are a reaffirmation of the importance of the therapeutic relationship, a focus on the whole person and lifestyle—not just the physical body, a renewed attention to healing, and a willingness to use all appropriate therapeutic approaches, whether they originate in conventional or alternative medicine. Integrative medicine represents a broader paradigm of medicine than the dominant biomedical

model. It comes from a growing recognition that high-tech medicine, while wildly successful in some areas, cannot fully address the growing epidemics of chronic diseases."<sup>5</sup>

Every 5 years the National Health Interview Survey asks tens of thousands of Americans about their health and IM use. The use of traditional healing practices is common. Thirty-eight percent of adults reported using IM, and asthma and allergies ranked in the top 15 most common medical conditions for which IM was used.<sup>6</sup> In 2012, 12.1% of healthy children (no chronic conditions) 4 to 17 years old used IM. Prevalence of IM use increased to 15.5% in children reporting 1 chronic condition and to 17.4% in those reporting at least 2 chronic conditions.<sup>7</sup> However, in children reporting a respiratory condition, allergies (food, respiratory, skin, hay fever) or eczema, IM use (including vitamins and minerals) increased to 64.7%, 64.1%, and 62.2%,<sup>7</sup> respectively. Adults used non-vitamin and non-mineral dietary supplements more than any other approach,<sup>8</sup> and children used vitamins and minerals most often.<sup>6</sup>

When folk medicines (remedies including prayer, healing touch or laying on of hands, charms, herbal teas or tinctures, magic rituals)<sup>9</sup> are included in the broad definition of what constitutes IM, rates of use increase substantially, with 80% of adolescents<sup>10</sup> and 93% of adults<sup>11</sup> diagnosed with asthma reporting use. IM is costly: in 2007 \$33.9 billion was spent by patients for visits to IM practitioners and the purchase of complementary products.<sup>12</sup>

The scientific evidence in support of IM is limited. Despite data that indicate a correlation between low levels of vitamins, antioxidants, minerals such as magnesium, and fatty acids and higher rates of asthma and atopy, dietary supplementation has not consistently been shown to prevent or treat disease.<sup>13</sup> The best support for dietary supplementation comes from a small number of clinical trials of patients with asthma whose diets were supplemented with vitamin D<sup>14</sup> and patients with allergy whose diets were supplemented with probiotics.<sup>15</sup> A small randomized controlled trial of mindfulness meditation did not improve lung function or disease control in patients with asthma,<sup>16</sup> although hyperventilation-decreasing breathing techniques alleviated asthma symptoms in 2 studies of children with asthma and in a large study (N = 600) of adults with asthma.<sup>17</sup> These findings have not been replicated in children.<sup>18</sup>

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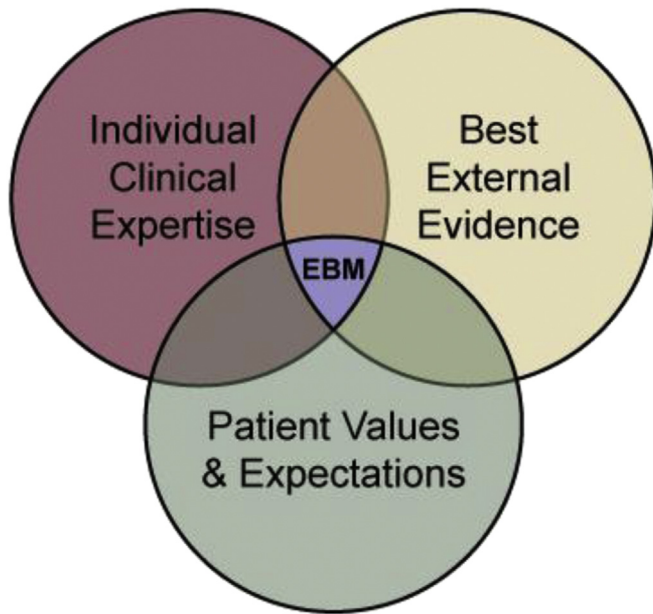


**Figure 1.** Evidence-based medicine (EBM) triad. Reprint permission provided by the Florida State University College of Medicine (<http://med.fsu.edu/index.cfm?page=medicalinformatics.ebmTutorial>).

Cardiopulmonary fitness improves with physical training in adults with asthma despite no objective improvements in lung function.<sup>19</sup> However, no recommendations could be made for acupuncture in asthma owing to a lack of evidence.<sup>20</sup> The Cochrane group is currently performing—but has not yet published—a review of yoga as a treatment for asthma.<sup>21</sup> Despite little evidence of efficacy for IM, data suggest that these approaches are well tolerated and are not harmful.

In 2009, the IOM Summit on Integrative Medicine and the Health of the Public proposed IM as a patient-centered solution to the American health care crisis.<sup>4</sup> With its high consumer demand and holistic approach to wellness and illness, IM is capable of satisfying the IOM mandate of seeking and valuing the voice of the patient in care decisions. However, IM is not without limitations and many questions remain. Is IM a model of care appropriate for specialty care? Can providers' concerns about the safety and effectiveness of IM be adequately addressed?

The IOM proposed 10 rules for improving health care; 7 of those rules are specific to patient-centered care and provide a framework within which to consider the advantages and shortcomings of IM. Those 7 rules are discussed below.

### Care Is Based on Continuous Healing Relationships

"Touch, time, and talk" are the most common explanations offered for why patients prefer alternative practitioners to allopathic care. Medical education curricula have recently been revised with an eye toward creating a new generation of humble healers who excel in touch, time, and talk and who are genuine in their interest in others' perspectives. Humility will require a new approach to patient-provider relationships. Future healers will need to be self-aware, empathetic, and appreciative of the opportunity to care for the sick and vulnerable.<sup>22</sup> Brief top-down instructions to subordinates, long a part of the culture of medicine, will need to be replaced by sustained engagement with equal partners. In the patient-centered continuous care setting common to allergy practice, patient satisfaction and clinical outcomes are optimized.<sup>23</sup> Most health care providers would like to practice in this manner. Unfortunately, care systems interfere with health care professionals' ability to engage with patients by demanding shorter appointments and electronic charting.

### Care Is Customized According to Patient Needs and Values

Patients often have a different orientation to what a cluster of symptoms means (illness representation), why disease occurs (explanatory model), and how and who to treat,<sup>24</sup> prompting many to seek care outside the biomedical systems. In fact, 80% of the world's health care is non-biomedical.<sup>25</sup> Patient-centered care has been proposed as an approach to cultural competency education, preparing providers to be responsive to and respectful of different epistemological worldviews that conflict with the medical model. Cultural competency training improves nonjudgmental attitudes and behaviors and increases the likelihood that patients' beliefs and treatment preferences will be elicited by providers.<sup>26</sup> When clinicians understand patient preferences, they can facilitate discussion of the risks and merits associated with specific treatment options in a way the patient understands and with respect for the patient's goals. The skill of providers in initiating discussions characterized by shared decision making can help reconcile differences between patient and provider preferences, leading to a mutually agreed to upon, high-quality decision that best matches the patient's needs with evidence-based recommendations. Research has demonstrated that those clinicians who use these types of effective communication skills see greater intentions to self-manage<sup>27</sup> and improved medication adherence and enhanced disease control in adults<sup>28</sup> and children<sup>29</sup> with asthma.

### The Patient Is the Source of Control

Compared with conventional biomedicine, patients believe that IM offers more opportunity for personal control over their health, helping them cope with illness and exercise active control over their health care decisions.<sup>30</sup> Too often, providers construct complex plans for achieving health goals without patient input and without considering whether patients can—or want to—implement the plan or agree with the goals set for them. Because chronic disease is managed largely at home, at the discretion of the patient and the patient's family, it is imperative that the patient's values are held in equal regard. Incongruous provider and patient goals likely contribute, in part, to dissatisfaction with conventional biomedical care and to low rates of adherence to medical recommendations.<sup>27–29</sup>

### Knowledge Is Shared and Information Flows Freely

"Doctor" comes from the Latin *to teach*. Historically, medical education emphasized "hard" scientific knowledge over the "soft" science of interpersonal communication and patient education, areas in which IM disciplines excel.<sup>31</sup> Luckily, that emphasis is changing. For disease self-management to be successful, patients need to have access to clinical knowledge that facilitates their learning to live with illness. Although providers might believe they are *educating* patients, too often they are merely *informing* patients. For example, providing patients with a printed handout, a Web resource, or oral instruction is nothing more than the transmission of facts that can be tested later to quantify what patients know. To be transformational, clinical knowledge must help patients gain the skills and personal experience needed to competently manage their condition. To be successful at disease management, the patient's concept of health—what it is, how it is achieved, and how it is sustained—must be considered in addition to the externally specified targets set by clinicians.<sup>32,33</sup>

### Decision Making Is Based on Evidence

Support for patient self-management is the basis for patient-centered care. Many clinical decision aids are available to assist patients in weighing the evidence in support of one treatment protocol over another.<sup>34</sup> When presented with the "truth," clinicians expect that patients will select the most effective treatment (even when providers themselves do not practice in accordance

with evidence-based guidelines<sup>35</sup>). However, the evidence supporting many treatment recommendations is lacking. At other times, patients simply do not find the evidence compelling.

How should providers respond when patients want to integrate alternative therapies with little—or no—evidence of effectiveness into a treatment plan that includes safe and efficacious prescription therapies? The provider's response should be predicated on answers to certain questions. Is the IM likely safe? Will patients continue to take prescription therapies as advised? Will patients be able to afford the costs of the 2 treatments? Will decisions about “stepping down” therapy be made by the medical team? If the answer to these questions is yes, then the therapeutic alliance would be strengthened by supporting the patient's decision to use IM, notwithstanding the high cost of IM and the negligible evidence demonstrating its efficacy. Even when providers believe that IM offers nothing more than a placebo, its use should be supported because the placebo effect is known to be a potent intervention.

## Safety

The greatest challenge posed by IM occurs when the patient rejects evidence-based medical treatment in favor of a therapy that has the potential for serious interactions or adverse events. If a minor is involved, the role of the clinician is to make clear that protection of the child is the first priority. Conversely, the right to self-determination is a challenge in caring for adults. For potentially dangerous IM practices, providers need to get to “no” just as in any clinical situation in which patients request inappropriate tests and treatments. When the context of the request is explored using open therapeutic communication, the provider–patient partnership can be preserved.<sup>36</sup> Structured approaches to evidence-based IM shared decision making are often successful in dissuading the patient from using a harmful treatment by substituting a “safe” alternative.<sup>37</sup> Without offering another option, there is a risk that the patient will reject conventional care altogether. In addition, offering safe IM choices might increase the patient's willingness to try conventional treatment, offering the clinician a “foot in the door” to provide care to a patient who otherwise might never acquiesce to biomedical treatment.

## Needs Are Anticipated

Like all patient-centered care models, IM focuses heavily on health promotion and wellness, stressing proactive rather than reactive care. This is particularly important in self-management of conditions in which loss of control can result in life-threatening situations and symptoms can persist despite adherence to evidence-based treatments. With its emphasis on healthy living and decreasing stress, IM offers different lifestyle behaviors that can support symptom self-management of a patient's disease. Practice-based IM treatments, if accommodated, can empower patients to create truly “personalized” care that enhances their satisfaction with biomedicine and with allopathic providers, setting the stage for improved clinical outcomes.

Integrative medicine is, and has always been, a patient-centered model of delivering care. Despite its shortcomings, IM must be incorporated into the new patient-centered paradigm. IM is a healing tradition that offers patients control over their health vis-à-vis a tailored plan that is safe, based on evidence, supports shared knowledge, and anticipates needs. In the redesigned health systems of the future, IM encourages patients to receive the care they need—and the care they want. It is only then that health can truly be optimized.

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