

## **How Alternative Therapies Impact Medical Care**

By Dean Shrock, Ph.D. © 2002

The most current data report that approximately 42% of the United States population (83 million people) are using Complementary and Alternative Medicine (CAM). In 1997 these visits totaled 629 million compared to 386 million visits to all primary care physicians. Interestingly, 96% of those who saw a CAM practitioner that year for a principle condition also saw a medical doctor. This suggests that people are not disillusioned by medical care in general, and that medical doctors remain the traditional source of information and advice on health issues. However, physicians usually have a lack of knowledge about the appropriateness or effectiveness of alternative health care approaches. Very few of these CAM approaches have been rigorously researched. A recommended resource discussing the most safe and effective CAM therapies and their scientific evidence is *The Best Alternative Medicine: What Works? What Does Not?* by Dr. Kenneth Pelletier, Director of the Complementary and Alternative Medicine Program at Stanford University School of Medicine.

In response to the public's interest in using these alternative modalities, Congress created the National Center of Complementary and Alternative Medicine (NCCAM) primarily to research the validity of the anecdotal reports of success with these CAM treatments. And in March 2002, the Final Report of the White House Commission on Complementary and Alternative Medicine Policy was published containing recommendations to maximize the potential benefits of CAM.

While there are an extensive number of these approaches, visits to chiropractors and massage therapists account for nearly half of all CAM visits, with relaxation techniques actually being the most used generally. The most common medical condition that people seek CAM approaches for are back problems (24%), with chiropractic accounting for 40% of this care. The next leading conditions are allergies, fatigue, arthritis, and headaches. However, almost 50% of these people use CAM without any input from a CAM practitioner or medical doctor. Approximately 90% are self-referred. Surveys consistently suggest that this is related to patients using these modalities for prevention and wellness.

The use of CAM therapies is a worldwide practice. While CAM is usually considered experimental in America, they are often considered mainstream abroad. Europe and Asia commonly use acupuncture, homeopathy, Traditional Chinese medicine, mind-body medicine, herbs, naturopathy, ayurvedic medicine, and spiritual practices. Germany leads the way in offering the widest range of mainstream and CAM therapies of any modern industrialized country. And, interestingly, homeopathy and acupuncture are primarily practiced by medical doctors throughout Europe. The history of CAM internationally and in America has been shaped by a combination of scientific, economic, and social factors.

### **Recent History of CAM in the United States**

Until the middle of the 19<sup>th</sup> century the vast majority of primary medical care in this country was provided by botanical healers, midwives, chiropractors, and homeopaths. This changed in the latter part of the 19<sup>th</sup> century with the development of the germ theory and advances in antiseptic techniques, anesthesia, and surgery. With a much more scientific-based medicine and medical school education, unorthodox healing systems began to lose their appeal. The discovery of life-saving hormones, sulfa drugs, and other antibiotics in the early and middle 20<sup>th</sup> century established conventional medicine as the standard of care in this country.

With the success in treating infectious diseases and other acute illnesses, medical care became more focused on chronic and degenerative diseases. An aging population increased the prevalence of chronic conditions such as arthritis, back pain, diabetes, hypertension, heart disease, and cancer. As more sophisticated technology was developed to diagnose and manage these chronic illnesses, the cost of health care began to rise dramatically. Costs more than tripled between 1965 and 1975 to nearly \$130 billion yearly. These expenditures in 2000 were more than \$1.2 trillion. The increasing rates of chronic conditions and the much greater expense led to the reemergence of less scientific remedies.

Whole foods and dietary supplements became popular for health promotion and prevention. Traditional foreign and indigenous health care systems became more prevalent, along with their related religious and philosophical beliefs. Transcendental Meditation, as an example, became widely known and practiced in the 1960's and 70's.

This led to a renewed interest in "natural" health care considerations, and a holistic health care movement. The American Holistic Medical and Nurses Associations were formed with an emphasis on treating the whole person (physical, mental, emotional, and spiritual). And by the 1980's, diet and life-style changes emerged and became known as "wellness". Personal fitness and exercise, yoga, stress management, and nutrition became common ways to complement conventional medical care. Until the 1960's, there was the belief that science and technology would do away with disease. But the ever-increasing cost of medical technology has created dissatisfaction and disillusionment for both the patient and physicians alike as a corporate takeover of health care has become commonplace.

Physicians now often resent their loss of autonomy to practice medicine. The emphasis on profit and cost-containment has created a greater impersonalization of medical care. And this has become one of the most identified reasons why people are turning to CAM practitioners for their care: They want to be listened to and cared for.

### **Current Status of CAM in the United States**

Institutional emphasis to see more patients in less time in order to generate income has taken from patient-centered care. Patients say that they would choose generally to have much more time (30 minutes vs. 7, which is the common amount of time currently) for patient visits. Physicians similarly report that they would prefer this additional time to

listen to the patient, time to understand the sources of distress, time to make an accurate diagnosis and sort out therapeutic options, and time to help the patient and family in complying with the treatment or changing it if it proves ineffective. However, within a managed care system, this is quite unrealistic. Clearly there needs to be a balance between efficiency and cost reductions and reasonable service expectations of patients.

The American Hospital Association reported an operating margin of .5% to 1% in fiscal 2001. This reality is likely to result in decreased quality care, although a significant number of hospitals have begun to offer community programs that focus on wellness or prevention. These often occur outside of the primary health care system, such that people don't know they exist, are uncertain of their potential benefit, and usually have to pay out-of-pocket; but pay out-of-pocket they do.

Approximately 60% of CAM users pay entirely out-of-pocket for this care, estimated conservatively at \$27 billion yearly, which is comparable with 1977 out-of-pocket expenditures for all U.S. physician services. Very few CAM services are covered by insurance, although many HMO's increasingly believe that offering CAM will increase their bottom line. Sixteen per cent of hospitals offered CAM services in 2000, up from 11% in 1999. However, insurance plans and their providers are appropriately concerned about their liability in offering these services. Yet these changes are clearly coming to medical practice: forced by economic necessity and consumer demand.

### **Factors Influencing Choice of CAM**

Patients claim that they often choose CAM when conventional medicine has been ineffective, especially with chronic conditions. They report that they use CAM because of word-of-mouth recommendations, fear of drugs and surgery, and because they say it works.

Users of CAM report that their attributes include:

1. An enhanced relationship with their practitioner
2. An emphasis on wellness and prevention
3. The ways in which illness is explained
4. The environment in which they receive treatment
5. Time and continuity of the same practitioner
6. A greater choice of therapies and therapists
7. Offers a sense of hope
8. A more human experience, including touch
9. Addresses their spiritual beliefs and values
10. Helps their emotional state and energy level
11. Caters to their personal coping styles
12. Quality of life considerations in general
13. Allows them to participate more fully in their care and gives a sense of control

#### 14. More individualized attention to their whole person vs. disease and symptom management

The primary concerns of CAM (for users and medical practitioners) relate to issues of safety of the therapies, the competence of the practitioner, and feelings of guilt that may be engendered suggesting that patients cause their own illness. And a very serious issue is that most patients don't tell their medical doctor about their use of CAM. They say the doctor didn't ask, that they forgot, or that they feared the doctor's disapproval.

The consistent medical journal admonition for medical doctors is that they ask their patients about CAM use. A recent study found that some commonly used herbal products can cause serious complications and are contraindicated for use with some prescribed drugs. This is particularly troubling. Almost 20% of all prescription users are taking them with herbal remedies and/or high-dose vitamins. Therefore, approximately 15 million adults are at risk for a potential adverse interaction.

#### **The Need For Research, Education and Training**

This leads back to the basic reason for the establishment of the NCCAM and the need to research CAM modalities. Approximately one half of all Americans are using health care approaches that have little or no scientific research to support them. Ethically and legally physicians cannot recommend treatments for which there is not research or for which they're unfamiliar with the research literature.

In an attempt to deal with this public health concern, more than two thirds of U.S. medical schools now offer CAM courses, usually as electives. When offered as a required course they often are found in Introduction to Clinical Medicine or Patient-physician Communication courses. The aim is not to make medical doctors experts in other forms of treatment, but to train them to know what other approaches may be useful and how to refer.

While research support for CAM is severely limited, a number of reviews report that approximately one half of physicians believe in the efficacy of five commonly used Cam modalities: acupuncture, chiropractic, homeopathy, herbs, and massage. Chiropractic, Traditional Chinese acupuncture, therapeutic massage, and naturopathic medicine have the most developed national education and training standards, which makes them easier to evaluate and research. Chiropractors are licensed to practice in all states, acupuncturists in 40, massage therapists in 30, and naturopathic physicians in 11. States vary considerably in their regulatory approaches to licensure and scope of practice. For example, Minnesota provides almost unlimited freedom to practice, and relies primarily upon informed consent for protection of health care customers.

Obviously there are many challenges in addressing the use of CAM. Will value be placed on CAM's claim of improving wellness and health vs. the time-honored concept of medical necessity and disease orientation? How do you add more subjects to an already overcrowded medical curriculum? Who's going to pay for the extensive research

necessary to test these CAM practices? How will this affect insurance coverage, cost, and malpractice issues? These are all very pressing issues and ones that will take considerable time and consideration.