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EDUCATION, INITIATIVES, AND INFORMATION RESOURCES

Response to a Proposal for an Integrative Medicine Curriculum

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ABSTRACT

Background: A paper entitled "Core Competencies in Integrative Medicine for Medical School Curricula: A proposal," published in *Academic Medicine*, stimulated a broad discussion among complementary and alternative medicine (CAM) educators. This discussion led to a formal process for responding to the issues raised by the paper.

Methods: Representatives from the Academic Consortium for Complementary and Alternative Health Care (ACCAHC) and the Oregon Collaborative for Complementary and Integrative Medicine (OCCIM) formed the ACCAHC/OCCIM Task Force to participate in a Delphi process of consultation and deliberation. This process led to a broad, cross-discipline agreement on important points to include in a response to the integrative medicine (IM) curriculum proposal.

Results: Five key areas of concern emerged: (1) the definition of IM as presented in the paper; (2) lack of clarity about the goals of the proposed IM curriculum; (3) lack of recognition of the breadth of whole systems of health care; (4) omission of competencies related to collaboration between MDs and CAM professionals in patient care; and (5) omission of potential areas of partnership in IM education.

Conclusions: A major overall theme emerging from the Delphi process was a desire for closer collaboration between conventional medical schools and CAM academic institutions in developing IM curricula. Several cross-disciplinary venues for addressing the Delphi Task Force themes include the National Center for Complementary and Alternative Medicine's R-25 Initiatives, the National Education Dialogue. OCCIM is presented as an example of a successful lateral integration approach.

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This response to the "Core Competencies" paper in *Academic Medicine*, June 2004, was developed by a task force of the Academic Consortium for Complementary and Alternative Health Care (ACCAHC) and the Oregon Collaborative for Complementary and Integrative Medicine (OCCIM), and endorsed by the whole ACCAHC in May 2005. Information about ACCAHC, OCCIM, and the ACCAHC/OCCIM Task Force can be found in Appendices 1 and 2 of this paper.

INTRODUCTION

A paper entitled "Core Competencies in Integrative Medicine for Medical School Curricula: A Proposal," was published in *Academic Medicine* in June 2004. It was authored by the Education Working Group of the Consortium of Academic Health Centers for Integrative Medicine (CAHCIM).[1] The paper defines Integrative Medicine (IM), and lists core competencies related to values, knowledge, attitudes, and skills that CAHCIM believes are fundamental to the practice of IM. It goes on to discuss teaching methods, experiential learning, faculty development, assessment of student achievement, and potential barriers to implementation of the proposed curriculum. The proposal was developed over 2 years by medical educators, and was endorsed by the CAHCIM Steering Committee in May 2003.[2]

There is much to be commended in the CAHCIM proposal, and many shared values between the CAHCIM group and the complementary and alternative medicine (CAM) educational communities. Nevertheless, a number of issues and concerns about the article were raised at a CAM academic symposium sponsored by the Academic Consortium for Complementary and Alternative Health Care (ACCAHC) in January 2005. In order to clarify major areas of concern, a modified Delphi process was carried out by a task force, comprised of CAM educators within ACCAHC and the Oregon Collaborative for Complementary and Integrative Medicine (OCCIM). Participants in the Delphi process were a select task force of educators from a variety of conventional and CAM disciplines including acupuncture and Oriental medicine, chiropractic medicine, massage therapy, nursing, direct entry midwifery, naturopathic medicine, and nutrition. Participants came to consensus on key areas of concern that would be included in a response to the CAHCIM article. The modified Delphi methodology and higher-rated results appear in Table 1.

Five key areas were identified: (1) the definition of Integrative Medicine; (2) the goal of an IM curriculum; (3) the breadth of whole systems of health care and the time it takes to gain competency in them; (4) collaboration between MDs and CAM professionals in patient care; and (5) mainstream and CAM partnership in developing integrative care.

THE FIVE AREAS OF CONCERN

Area 1: Definition of IM

The Task Force recognized five concerns related to the definition of IM:

• The CAHCIM paper leaves the impression that conven-

TABLE 1. FINAL RESULTS OF THE MODIFIED DELPHI PROCESS FOR RESPONSE TO THE CAHCIM PAPER

Final results of the modified Delphi process for developing a response to the CAHCIM article are listed below.[a] The purpose of the process was to identify major points of agreement and concern as guidance for authors writing a response to the CAHCIM paper "Core competencies in integrative medicine for medical school curricula: A proposal" (Acad Med. 2004;79)

Rating scale used: 5 = extremely important (highlight in the response); 4 = very important (mention in the response); 3 = somewhat important (appendix material); 2 = small importance (appendix or leave out); 1 = not at all important (leave out).

Mean	*Median*	*Mode*	*Points of agreement/problems/omissions*
5.0	5	5	The definition of integrative medicine leaves the potential impression that an allopathic medical physician may simply incorporate what they perceive to be good CAM therapies rather than referring or co-managing and collaborating with CAM providers. (p. 522) **Problem**
4.9	5	5	Missing: "that integrated care consists of MDs and CAM practitioners as partners and that CAM is not an add-on to medical care." **Omission**
4.7	5	5	Missing: Analysis and recognition of the time it takes to gain competency in CAM knowledge and standards and skills to be an effective practitioner of any one or more disciplines. **Omission**
4.6	5	5	Missing: Training medical students how and when to refer patients for evaluation and treatment by CAm professionals. **Omission—Competency**
4.6	5	5	"Describe the distinction between integrative medicine (IM) and CAM." This appears to be a continuation of the *us* and *them* mindset rather than seeing that CAM providers, faculty and systems could and should be part of integrative medicine. (Knowledge, 5, p. 524) **Problem**
4.6	5	5	Missing: The major alternative medical systems developed, credentialed, and licensed in Western cultures (chiropractic, homeopathic medicine, naturopathic medicine). (Knowledge, p. 24, #8) **Omission**
4.6	5	5	Lack of clarity about the goal of the proposed curricula. Question: Is the curricula designed to improve physician knowledge about CAM systems, modalities and therapies—*or* to train physicians to use CAM systems or modalities or therapies in conjunction with allopathic treatments? **Problem**
4.4	5	5	Missing: Knowledge and skills that would facilitate developing collaborative relationships with CAM providers, academic institutions and professions. Examples: knowledge for appropriate CAM referral or co-management, and how to distinguish evidence-based CAM providers from non-evidence based CAm providers. **Omission—Competency**

TABLE 1. FINAL RESULTS OF THE MODIFIED DELPHI PROCESS FOR RESPONSE TO THE CAHCIM PAPER (*CONT'D*)

Final results of the modified Delphi process for developing a response to the CAHCIM article are listed below.[a] The purpose of the process was to identify major points of agreement and concern as guidance for authors writing a response to the CAHCIM paper "Core competencies in integrative medicine for medical school curricula: A proposal" (Acad Med. 2004;79)

Rating scale used: 5 = extremely important (highlight in the response); 4 = very important (mention in the response); 3 = somewhat important (appendix material); 2 = small importance (appendix or leave out); 1 = not at all important (leave out).

Mean	*Median*	*Mode*	*Points of agreement/problems/omissions*
4.4	5	5	Missing: Reference to the benefits of developing formal inter-institutional relationships with academic CAM colleges for educational, experiential and research opportunities, including full training in their disciplines and modalities. **Omission**
4.3	4	4	Missing: Utilizing faculty from CAM professions to teach medical students about their disciplines. **Omission**
4.3	5	5	"Demonstrate skills to communicate effectively a) with patients about their use of CAM in a respectful and culturally appropriate manner, b) with patients and all members of the interdisciplinary health care team in a collaborative manner to facilitate quality patient care. (Skills, 3, p. 525) **Point of Agreement**
4.3	4	4.5	Input was limited to participants from conventional medical education. No mention of national and state government recognized CAM standards, national consensus guidelines and competencies, curricula and professions as sources for consultation. **Problem**
4.2	4	4	Implication that Integrative Medicine will be the source of information on CAM, rather than referring patients to CAM practitioners… general tone… that authors want to include CAM but not CAM practitioners in their vision of Integrative Medicine. (p. 529) **Problem**
4.0	5	5	The proposal is focused through the lens and culture of conventional medicine. Example: CAM is defined in relationship to biomedicine as complementary or alternative, but is considered integrative if delivery by a conventional doctor. **Problem**
4.0	4	5	Missing: The CAM professional as a partner in decision-making. **Omission**
4.0	4	5	Desirability of including competencies designed to make medical students more knowledgeable and skillful in their relationships (collaboration) with CAM providers, and therefore, more effective in the management of their patients. **Point of Agreement**
4.0	4	4	Missing: Developing collegial relationships with CAM providers (Values, 1, p. 523) **Omission—Competency**
4.0	4	4	"A respect for the potential of a variety of healing approaches to be effective for the treatment of certain conditions." [similar: deeper appreciation of CAM care] (Attitudes, 4, p. 524) **Point of Agreement**
4.0	4	4	Missing: That many of the competencies included originate in CAM paradigms of care, i.e., CAM contributions to the proposed paradigm of health care. **Omission**

[a]The Delphi process provides a way to obtain the opinions of a number of designated experts on a particular topic without having face-to-face meetings.) A modified Delphi process was chosen for this project because it provided an efficient, cost-effective way to convene the Task Force and come to consensus about issues to highlight in a response to the CAHCIM article. Participants in the Delphi process were a select task force of educators from a variety of CAM disciplines including acupuncture and Oriental medicine, chiropractic medicine; massage therapy, direct entry midwifery, naturopathic medicine, nursing, and nutrition.

The modified Delphi process used here began with three open-ended questions about the CAHCIM article (i.e., points of agreement, problems, and omissions). The responses from step 1 were used to develop a questionnaire for rating the importance of the identified items using a 5-point Likert scale from #1 not at all important, to #5 extremely important (step 2). The rating results from step 2 were used to rank items in order of importance (step 3). The Task Force discussed step 3 results. A final questionnaire provided participants with the opportunity to rate items to mention or highlight in a response article (step 4). In step 4, space was provided for Task Force members to write in items from previous steps, which they felt deserved consideration even though they were not rated highly by the group as a whole.

tional medical physicians may simply incorporate into their practices what they perceive to be good CAM therapies rather than referring to or comanaging and collaborating with CAM providers. 1 Subsequent to the publication of their article, CAHCIM revised the definition satisfying the above concern (see Appendix 4).

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- The CAHCIM paper does not include the option of integrated care with MDs and CAM practitioners as partners, and seems to propose that CAM be an add-on to conventional medical care.
- Occasionally in the paper, language appears to reflect a continuation of the *us* and *them* mindset rather than seeing that CAM providers, faculty, and systems could and should be part of IM.[1]
- The paper gives the impression that conventional medical institutions want to include CAM, but not necessarily CAM practitioners, in their vision of IM.
- CAM is defined in relationship to biomedicine as complementary or alternative, but is considered integrative if delivered by a conventional physician.

Area 2: Goals of an IM curriculum

It is unclear whether the guidelines and competencies are designed to improve physician knowledge about CAM systems, modalities, and therapies, *or* to train physicians to use CAM systems, modalities or therapies in conjunction with conventional treatments. Although the former is doable and desirable, there is concern that the latter is not feasible given the limited time for CAM in the overall conventional medical curriculum.

Task Force members were in agreement with two challenges identified in the potential barriers section of the CAHCIM paper. The first is that alternative health care systems often challenge the paradigms of human health and illness that support modern medicine, and the second is creating time for integration of the proposed IM competencies in medical school curricula. The Task Force acknowledged that some practitioners are dually trained: for example, an M.D. who trains at a CAM school for acupuncture and Oriental medicine. Dual training was considered to represent a qualification that is distinctly different and beyond the topic of developing an IM curriculum in conventional medical schools.

Area 3: Breadth of whole systems of health care

The Task Force also noted the lack of recognition in the CAHCIM paper of the time it takes to gain competency in CAM knowledge and skills. This may reflect a lack of recognition of the breadth and depth of the fully developed and independent systems of health care in the fields of chiropractic medicine, naturopathic medicine, acupuncture and Oriental medicine, as well as disciplines such as massage therapy, nutrition, direct entry midwifery, and homeopathic medicine. Delphi ratings indicated very strong concern about such lack of recognition. There was similar concern about the lack of clarity around the use of terms such as *modalities, therapies, disciplines, systems*, and *approaches.* For example, using the terms *modality* or *approach* to refer to *whole systems of health care*, like naturopathic medicine, as well as to single *therapeutic disciplines*, such as massage therapy, reflects a lack of understanding of the degree of complexity involved in each and of the theory, knowledge, and skills required by their respective practitioners (see Appendix 5 for definitions).

Area 4: Collaboration between MDs and CAM professionals in patient care

The Task Force identified an important omission in the proposed IM competencies (i.e., training medical students how and when to refer patients for evaluation and treatment by CAM professionals). A related concern was the implication in the paper that IM will be the sole source of information about CAM, rather than referring patients to CAM practitioners who are more comprehensively trained in these fields. Proposed skill competency number 3 calling for physicians to "demonstrate skills to communicate effectively . . . with patients and all members of the interdisciplinary health care team in a collaborative manner to facilitate quality patient care" was rated highly as a point of agreement with the CAHCIM paper.[1]

Area 5: Partnership in developing integrative care

Several highly rated items indicated a desire for partnership between conventional medicine (CM) and CAM in the future development of integrative health care. The CAHCIM paper did not acknowledge that this partnership is not presently a reality. The Task Force also noted the following items as missing from the CAHCIM paper: (1) knowledge and skills that would facilitate developing collaborative relationships with CAM providers, academic institutions, and professions; (2) reference to the benefits of developing formal interinstitutional relationships with academic CAM colleges for educational, experiential, and research opportunities, including full training in their disciplines; (3) utilizing faculty from CAM professions to teach medical students about their disciplines; (4) the CAM professional's potential role in decision-making; and (5) developing collegial relationships with CAM providers.

The five major areas of concern described above suggest strong CAM support for a collaborative partnership with CM, provided it can achieve appropriate recognition and participation for CAM professionals. Such a truly collaborative partnership will be required to develop the IM biomedical school curricula that will meet future needs. The implications of the results of the Delphi process and opportunities for future action are discussed below.

IMPLICATIONS

In 1998, the federal government mandated that the National Center for Complementary and Alternative Medicine (NCCAM) apply rigorous scientific research to "study the integration of alternative treatment, diagnostic and prevention systems, modalities, and disciplines with the practice of conventional medicine as a complement to such medicine and into health care delivery systems in the United States."* AU6

*The National Center for Complementary and Alternative Medicine is established by Congress under Title VI, Section 601 of the Omnibus Appropriations Act of 1999 (P.L. 105-277). This bill amends Title IV of the Public Health Service Act and elevates the status of the Office of Alternative Medicine to a National Institutes of Health Center. See online document at: www.nih.gov/about/almanac/organization/NCCAM.htm Accessed April 21, 2005. *To establish within the National Institutes of Health an agency to be known as the National Center for Complementary and Alternative Medicine. S. 2440.* Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1999 SEC. 601. ESTABLISHMENT OF THE NATIONAL CENTER FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE. Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended- Online document at: http://thomas.loc.gov/cgi-bin/query/F?c105:2:./temp/~c105ML7lPo:e117404 Accessed April 21, 2005. AU12

Yet only recently have conventional medical schools taken initial steps toward recognizing the benefits of CAM. Recent surveys report that 60% of CM schools, 95% of osteopathic schools, and 85% of nursing schools include some CAM content in their curricula.[3] Although these numbers are promising, the CAM courses offered in those settings are often electives and not part of the core curriculum.

In the past several years, NCCAM has awarded over 15 R25 grants to conventional medical centers to develop CAM curricula in biomedical schools. CAHCIM has served as a vehicle for communication among medical schools engaged in this effort.[2] CAHCIM's work in developing a shared set of competencies for IM is praiseworthy. The humanistic values of patient-centered care and a holistic perspective of illness and healing shine through as deeply held shared values among the providers and educators of IM, nursing, and CAM, as well as others in health care.

As defined by NCCAM, integrative medicine "combines mainstream medical therapies, and CAM therapies for which there is some high-quality scientific evidence of safety and effectiveness."[4] Furthermore, the Institute of Medicine (IOM) report on CAM in 2005 recommended that "health profession schools incorporate *sufficient* information about CAM into standard curriculum . . . to enable licensed professionals to competently advise their patients about CAM" [emphasis added].[5] Despite NCCAM and CAHCIM definitions of IM, and guidance by IOM, it is necessary to clarify the IM definition and its curricular goals, including "CAM consciousness, CAM literacy, comanagement and referral."[6] A major overall theme resulting from the Delphi process was the development of closer collaboration between CM and CAM academic institutions as essential to achieve such clarity.

Serious consequences for patient care might occur from failure to achieve true CM/CAM collaboration in developing IM. Referring to the integration of health care systems abroad, Bodecker has proposed that medical control over the integration process has resulted in the loss of important elements of traditional CAM theory and practice.[7] According to the IOM, this could undermine both the CAM therapy and conventional medical practice by making the healing process less effective or even ineffective.[4]

Furthermore, the IOM report noted that "medical pluralism should be distinguished from cooptation of CAM therapies by conventional medical practices."[4] To promote health care pluralism, and minimize the risk of cooptation, collaboration across disciplines at the academic level is necessary. The resulting dialogue would increase understanding, develop mutual respect, clarify common values, and encourage further communication and interaction among health care professionals with a shared purpose. A more expansive appeal for a pluralistic model was recently presented by Kaptchuk and Miller.[8]

The IOM report represents the largest federal agency consensus to date concerning CAM and integrative health care policy. The overarching rubric presented in the report as a guideline for future development is "the goal of providing comprehensive care that is safe and effective, that is collaborative and interdisciplinary, and respects and joins effective interventions from all sources." This guiding principle provides the logical basis for proceeding with IM development.[4]

Similarly, the reports of the White House Commission on Complementary and Alternative Medicine Policy[9] and The National Policy Dialogue to Advance Integrated Health Care: Finding Common Ground)[10] call for mutual respect among whole systems of health care when concepts concerning IM are being developed. Ultimately, the highest priority must be what is best for patients and for creating healthy learning and working environments for students and clinicians. Both the widely supported principle of "patient-centered care" and the IOM report on CAM advocating a multidisciplinary and collaborative approach provide excellent touchstones for the process of integration.

OPPORTUNITIES FOR ADDRESSING TASK FORCE THEMES

There are several promising cross-disciplinary venues for addressing the themes highlighted in the Delphi process. The paragraphs below describe initiatives that are already moving forward in areas of collaboration and partnership among CAM and conventional health care institutions.

National Education Dialogue (NED)

Conventional and CAM health care educators convened the National Education Dialogue to Advance Integrated Healthcare: Creating Common Ground (NED) to explore common language, examine best practices, consider collaborative development of educational resources, articulate shared values, foster interinstitutional and interdisciplinary relationships, and enhance abilities to provider leadership in change creation.[12] NED was established by the Education Task Force of the Integrated Healthcare Policy Consortium[13] in March 2004, as a national vehicle for educators from CAM and conventional health care professions to convene and engage in collaborative projects and report on progress.

NED's vision, mission, and goals define a set of priorities and a blueprint for moving key recommendations in the IOM report forward. The NED priorities are compatible with the themes developed in the Delphi process. Institutions, educators, and diverse disciplines can compare and evaluate outcomes of existing models, and develop new approaches in an open, collegial, and outcome-oriented process that combines task force-based collaborative project work with a series of professionally facilitated meetings.

The following NED goals provide opportunities to work on the themes developed in the Delphi process. These are

reflected in either NED or ACCAHC's planning documents and in task force goals:

Foster active inter-institutional academic collaboration between CAM and conventional health profession institutions. Develop an intentional, formal approach to endorse best practices concerning relationships between CAM and conventional health care institutions. (*NED goals, ACCAHC goals*)

Develop required curricula and core competencies in collaborative health care. Include survey curricula on all healing systems and disciplines. Convene a series of annual meetings with CAM and conventional health care educators to accomplish this. (*ACCAHC Task Force on Educational Guidelines, Curricula, and Competencies; NED Program June 2, 2005, NED Goals 2004*)

Together, the conventional and CAM disciplines at NED may want to evaluate the possibility of developing a proposed accreditation guideline that would require all CAM and conventional health care colleges/schools to incorporate training in collaborative health care. (*From ACCAHC Retreat February 2–5, 2005*)

Create a process for distinguishing and describing portable, shared, and adjunctive competencies. Identify and recognize existing adjunctive and comprehensive standards and competencies established in CAM discipline, modality, and therapy training. Develop a process for identifying collaborative and portable skills, and the limits and extent of practice associated with them, for those who want to practice certain CAM skills in collaboration with ACCAHC's CAM disciplines. (*NED Goals 2004*)

Create collaborative cross-disciplinary exchange programs. "Doctors [and practitioners], who train together, treat together."[14] Develop bridge curricula between CAM, Conventional Medicine, and public health academic institutions. Bring disciplines together in cross-disciplinary academic settings through defined fellowships and exchange programs at various levels of depth and exposure. Design these programs collaboratively. (*ACCAHC Goals 2005, NED Goals 2004*)

Develop funding and support for CAM accredited school and universities to support intra- and inter-faculty and curriculum development. Quality health care education is essential to safe and effective health care services. Throughout the United States, CAM accredited schools are exceptional models and systems for this training. Providing federal and philanthropic support to CAM academic institutions and faculty for their faculty, program and curriculum development will strengthen their capacity to create curricula and guidelines in partnership with the conventional academic health care community. (*ACCAHC Goals 2005, NED Goals*)

USE OF A LATERAL INTEGRATION APPROACH: OREGON COLLABORATIVE FOR COMPLEMENTARY AND INTEGRATIVE MEDICINE (OCCIM)

Institutions can evaluate and strengthen local and regional collaboration through a *lateral integration* approach, thereby providing additional opportunities to address the Delphi themes. By using lateral integration approaches similar to those developed in the OCCIM experience, it is possible to create and sustain productive, meaningful collaboration between health care providers/educators at schools of conventional medicine and CAM. A successful partnership, the Oregon Collaborative for Complementary and Integrative Medicine (OCCIM), currently exists in Portland, Oregon and exemplifies the themes identified and advocated in this Delphi process. OCCIM includes the National College of Naturopathic Medicine (NCNM), the Oregon College of Oriental Medicine (OCOM), Western States Chiropractic College (WSCC), and Oregon Health & Science University (OHSU). An official memorandum of understanding was signed in May 2004 as part of a National Institutes of Health-NCCAM R25 grant to create a CAM curriculum for the OHSU Medical School. The educational grant is part of a long history of collaboration between allopathic medicine providers and the CAM community in Oregon. It has included two prior NCCAM P50 CAM Research Center grants: one at OHSU in neurologic disorders and another at Kaiser Permanente Center for Health Research, in craniofacial disorders, both of which involved NCNM, OCOM, and WSCC. The current R25 at OHSU is part of the NCCAM initiative to support Schools of Medicine in the integration of CAM content into their core curriculums.

The OHSU program is unique in undertaking a *lateral* collaboration versus a vertical collaboration. This approach is distinctive and needs to be emphasized. The success of the Portland grant rests on two major factors, the first of which is the long-standing personal relationships between faculty at OHSU and the three CAM colleges. For over 15 years, faculty at all four schools have been guest speakers, facilitated student experiences, and jointly conducted research together. An open attitude of respect and appreciation for the various approaches has existed among faculty involved in these relationships. The second factor is support at the highest levels of OHSU for integration of CAM content into the School of Medicine curricula. Support for distinguished lectures and the integration of advanced clinical training have widened exposure to CAM at OHSU. There is every expectation that with the completion of the grant in 2007, the collaboration will continue to grow. Thus, the OHSU program and the development of OCCIM are

excellent examples of lateral collaboration, which can be replicated throughout the United States to facilitate development of the Delphi themes.

CONCLUSIONS

A collaborative partnership that promotes and encourages mutual respect among conventional medicine and CAM professionals is necessary to lay a firm foundation for the development of IM medical school curricula. The themes that emerged from the Delphi process, and the collaborative process employed, point the way to the future. Vital but missing elements for accomplishing successful integration of CAM health care disciplines, systems, and modalities into contemporary health care delivery systems, are clearly identified in the five themes that emerged from the Delphi process. Important interdisciplinary projects are currently under way and address some of the concerns raised by the ACCAHC/OCCIM Task Force. However, future success will be dependent upon achieving truly collaborative CM/CAM partnerships. Additional funding will be necessary to build upon current interdisciplinary efforts.

As the OCCIM experience has shown, relationships built on shared experiences can successfully lead to greater respect and understanding, and ultimately create more effective collaboration. Finally (and most important of all our concerns), we must not forget that the true beneficiaries of achieving a truly collaborative partnership will be our patients. It is our patients who stand to benefit the most from the meeting of our diverse disciplines, our learning to work together, and our increasingly effective communication and interaction on their behalf.

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REFERENCES

1. Kligler B, et al. Core competencies in integrative medicine for medical school curricula: A proposal. *Academic Med* 2004; 79:521–531. AU11
2. Consortium of Academic Health Centers for Integrative Medicine: Represents 38 academic medical centers developing integrative medical programs. Online document at: www.imconsortium.org Accessed August 6, 2007.
3. Ernst E. Obstacles to research in complementary and alternative medicine. Med J Aust 2003;179:279–180.
4. National Center for Complementary and Alternative Medicine. What is complementary and alternative medicine (CAM)? Online document at: http://nccam.nih.gov/health/whatiscam/index.htm#3 Accessed April 21, 2005.
5. Committee on the Use of Complementary and Alternative Medicine by the American Public. Complementary and Alternative Medicine in the United States: Institute of Medicine. Washington, DC: The National Academies Press, 2005.
6. Nedrow A. Lecture: Overview on Complementary and Alternative Medicine. Portland: Oregon Health & Science University, 2004. Online document at: www.ohsu.edu/medicine/residency/handouts/0405handouts/AlternativeMedicine120204.ppt Accessed April 21, 2005.
7. Bodeker G. Lessons on integration from the developing world's experience. BMJ [Clin Res] 2001;322:164–167.
8. Kaptchuk TJ, Miller FG. Viewpoint: What is the best and most ethical model for the relationship between mainstream and alternative medicine: Opposition, integration, or pluralism? Acad Med 2005;80:286–290.
9. White House Commission on Complementary and Alternative Medicine Policy (WHCCAM). Final Report, March 2002. Online document at: www.whccamp.hhs.gov/finalreport.html Accessed April 21, 2005.
10. Traub M, Quinn S, eds. The National Policy Dialogue to Advance Integrated Health Care: Finding Common Ground. Report of the Integrated Healthcare Steering Committee. 2002. AU13
11. Pearson N. Project Title: CAM Practitioner Research Education Grant. National Center for Complementary and Alternative Medicine, Bethesda. Online document at: http://nccam.nih.gov/research/concepts/consider/research-education.htm Accessed April 21, 2005.
12. Horrigan B. National Education Dialogue begins. Explore 2005;1:9–10.
13. Integrated Health Care Policy Consortium (IHPC). Online document at: www.ihpc.info/ Accessed August 6, 2007.
14. Jensen C. Keynote address. Complementary Health Plan Conference. Portland, 2002. AU14

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Appendix 1: The Academic Consortium for Complementary and Alternative Health Care (ACCAHC)

Description of ACCAHC

The Academic Consortium for Complementary and Alternative Health Care (ACCAHC) was formed in 2004. ACCAHC comprises the associations of colleges, recognized accrediting agencies and academic communities of the licensed, accredited and emerging complementary and alternative medicine (CAM) professions including Acupuncture and Oriental medicine, Chiropractic, Clinical Nutrition, Massage Therapy, Direct Entry Midwifery, and Naturopathic Medicine.

ACCAHC vision

ACCAHC envisions a health care system that is multidisciplinary and enhances competence, mutual respect, and collaboration across all CAM and conventional health care disciplines. This system will deliver effective care that is patient centered, focused on health creation and healing, and readily accessible to all populations.

ACCAHC mission

The mission of ACCAHC is to create and sustain a network of national CAM educational organizations and agencies, which will promote mutual understanding, collaborative activities, and interdisciplinary health care education.

ACCAHC values

- The diversity and traditions that exist in federally accredited CAM institutions as well as recognized emerging CAM fields that wish to become federally accredited CAM institutions.
- The Institute of Medicine (IOM) statement that "the goal of integrating care should be the provision of comprehensive care that is safe and effective care, that is collaborative and interdisciplinary, and care that respects and joins effective interventions from all sources."
- Public accountability and standards of practice, which emphasize patient-centered care, patient safety, practice competencies, professionalism, and a rigorous code of ethics.
- The CAM paradigms and their academic and clinical applications, which recognize the intimate relationship between health, mind, body, spirit, and environment, and emphasize health promotion, healing, prevention, and wellness.
- The importance of ensuring that CAM academic health care institutions have direct and equitable access to all public and private support systems.
- Furthermore, ACCAHC supports evolving CAM academic health centers and institutions as they emerge through the benchmarking processes of establishing high standards and developing academic curriculum, research, clinical training, future leaders, and policy action that will affect the transformation of our health care system.

ACCAHC member organizations

Association of Accredited Naturopathic Medical Colleges (AANMC)—Paul Mittman, ND, President

American Massage Therapy Association Council of Schools (AMTA-COS)—Cynthia Ribeiro, NCTMB, Liaison

Association of Chiropractic Colleges (ACC)

Frank Zolli, DC, Ed.D., President

David O'Bryon, JD, Executive Director

Australian Center for Complementary Medicine Education and Research (ACCMER)—Stephen Myers, ND, MD, PhD, Director

Ayurvedic Academy & Natural Medicine Clinic—Vivek Shanbhag, NM (MD, Ayu-India), Director

Dietetic Internship and MSDPD—Suzzanne Nelson Myer, RD, MS, CD, Director, Bastyr University

Council on Chiropractic Education, Inc.—JAN SCHWARTZ, lmt, nctmb, vICE PRESIDENT

Council of Colleges of Acupuncture and Oriental Medicine (CCAOM)

Catherine Niemiec, JD, LAc, Vice-President

Elizabeth Goldblatt, PhD, MPA/HA, Past President

Advisory Member: Lixin Huang, MS, President

Council on Naturopathic Medical Education (CNME)

Don Warren, ND, DHANP, President

Dan Seitz, JD, Executive Director

Emperor's College—Yi Qiao, MPH, LAc, Commissioner

Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM)

Midwifery Education Accreditation Council (MEAC)—Sonia Ochoa, MD (Mexico), Professional Member

Naturopathic Midwifery Department—Morgan Martin, ND, LM, Chair, Bastyr University

ACCAHC/OCCIM Task Force—Pat Benjamin, PhD

IHPC-ETF National Education Dialogue—John Weeks, Project Director

ACCAHC Consortium Director—Pamela Snider, ND

Appendix 2: Oregon Collaborative for Complementary and Integrative Medicine (OCCIM)

Description of OCCIM

The Oregon Collaborative for Complementary and Integrative Medicine (OCCIM) is a collaborative project between key educators from Oregon Health & Science University (OHSU), Oregon College of Oriental Medicine (OCOM), Western States Chiropractic College (WSCC), and the National College of Naturopathic Medicine (NCNM).

OCCIM mission

The current mission of OCCIM is to launch a 4-year longitudinal complementary and alternative medicine (CAM) curriculum (Oregon CAM Course) for medical students at OHSU so they can demonstrate knowledge and understanding of the nature and extent of the health care disciplines, modalities, and professionals that constitute complementary and alternative medicine (CAM) in order to (1) evaluate the effectiveness of CAM, (2) advise patients who are interested in CAM health care disciplines and modalities, (3) appropriately refer patients to CAM providers, and (4) recognize the potential benefits and/or risks existing at the interface between CAM and allopathic medicine.

OCCIM Oregon CAM course

The development of the curriculum for the Oregon CAM Course was made possible by an NIH NCCAM R-25 grant awarded to OHSU in June 2002. It is directed by a diverse Advisory Council composed of representatives from participating schools and leaders of the Portland Complementary and Integrative Medicine community.

OCCIM future goals

The members of OCCIM envision continuing their collaboration through additional grant funding, joint research and shared programs for students and faculty at participating institutions. Support for ongoing professional education and the clinical practice of integrative medicine in the Portland community will continue to be a goal of OCCIM.

OCCIM Member Organizations

Oregon Health and Science University
Peter O. Kohler, MD, President
Ed Keenan, PhD, Associate Dean of School of Medicine
Anne R. Nedrow, MD, Oregon CAM Course Program Director

National College of Naturopathic Medicine
William Keppler, PhD, President
Richard Barrett, ND, Associate Professor

Oregon College of Oriental Medicine
Michael Gaeta, EdD, President
Richard Hammerschlag, PhD, Research Director
Robert Kaneko, LAc, Clinic Director

Western States Chiropractic College
Joseph Brimhall, DC, President
David Peterson, DC, Professor, Chiropractic Sciences
Mitch Haas, DC, MA, Professor & Dean of Research

Appendix 3: The Members of the Academic Consortium for Complementary and Alternative Health Care (ACCAHC)/ Oregon Collaborative for Complementary and Integrative Medicine (OCCIM) Task Force*

Academic Consortium for Complementary and Alternative Health Care (ACCAHC) Task Force Members

Chair: Reed Phillips, DC, PhD
Board Member, Immediate Past-President
Council on Chiropractic Education (CCE)

Patricia Benjamin, PhD
Member
ACCAHC/OCCIM Task Force

Morgan Martin, ND, LM
Chair, Naturopathic Midwifery Department
Bastyr University

Suzzanne Nelson Myer, RD, MS, CD
Director, Dietetic Internship and MSDPD
Bastyr University

Catherine Niemiec, JD, LAc
Vice-President
Council of Colleges of Acupuncture & Oriental Medicine (CCAOM)

David O'Bryon, JD
Executive Director
Association of Chiropractic Colleges

Sonia Ochoa, MD (Mexico)
Professional Member
Midwifery Education Accreditation Council (MEAC)

Pamela Snider, ND
Consortium Director
Academic Consortium for Complementary and Alternative Health Care (ACCAHC)

Don Warren, ND, DHANP
President
Council on Naturopathic Medical Education (CNME)

John Weeks
Project Director, National Education Dialogue
Executive Advisor, Lucy Gonda Foundation

Oregon Collaborative for Complementary and Integrative Medicine (OCCIM) Task Force Members

Richard Barrett, ND
Associate Professor
National College of Naturopathic Medicine

Tim Chapman, PhD
Vice President of Academic Affairs
Oregon College of Oriental Medicine

Richard Hammerschlag, PhD
Research Director
Oregon College of Oriental Medicine

Mitch Haas, DC, MA
Professor & Dean of Research
Western States Chiropractic College

Robert T. Kaneko, LAc
Dean of Clinics
Oregon College of Oriental Medicine

Anne R. Nedrow, MD
Medical Director, Women's Primary Care/Integrative Medicine
Center for women's Health, OHSU

David H. Peterson, DC
Professor, Chiropractic Sciences
Western States Chiropractic College

Catherine Salveson, RN, PhD
School of Nursing
Oregon Health and Science University

*The ACCAHC/OCCIM task force, composed of members from ACCAHC and OCCIM, developed the survey, data, and themes reported in this paper. ACCAHC is a part of the Education Task Force, a national working group of the Integrated Healthcare Policy Consortium (IHPC).

Appendix 4: A Modified Definition of Integrative Medicine

Consortium of Academic Health Centers for Integrative Medicine

The authors are pleased to note that on May 15th, 2005 the Steering Committee f the Consortium of Academic Health Centers for Integrative Medicine modified their definition of Integrative Medicine in response to suggestions from the Academic Consortium for Complementary and Alternative Health Care, made through the Education Task Force of the Integrated Healthcare Policy Consortium. The existing definition prior to May 15, 2005,

"Integrative Medicine is the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person is informed by evidence, and makes use of all appropriate therapeutic approaches to achieve optimal health and healing."

was modified to

"Integrative Medicine is the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, *healthcare professionals and disciplines* to achieve optimal health and healing." [emphasis added]

The authors are deeply appreciative of this decision and recognize it as an important step to developing a more patient-centered and collaborative health care system between our many disciplines.

APPENDIX 5: THE ACADEMIC CONSORTIUM FOR COMPLEMENTARY AND ALTERNATIVE HEALTH CARE (ACCAHC)

Definitions developed by ACCAHC/NED Definitions and Terms Task Force, National Education Dialogue to Advance Integrated Health Care (Chair: Jan Schwartz, LMT. www.ihpe.info)

Integrated health care: This term describes a collaborative, team care approach between a variety of Western medical, traditional and indigenous, and CAM licensed health care providers. It implies a comprehensive access to a full range of health care systems based on patient need and cost effectiveness.
http://nnlm.gov/archive/healthinfoquest/pathfinders/termsCAM.html 08/05/07

Approach: In medicine, the method or procedure used to address a situation, such as surgery or other treatment plan[iii].

Therapy: A specific treatment for a specific condition or symptom, within a modality or from a combination of modalities. Examples are a vitamin for arthritis or an herb for the flu, or a vitamin and massage for arthritis, etc.

Profession: A calling or vocation requiring specialized knowledge, methods, skills, and training in a defined preparation or an institution of learning, in the scholarly, scientific, clinical, artful and historical, social and cultural principles underlying such methods and skills. A profession continuously enlarges and evaluates its body of knowledge, functions autonomously in formulation of policy, and maintains by force of organization or concerted opinion high standards of achievement and conduct. Members of a profession are committed to continuing study, are guided by a code of ethics, place service above personal gain, and are committed to providing practical services vital to human and social welfare. (adapted)[iv]

Modality: A form of application or employment of a therapeutic agent or regimen.[i] A modality for one profession may be another health care profession's whole discipline or system. Examples of modalities found in many health care systems are diet and nutrient therapy, physical medicine, pharmacology and others. Training and standards for modalities vary between systems. In licensed health care professions they may be defined by state licensing and accreditation standards and board examinations. Some modalities, such as botanical medicine, are also emerging professions.[vi] Distinguishing between modality level and discipline level training and practice is essential.

Health care system: A discipline or system of health care is "the structure or whole formed by the essential principles or facts of a science or branch of knowledge or thought: an organized or methodically arranged set of ideas, theories or speculations . . . [This] may imply that the component units of an aggregate exist and operate in unison or concord according to a coherent plan for smooth functioning.[vii] *From NCCAM: "Whole medical systems* involve complete systems of theory and practice that have evolved independently from or parallel to allopathic (conventional) medicine. Many are traditional systems of medicine that are practiced by individual cultures throughout the world. Major Eastern whole medical systems include Traditional Chinese Medicine (TCM) and Ayurvedic medicine, one of India's traditional systems of medicine. Major Western whole medical systems include homeopathy and naturopathy. Other systems have been developed by Native American, African, Middle Eastern, Tibetan, and Central and South American cultures. . . .[viii]

A whole system of health care is typically titled by its system name, and usually comprises modalities. Therapeutic interventions exist within these modalities. A whole system or discipline of health care may incorporate a discrete and limited amount of knowledge or a group of strategies from another system or discipline, functioning in practice at the level of a modality, rather than incorporating the entire system itself.

Health care disciplines: A branch or domain of knowledge, instruction, r learning. Nursing, medicine, physical therapy, and social work are examples of health-related or professional disciplines.[ii] For the sake of this discussion, the terms "profession" and "discipline" can be used interchangeably. A whole health care system is also a health care discipline. Not all health care disciplines consider themselves whole health care systems; for example, massage therapy and direct entry midwifery are full health care disciplines (and professions), but do not consider themselves whole health care systems. Naturopathic medicine, chiropractic medicine, acupuncture and Oriental medicine and Ayurvedic medicine (as stated by NCCAM) are health care disciplines that are also whole systems of health care.

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i. Stedmans Medical Dictionary for the Health Professions and Nursing. 5th ed. Philadelphia: Lippincott Williams & Wilkins, 1990.
ii. Taber's Cyclopedic Medical Dictionary. 19th ed. Philadelphia: F.A. Davis Co., 2001.
iii. Mosby's Dictionary of Complementary and Alternative Medicine. St. Louis: Elsevier Mosby, 2005.
iv. Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health. 5th ed. Philadelphia: WB Saunders Co., 1992.
v. MEDLINE plus: Merriam-Webster Medical Dictionay. Bethesda: U.S. National Library of Medicine: National Institutes of Health, 2001.
vi. Snider P. Submission to Center for the Health Professions Task Force on developing a model for emerging professions. Fall 2000.
vii. Webster's Third New Inernational Dictionary. Chicago: Encyclopaedia Britannica, 1986.
viii. National Center for Complementary and Alternative Medical Systems: An Overview—Naturopathy. NCCAM Publication No. D236. October 2004. Available from: http://nccam.nih.gov/health/backgrounds/wholemed.htm#nature Accessed

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BENJAMIN

AU1
Is this the journalist? If not please supply degrees for Weeks

AU2
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AU3
City and state for Council?

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