

National Education Dialogue to Advance Integrated Health Care: *Creating Common Ground*

A Project of the Education Task Force
of the Integrated Healthcare Policy Consortium (IHPC)

Progress Report

March 2004 – September 2005

Published by:

National Education Dialogue Planning Committee

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A Project of the Education Task Force
of the Integrated Healthcare Policy Consortium (IHPC)

Progress Report

Planning, Dialogue and Project Development
March 2004 – September 2005

Onsite Meeting
May 31, 2005 – June 3, 2005
Georgetown University Conference Center
Washington, D.C.

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1. Members, Consortium of Academic Health Centers for Integrative Medicine
2. Academic leaders, distinctly licensed CAM professions (many are members of Academic Consortium for Complementary and Alternative Health Care)
3. Holistic nursing; holistic transformative and functional medicine; public health

National Education Dialogue to Advance Integrated Health Care: *Creating Common Ground*

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Executive Summary

Background: Out of Our Individual Educational Silos

The widespread use of complementary and alternative medicine (CAM) has stimulated exploration of how best to educate practitioners to respond to consumer interest. Reports from the White House Commission on Complementary and Alternative Medicine Policy (2001),¹ the National Policy Dialogue to Advance Integrated Care: Finding Common Ground (2001)² and the Institute of Medicine (2005)³ have each promoted significant shifts in the education of healthcare professionals. Action, while limited, has focused on policy clarification, pilot projects and development of an infrastructure to support change creation.

In March 2004, the Integrated Healthcare Policy Consortium (IHPC) began a project meant to serve these emerging educational interests. IHPC is a nationally based, not-for-profit organization with a successful track record in finding and implementing common ground among diverse groups. The project, which links educators from across healthcare professions, is the National Education Dialogue (NED) to Advance Integrated Health Care: *Creating Common Ground*. The principals in NED are leaders from conventional academic health centers, holistic nursing, public health and representatives of the councils of colleges and accrediting agencies of five CAM fields with federally recognized education (chiropractic, acupuncture and Oriental medicine, massage therapy, naturopathic medicine and direct-entry midwifery). They view their work as a multi-year process.

NED's multidisciplinary initiative rests on the premise that students educated in an environment of mutual respect and collegiality among disciplines will be more likely to practice collaborative health care than those educated in separate silos.

NED created its first common ground between these diverse academic interests by clarifying its vision:

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

“Our ultimate goal should be to create a healthcare delivery system that is comprehensive, patient-centered, evidence-based and cost-effective. What you are doing here [with the National Education Dialogue], this great collaborative work, is one of the most important things anyone can do to implement this report.”

Stuart Bondurant, MD
Chair, Institute of Medicine Committee on the Use of Complementary and Alternative Medicine (CAM) in the United States

“I view the entire CAM collaboration as not about CAM at all. It's about students from different disciplines coming together so that this generation, as it goes through its education, will have a different relationship to other disciplines than what exists now.”

Adi Haramati, PhD
Director of Education for Physiology and Biophysics, Georgetown University School of Medicine

1. White House Commission on Complementary and Alternative Medicine Policy (WHCCAM). Final Report, March 2002. <http://www.whccamp.hhs.gov/finalreport.html>. Accessed 4/21/05.

2. Traub M, Quinn S, (eds). The National Policy Dialogue to Advance Integrated Health Care: Finding Common Ground, 2002. Report of the Integrated Healthcare Steering Committee.

3. 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.

This Progress Report reflects 15 months of work by multidisciplinary NED teams, including three surveys, two face-to-face retreats, and the convening of 70 educators at Georgetown University Conference Center, May 31–June 3, 2005.

Call to Action: Shift Institutional and Organizational Behavior

The collaborative care advocated by the Institute of Medicine (IOM) and other investigators suggests that change must occur not only in curriculum, but also in the habits of educational institutions and organizations representing health profession disciplines.

The level of integration of conventional and CAM therapies is growing. That growth generates the need for tools or frameworks to make decisions about which therapies should be provided or recommended, about which CAM providers to whom conventional medical providers might refer patients, and the organizational structure to be used for the delivery of integrated care. The committee believes that the overarching rubric that should be used to guide the development of these tools should be the goal of providing comprehensive care that is safe and effective, that is collaborative and interdisciplinary, and that respects and joins effective interventions from all sources.⁴

Participants in the NED meeting strongly affirmed the importance in change creation of useful projects in which educators from diverse healthcare disciplines work through shared processes toward common goals. NED's planning team has chosen to focus 2005–2007 work on recommendations 1–4, below: supporting development of inter-institutional relationships, creating collaboratively developed educational resources on the disciplines, developing a statement of shared values, and making available educational resources that will assist educators working to create quality integrated healthcare education. These projects will model the integration we ultimately seek to manifest in the care practiced by our distinctly trained professionals.

This Progress Report of the National Education Dialogue is meant to inform educators, policymakers, members of the media and leaders of diverse healthcare disciplines about the priorities of educators in creating collaborative, integrated care. Our intent is to assist individual institutions and organizations in fulfilling their distinct missions. The NED Planning Team and participants wish to stimulate development of a new kind of collaborative care such as is called for in IOM's document.

“We started out our work in developing these ideas for educational resources on the disciplines with a very simple premise: If you wish to collaborate with someone, the more you know about the person and the field with which you wish collaborate, the more effective and useful to the patient that collaboration is going to be.”

Dan Sietz, JD
Executive Director, Council on
Naturopathic Medical Education

“From the very beginning when our integrative center started, we worked hard to establish a very strong culture of collaboration with the CAM community. We did that for two reasons. One is competence. We recognized that there was a critical competence that we didn't have at the university. We needed to bring in partners to build a program. The other reason was credibility. We felt that to be a credible program, both internally and externally, we needed to have an expanded network.”

Mary Jo Kreitzer, RN, PhD
Director, Center for Spirituality
and Healing, University of
Minnesota

4. 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. p. 216

This Report is meant to have additional, practical value. To shift behavior, we must shift investment. It is our hope that this work will stimulate broader and deeper support for all who are seeking to practice the inter-institutional, interdisciplinary, collaborative values in our current educational processes that we seek to create in the future of health care.

Common Ground: Priorities

NED surveys showed significant agreement (>80%) on these priority recommendations:

1. Facilitate development of inter-institutional relationships and geographically based groupings of conventional and CAM institutions and disciplines in diverse regions. Promote student and faculty exchanges, create new clinical opportunities, facilitate integrated post-graduate and residency programs, and provide opportunities for students to audit classes and share library privileges.
2. Create resource modules on teaching about distinct CAM, conventional and emerging disciplines (approved by the disciplines), which can be used in a variety of formats—from supporting materials in such areas as definitions and glossaries to full curricular models.
3. Share educational and faculty resources and information on inter-institutional relationships, including samples of existing agreements and existing educational resources through development of a website.
4. Continue multidisciplinary work to create a concise statement of core values, which have resonance across the disciplines and can guide efforts to create quality integrated healthcare education.
5. Collaboratively develop and sponsor continuing education initiatives designed to draw participants from diverse disciplines.
6. Create collaboratively developed educational resources to prepare students and practitioners to practice in integrated clinical settings.
7. Develop an outline of skills and attitudes appropriate for those involved in collaborative integrated health care.
8. Assist individuals with making institutional changes by offering support for leadership in change creation. Explore strategies for overcoming the challenges of prejudice, ignorance and cultural diversity.
9. Explore third-party clinical sites that serve the underserved (such as community health centers) as locations for developing clinical education in integrated healthcare practices.

“My wife caught up with me about midnight [the last night of the onsite NED meeting] and asked what I’ve been doing for the last few days. I said, ‘We’ve been searching for the soul of healthcare education.’”

David O’Byron, JD
Executive Director, Association of
Chiropractic Colleges

“I came home from the meeting as a changed professional. I know as an educator I am doing some things differently. I called up a local acupuncture school to see if they were interested in our clinic as a training site. I got in touch with a naturopathic medical educator for a journal feature I edit. The meeting gave me some ideas, and I am acting on them.”

Ben Kligler, MD, MPH
Director of Education and
Research, Beth Israel Medical
Center for Health and Healing

National Education Dialogue: Recommendations for Action

The following reflect all of the core recommendations of the NED activity up to the onsite meeting in June 2005.

1. Identification and fostering of optimal inter-institutional relationships

- Develop website to share best practices, sample agreements and other useful tools.
- Encourage development of geographically based groupings of conventional and CAM institutions in diverse metropolitan areas and regions. These “local pods” would promote arrangements to share library privileges, audit classes, hold student-to-student and faculty exchanges, create new clinical opportunities, and facilitate integrated residency programs.
- Consider development of a conference that focuses on assisting institutions in developing formal research, and clinical and classroom relationships with institutions and programs that train other disciplines.

2. Collaborative development of educational resources

- Create resource modules on teaching about distinct conventional and CAM disciplines (approved by the disciplines), which can be used in a variety of formats—from supporting materials to full curricular models.
- Develop website to foster sharing of educational resources. Gather materials that are already available; don't reinvent the wheel. Develop visually appealing materials. Consider a range of media, including PowerPoint slides and downloadable video.
- Develop a directory of people who can be resources, presenters or faculty on interdisciplinary relationships and other key topics.
- Place the work on definitions as a subset of the work on educational resources.
- Collaboratively develop and sponsor continuing education programs designed to draw participants from diverse disciplines. Such continuing education should model collaborative, patient-centered care.
- Develop training modules and educational resources to prepare students and practitioners to practice in collaborative, interdisciplinary clinical environments.

“Well, one of the joys [in this work with members of CAM disciplines] is that familiarity breeds respect, understanding, and collaboration. And I think that's critical. There just has to be some getting together around a mutual project.”

Ron Schneeweiss, MBChB
Professor, Department of
Family Medicine, University of
Washington

“One of our goals as a massage therapy institution is to graduate research-literate massage therapists. In appraising that competency, we recognized that it wasn't just a curriculum issue. We needed to change the culture of our institution so that our students would be excited about research.”

Mary Ann DiRoberts, MSW, MEd
Executive Director, Muscular
Therapy Institute

3. Exploration of shared values, skills and attitudes

- Work with the re-assembled team to create a new draft of the values document. Aim for short phrases that will integrate the broadest possible overarching statement of values.
- Submit this draft to the NED planners and participants for review and internal endorsement.
- Reconsider the value, structure and potential grant availability for a campaign to gain formal endorsement of the new values statement from an expanding network of organizations seeking to enhance collaborative care.
- Begin developing a document that outlines skills and attitudes for those involved in collaborative, integrated health care.

4. Training for leadership skills in change creation

- NED should continue to have leadership development as a core focus.
- Explore establishing an institute devoted to developing leadership skills among integrated healthcare leaders.

5. CAM access for the underserved

- Increase awareness in conventional academic health centers and community clinics regarding CAM schools' willingness to create preceptorship sites where student clinicians might donate services as a part of their educational mission. Financial constraints restricting development of clinical education opportunities might thereby be overcome.
- Explore schools of public health as a venue to bring together CAM and conventional providers, including a survey of existing public health programs in relationship to goals stated in two recent IOM reports—one on CAM and one on public health.
- Explore third-party clinical sites such as community health centers and other programs for the underserved as locations for developing quality clinical education in integrated health care practices.

6. Collaborative continuing education

- Use the multidisciplinary NED network as a basis for creating mixed sponsorship of continuing education programs that practice integration in the process of teaching about integration.
- Consider a video combined with an onsite moderator, or an interactive video experience, where people gather at several locations around the country and interact with the presenters.
- Structure the educational experience so that afterward people understand how to model collaborative care in their own institutions.

“Within our college, one of the big issues in working with (the consortium of medical schools and CAM schools) is integrating all of the pieces. We must integrate research with curriculum, we must train faculty, and we must get students on board with the program and keep them informed about what’s going on.”

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

- Focus on empowering local practitioners and local institutions to maintain the principal focus of offering the greatest benefit to the patient.

7. Assessment of competencies

- Collect best practices on teaching and assessment in the affective domain.

8. “Shadow issues” between disciplines

- Consider a smaller meeting, perhaps under NED sponsorship, to specifically look at the frequent misperceptions and assumptions about, and the emotional, cultural and economic barriers to, integration, in an effort to find strategies to overcome them.

9. Creating a financial base to further the mission

- Continue to seek ongoing support from participant organizations.
- Seek philanthropic partners for specific initiatives.
- Explore public funding options.

“Somewhere in each of our worlds, there is probably a person, an organization, a foundation, that will rally to the goals and enthusiasm you bring home from this meeting. I want to invite everyone here to think with us about the mechanisms we could use to really carry the Dialogue forward to its full potential. That means helping us open doors.”

Sheila Quinn
Board Chair, IHPC; Senior Editor,
Institute for Functional Medicine

Report

Invocation: The Institute of Medicine and the Purpose of the National Education Dialogue

In January 2005, the Institute of Medicine (IOM) of the National Academy of Sciences released a report entitled “Complementary and Alternative Medicine (CAM) in the United States.” Citing widespread use of complementary and alternative medicine (CAM), the IOM committee called for “comprehensive care that is safe and effective, care that is collaborative and interdisciplinary, and care that respects and joins effective interventions from all sources.”

The IOM committee declared that “education about CAM is needed for both conventional medical practitioners and CAM practitioners.” The committee also concluded that “for those in conventional practice, it is important to learn about CAM to appropriately interact with and advise patients in a manner that contributes to high-quality, comprehensive care.” Yet the committee also noted “there is no consensus on what should be taught about CAM to conventional medical practitioners.”⁵

The IOM report underscored the value of a multi-year project among educators involved in CAM and integrated health care sponsored by the Integrated Healthcare Policy Consortium (IHPC) (see Mission of IHPC, below). The IHPC shares the IOM vision of creating a more comprehensive and effective healthcare system. The National Education Dialogue (NED) to Advance Integrated Health Care: Creating Common Ground is an IHPC project (see Mission of NED Convener, p. 8).

NED’s core goal is to enhance health care by creating common ground between educators and institutions involved in the education of healthcare professionals. NED’s multidisciplinary work rests on the premise that students who are educated in an environment of mutual respect and collegiality between disciplines will be more likely to practice quality integrated health care than those educated in separate silos. Today, students in healthcare professional schools typically have few if any opportunities to study or work across the CAM-conventional medicine chasm. Is it any surprise that these students finish their training ill-equipped to function collaboratively as part of the kind of healthcare mix that the IOM recommends and consumers are increasingly choosing?

“The level of integration of conventional and CAM therapies is growing. That growth generates the need for tools and frameworks to make decisions about when therapies should be provided or recommended, about which CAM providers to whom conventional medical providers might refer patients, and the organizational structure for the delivery of care.”

Complementary and Alternative Medicine in the United States,
Institute of Medicine, p. 216

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. p. 238

NED is dedicated to removing barriers between disciplines and between health professional students. Many institutions and disciplines acknowledged the value of this work by financially cosponsoring the NED activity (see NED Sponsors, inside front cover). Individuals representing 35 institutions and organizations joined in teams to participate in NED projects. Finally, 70 educational leaders from across disciplines met to create common ground at Georgetown University Conference Center May 31–June 3, 2005 (see Participants in the NED Meeting by Educator Group [p. 9], and full list inside back cover).

Stuart Bondurant, MD, executive dean of Georgetown University Medical Center and chair of the IOM committee that produced the IOM report “Complementary and Alternative Medicine (CAM) in the United States,” keynoted the NED gathering. He called education the major factor that will shape integrative medicine over the next decade.

Bondurant affirmed the NED mission: “CAM use is widespread, and here to stay. Our ultimate goal should be to create a healthcare delivery system that is comprehensive, patient-centered, evidence-based and cost-effective. What you are doing here, this great collaborative work, is one of the most important things anyone can do to implement this report.”

This Progress Report documents the NED work to date and offers directions for future work of the NED and other institutions and organizations that share the vision of more collaborative health care.

Mission of the NED Convener, the Integrated Healthcare Policy Consortium

The NED was developed through the Integrated Healthcare Policy Consortium (IHPC), a national organization founded in 2001. The organization’s mission is as follows:

- Identify, articulate and advocate public policy that will improve access to high-quality integrated healthcare services, including the full range of health systems, disciplines and modalities.
- Direct the national healthcare policy agenda toward health promotion and improved community and public health.

In collaboration with other like-minded organizations, the IHPC convenes consensus-seeking meetings to establish policy directions, articulate policy statements that further our mutual goals, and support the enactment of those policies. For more information see: www.ihpc.info

“I think in our work which became the Oregon Collaborative for Complementary and Integrative Medicine, the key has been to establish from the beginning a lateral relationship between all four schools in our collaboration. We have this lateral dimension in all three aspects of our collaboration: research, education and clinical care.”

“I cannot overstate the difference it makes for us in working with faculty from a CAM school versus working with a community practitioner who isn’t involved in education. Because the dialogue of education is understood by these CAM educators, we understand common language around education as our baseline, and we build from there in finding common ground on medical words and issues. This has been a huge plus for us in our work with the CAM disciplines.”

Anne Nedrow, MD
Education Director, Oregon
Health Sciences University—
Oregon Collaborative for
Complementary and Integrative
Medicine

Participants in the NED Meeting by Educator Group

Acupuncture and Oriental Medicine	7*
Allied Health	4*
Chiropractic	9*
Conventional Academic Medicine	15**
Integrated Healthcare, other	12
Massage Therapy	10*
Direct-Entry Midwifery	2*
Naturopathic Medicine	8*
Nursing	2
Public Health	2
Other	3

* Of these 40, 16 represent institutions and organizations that are active members of the Academic Consortium of Complementary and Alternative Health Care (ACCAHC).

** Of these 15, 11 represent institutions that are active members of the Consortium of Academic Health Centers for Integrative Medicine (CAHCIM).

Findings and Recommendations Through NED Action

The NED has been an intensely interactive, collaborative process (see process elements, Appendix 1). Given the historic tensions and present distance between most leaders of these separate disciplines, planners sought to err on the side of inclusion in developing work product and recommendations. Key findings, by theme, follow.

Identification and Fostering of Optimal inter-institutional Relationships

A NED team engaged a pre-meeting NED survey of all accredited CAM schools (N=130) and all conventional programs that are members of the conventional academic consortium (N=28). The goals were to develop baseline information on the current status of inter-institutional relationships and to identify best practices. Roughly 85% of respondents—whether CAM (86%) or conventional (85%)—agreed that “creating a fully integrated healthcare system will require that programs like ours develop stronger, multidimensional, inter-

“The rich network of relationships that exists between Minnesota and the Big Island is the single most important factor in this collaboration that has grown between us and allowed the program to work.”

Michael Traub, ND
Co-Chair, Education Working Group, Hawai'i State Consortium for Integrated Health Care

Toward Integrated Healthcare Education: A Timeline of Recent Influences

IHPC's NED gathering was informed by the work of many others, including government agencies and other not-for-profit organizations, over the past six years. This chronology provides a brief overview of some milestones on the road to the National Education Dialogue.

1999 March	National Plan to Advance Integrated Healthcare submitted to Congress by a multidisciplinary group led by Hon. Berkley Bedell
1999 December	NCCAM announces first call for proposals for educational program development grants (R-25)
2000 May	1 st Integrative Medicine Industry Leadership Summit (followed by two subsequent annual gatherings)
2001 November	National Policy Dialogue (NPD) meets at Georgetown University Conference Center and reports its recommendations in early 2002
2001	The Bravewell Collaborative (formerly the Philanthropic Collaborative for Integrative Medicine) sets support for a conventional academic consortium for integrative medicine as a top strategic initiative
2002 January	Integrated Healthcare Policy Consortium (IHPC) forms out of the NPD Steering Committee
2002 January	Consortium of Academic Health Centers for Integrative Medicine (CAHCIM) established (conventional academic consortium)
2002 March	White House Commission on Complementary and Alternative Medicine Policy Report published
2002	Education Task Force of Integrated Healthcare Policy Consortium established
2003 November	Plans for NED brainstormed after the first Bravewell Awards dinner in New York City
2004 March	Receipt of philanthropic support from the Center for Integrative Health Medicine and Research initiates NED organizing activity
2004	NCCAM announces call for "reverse R-25" education grant program
2004	Academic Consortium for Complementary and Alternative Medicine (ACCAHC) formed as part of the NED process
2004 June	<i>Academic Medicine</i> publishes article, endorsed by the Conventional Academic Consortium, on competencies in integrative medicine
2004 July	NED Planning Team meets to set vision, mission, goals and deliverables
2004 September	NED team approves Vision, Mission, Goals and Deliverables document, envisioning a multi-year process
2004 October	ACCAHC team links with the Oregon Collaborative for Complementary and Integrative Medicine to begin modified Delphi survey project on CAM and conventional values
2004 December	NED team begins development of survey on the status of inter-institutional relationships in Conventional Academic Consortium programs (N=28) and accredited CAM programs/institutions (N=130)
2005 January	Institute of Medicine (IOM) publishes its report on CAM
2005 January	Multidisciplinary NED Task Force on Values, Knowledge Skills and Attitudes begins developing a draft working document to guide education of all healthcare professionals
2005 February	ACCAHC team meets in face-to-face retreat at Southern California University of Health Sciences and develops Vision, Mission, Goals and Deliverables (adopted 03/05)
2005 March-May	Receipt of a series of sponsorship grants creates financial viability of NED for year one (March 2004–June 2005)
2005 May	Conventional Academic Medicine Consortium steering committee honors changes, requested by NED and ACCAHC, in that organization's formal definition of "integrative medicine"
2005 June	NED meeting at Georgetown University Conference Center

institutional relationships [with educational institutions from other disciplines].” Formal relationships are presently rare. For example, less than one-quarter of the conventional academic programs that have an integrative medicine program typically have such a relationship with a CAM institution in any specific discipline. Present interdisciplinary educational initiatives are usually based on individual relationships (Appendix 2 includes sample findings).

Intriguing pilots in many metropolitan areas—“geographic pods” as the NED planners refer to them—are beginning to provide health professional students more in-depth and useful experience of other disciplines. Grant programs from the National Institutes of Health National Center for Complementary and Alternative Medicine (NCCAM) have played an important role in shifting institutional behavior. Participants have found reports from these models and the experience of other colleagues extremely useful. Work toward “describing and sharing best practices in inter-institutional relationships and inter-disciplinary collaboration” was viewed by 95% of participants as important in advancing integrated health care. Over 60% of respondents to the pre-meeting NED survey stated that they would find conferences on development of inter-institutional relationships valuable (see Appendix 3 for brief summaries). NED also gathered and shared formal examples of a dozen inter-institutional agreements regarding education, research and clinical services. Examples include an affiliation agreement for education between a conventional medical school and a school of traditional acupuncture and Oriental medicine for educational services, and a naturopathic medical school agreement with a conventional medical center establishing procedures for training medical residents. Nearly 80% sought examples of existing inter-institutional agreements as a useful tool in forging new relationships (see Appendix 4 for titles of the agreements shared).

Recommendations:

- 1. Develop a website to share best practices, sample agreements and other useful tools.*
- 2. Encourage development of geographically based groupings of conventional and CAM institutions in diverse metropolitan areas and regions. These “local pods” would promote arrangements to, for instance, share library privileges, audit classes, hold student-to-student and faculty exchanges, create new clinical opportunities and facilitate integrated residency programs.*
- 3. Consider development of a conference that focuses on assisting institutions in developing formal research, clinical and classroom relationships with institutions and programs for training other disciplines.*

“One of the things that became an interesting byproduct of our relationship as a part of a cluster of schools associated with Oregon Health Science University was that the CAM schools got to know each other more as CAM schools. We began to realize that we weren’t communicating among each other as much as we should be.”

David Peterson, DC
Professor, Western States
Chiropractic College

“Our massage students experience incredible growth in self-confidence in their interaction with medical students. They learn to articulate better. They learn to talk about things that they’re feeling with their hands. They’ll walk out of the room and say, ‘We knew maybe the same or a little bit more about the musculoskeletal system than the medical students did.’ This is huge growth process for them.”

Cathy McInturff Ayers, LMT
Director of Education, Potomac
Massage Training Institute

Collaborative Development of Educational Resources

A multidisciplinary NED working group leading up to the NED onsite gathering identified two types of educational resources for which NED's diversity could be a particularly useful. One type is the creation of resources for training both CAM and conventional professionals about the distinct disciplines. The group suggested that each discipline follow a similar format and guidelines. Their work would be reviewed and critiqued by representatives of their own and other disciplines before finalization. A second type of resource would support students of all types with a professional interest in developing collaborative skills for their clinical work in an integrated care environment. One line of discussion considered whether accrediting agencies for health professional education might develop a new standard to ensure that students are educated to participate competently in a respectful, collaborative, multidisciplinary environment, including both CAM and conventional colleagues.

Collaborative development of actual curriculum models was set aside in favor of collaborative development of educational resources that could support curriculum development of varying types and depth in any institution. Dialogue among the participants on this topic was resolved by acknowledging the individuality of institutional needs and interests. This work of advancing integrated healthcare education was viewed as important by 93% of the participants in the onsite survey and was rated as one of the top three priorities for ongoing work.

An ACCAHC-led NED task force took the lead in developing the resource ideas, which were modified by conventional educators on the NED team. Participants agreed generally that this survey-type educational material is a good first step. Knowledge of disciplines was viewed as a necessary starting place for development of other collaborative skills in an integrated environment. The view supported by the participants was that the more knowledge a healthcare practitioner has about other disciplines, the better he or she will be able to collaborate and assist patients who are accessing multiple healthcare treatments. Well-developed resources that aid this type of knowledge and collaboration will facilitate quality patient care. A well-formulated survey course, or set of courses, would provide an important basis for encouraging collaboration in order to better serve patients (Appendix 5 is the document prepared pre-meeting).

NED planners also set as a deliverable the preparation and delivery of a glossary to support the use of common language. This goal is to help ensure that all participants in integrated health care are working from common understanding of terms in their education, practice and subsequent communication. An example is the frequent

“Using the terms ‘modality’ or ‘approach’ to refer to whole systems of health care, such as naturopathic medicine or therapeutic disciplines like massage therapy reflects a lack of understanding of the complexity of the theory, knowledge and skills inherent in their practice.”

Jan Schwartz, LMT
Vice President,
Cortiva Education, Inc.

“I think this work together is the beginning of changing from thinking of ourselves as alternative to thinking of ourselves as integral.”

Mark Hyman, MD
Board Chair, Faculty,
Institute for Functional Medicine

interchange of words as diverse as “approach” and “modality” and “system” and “discipline” as though each were equivalent. While a significant majority of NED meeting participants view gaining clarity and agreement on definitions as important, a vocal subset opposed definition-setting as a separate priority focus for NED. The participant survey at the end of the NED meeting showed that 91% of participants view “agreement by diverse organizations, conventional and CAM, on the use of common definitions and terms” as either very important (35%) or moderately important (56%). This work was placed under educational resource development. A draft glossary of CAM “discipline-specific” (rather than common) terms was developed by the ACCAHC Task Force and its members and provided to NED participants. (see Appendix 6).

The participants strongly affirmed that their educational mission extended beyond the present and future students to also include efforts to re-educate the hundreds of thousands of professionals who are currently practicing. Participants noted that while all fields offer continuing medical education programs on integrated care, most of these educational programs are presented to a non-integrated audience. Notably, the experience of participating with the diversity of disciplines at the NED gathering—historic in bringing educators from across disciplines into the same room and to the same tables—was viewed by many as the most significant outcome of the meeting. Continuing education efforts to train existing practitioners, both conventional and CAM, in integrated healthcare practices was viewed as important to integrated health care by 89% of those surveyed onsite.

Recommendations:

- 1. Create resource modules on teaching about the distinct conventional and CAM disciplines, which can be used in a variety of formats—from supporting materials to full curricular models.*
- 2. Develop website to foster sharing of educational resources. Gather materials that are already available; don't reinvent the wheel. Develop visually appealing materials. Consider a range of media, including PowerPoint slides and downloadable video.*
- 3. Develop a directory of people who could be potential resources, presenters or faculty on interdisciplinary relationships and other key topics.*
- 4. Place the work on definitions as a subset of the work on educational resources.*
- 5. Collaboratively develop and sponsor continuing education initiatives that are designed to draw participants from diverse disciplines. Such continuing education should model collaborative, patient-centered care.*
- 6. Develop training modules on skills for practicing in a collaborative environment.*

“The impetus for our bridge-building with conventional medical research programs was that Oriental medicine research was already taking place. We knew important decisions were being made based on that research, but we also knew that some of the questions being asked, and the ways that those questions were being pursued, didn't always reflect the clinical experience and cultural values of our faculty. We wanted to engage our faculty in the research dialogue and actively participate in shaping the future of our profession.”

Peter Wayne, PhD
Director of Research, New
England School of Acupuncture

Exploration of Shared Values, Skills and Attitudes

NED planners prioritized establishing “both a process and commitments for developing a compatible set of core competencies and values across disciplines.” Pre-meeting, NED charged a multidisciplinary NED-ACCAHC task force with drafting such a statement (see Appendix 7). Team members envisioned a document that could be formally endorsed by diverse parties and serve as guidance for the long-term integration efforts that would help realize the IOM’s recommendations without supplanting individual organizational values statements. Members found a remarkable congruence of values between and across disciplines. Most agreed that questions surrounding competencies should be left to individual professions and that a shared examination of the skills and attitudes needed to manifest these values would be a useful second- or third-year effort.

Participants in the NED meeting engaged in a freewheeling response to the draft values statement, utilizing a “World Café” process which maximized input from the gathered community. While a vocal subset of participants questioned prioritizing the values initiative, a participant survey at the end of the meeting found that 91% viewed “endorsement of a shared values statement by conventional and CAM organizations as a basis for work on integrated health care education” as either “very” (35%) or “moderately” (56%) important. An additional group of participants volunteered to join the team that would take the lead in creating a new draft of the values statement. Consensus held that this document would be best as a pared-down statement of core, shared values. The proposal of the NED task force to further circulate this document for formal approval by participating institutions was tabled, given that substantial work is needed on the statement.

ACCAHC leaders initiated a parallel NED process on competencies and values through a survey of CAM educators and agency leaders using a modified Delphi process, reviewing a paper on competencies in conventional integrative medicine published by conventional academic leaders in *Academic Medicine*.⁶ The ACCAHC task force linked with the Oregon Collaborative for Complementary and Integrative Medicine (OCCIM) to conduct the Delphi survey project. “The report’s findings and data were presented as part of the panel exploration of key values in integrating healthcare education.” The five key recommendations from this survey and consultative process create a common voice among CAM academics relative to core competencies and curricular directions established by conventional institutions. “Although many shared values were recognized in the proposed IM core competencies, five key areas of concern emerged: 1) the definition of IM as presented

“Perhaps the wisest thing for all of us leaders who are so focused on our specific individual missions and visions is to take a breath, slow down and take the time to understand better the people we want to address. In finding our similarity with them, we can move together with them to make our visions become reality.”

Carla Mariano, RN, EdD
Coordinator, Advanced Practice
Holistic Nursing Program, New
York University

“This process is bigger than any one group and needs to be shared as soon as possible. These core values and concepts are universal and for all. It is the format and the language in a document that can move the process more quickly to create transdisciplinary healing dialogues.”

Barbara Dossey, PhD, RN
Director, Holistic Nursing
Consultants

6. Kigler B, Maizes V, Schlachter S, Park CM, Gaudet T, Benn R, et al; Education Working Group, Consortium of Academic Health Centers for Integrative Medicine. Core competencies in integrative medicine for medical school curricula: a proposal. *Acad Med*. 2004 Jun;79(6):521-31

in the article; 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 medical doctors and CAM professionals in patient care; and 5) omission of potential areas of partnership in IM education. 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”⁷ (see Appendix 8). The ACCAHC outcomes have been finalized and submitted for publication.

An additional outcome of this deliberative process was a successful request to the conventional academic medicine consortium that the definition of “integrative medicine” be changed to better reflect the importance of the integration of diverse disciplines (see p. 16).

Recommendations:

1. *Work with the re-assembled team to create a new draft of the values document. Aim for short phrases that will integrate the broadest possible overarching statement of values.*
2. *Submit to the NED planners and participants for review and internal endorsement.*
3. *Reconsider the value, structure and potential grant availability for a campaign to gain formal endorsement of the new values statement from an expanding network of organizations seeking to enhance collaborative care.*
4. *Begin developing a document that outlines skills and attitudes for those involved in collaborative, integrated health care.*
5. *Incorporate the Delphi findings into the values, skills and educational resources developed by NED.*

Training for Leadership Skills in Change Creation

Prior experience in integration efforts by NED planners taught the group that making affirmative changes in the practices of educational institutions requires more than good ideas. The conservatism of educational culture, whether conventional or CAM, hampers implementation of even proven strategies. The cross-cultural issues in the CAM-conventional and the inter-institutional work between distinct CAM disciplines can thicken the resistance. NED leaders determined that a core theme in the dialogue must be education for change creation.

Respecting this interest, NED leaders chose as the meeting facilitator a former college president with a background in working in multidisciplinary environments in change creation. The “leadership

“This is the first time in 30 years I’ve been in a room with so many medical doctors when the decibel level has remained relatively normal. I’ve realized that we’re all in this together, despite our differences. We all have to deal with the same issues in providing care for our patients.”

Frank Zolli, DC, EdD
Chair, Association of
Chiropractic Colleges

“Twenty years ago, it seemed my patients were being told they were taking their child’s life into their hands by taking them to see me. Now there is a collaboration. We are speaking to medical doctors and to physician groups. We are getting referrals from the hospital. There’s been an amazing change in the atmosphere and openness to have that kind of collaboration.”

Don Warren, ND, DHANP
President, Council on
Naturopathic Medical Education

7. Benjamin P, Phillips R, Don Warren, ND, Salvesson C, Hammerschlag R, Snider P. Response to a Proposal for an Integrative Medicine Curriculum. in press 2005

for change” theme was woven into the fabric of the meeting. A session focused on change principles. Participants considered how learning—and in this field, especially experiential learning—must precede change. Long-held underlying assumptions must be examined. Participants met in small groups to identify key elements necessary to create shifts in culture and institutional behavior. Among those identified were strong personal relationships, shared values and mission, long-term commitment to continuous education, funding support, and clarity on desired outcomes. Formal, contractual relationships were advocated by some as a necessary foundation for substantive change, while others argued that the presently politicized environment makes informality a necessity. Nearly everyone agreed that respected leadership and strong sponsorship from the president or department head are necessities (see Appendix 9).

Recommendations:

1. *Continue to have leadership development as a core focus of NED.*
2. *Explore an institute devoted to developing leadership skills for integrated healthcare leaders.*

Creating an Inclusive Definition of “Integrative Medicine”

One early outcome of the NED process was a change in the definition of “integrative medicine” as earlier adopted by educators from the Consortium of Academic Health Centers for Integrative Medicine. The shift reflects explicit recognition of the importance of integrating “health professionals and disciplines” and not merely “approaches.” The amendment, requested by ACCAHC members through the NED process, was accepted by the Steering Committee of the Conventional Academic Consortium in May 2005.

Prior Definition—Consortium of Academic Health Centers for Integrative Medicine (adopted December 2004)

Integrative medicine is the practice of medicine that reaffirms the importance of 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 [bold added].

Revised Definition during NED Process—Consortium of Academic Health Centers for Integrative Medicine (adopted May 2005)

Integrative medicine is the practice of medicine that reaffirms the importance of 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 [bold added].

This change accepted a core recommendation of CAM academic leaders who sought to ensure that integrative medicine acknowledged the distinct healthcare value offered by separate disciplines.

“Coercion isn’t the word I would like to use here. But there are instances where you basically need to force people to come into the room. You have to be confident enough and have enough chutzpa to feel that this is good for them, they just don’t know it yet.”

Adam Perlman, MD, MPH
Executive Director, Institute for Complementary and Alternative Medicine, University of Medicine and Dentistry of New Jersey

“Our CAM educators were very pleased with how quickly the conventional academic consortium embraced the amendment to their definition of integrative medicine to emphasize collaboration between the disciplines. It was respectful. Now it is incumbent upon us in the CAM fields to see that our own self-definitions highlight the importance of knowing how and when to work with others.”

Pamela Snider, ND
Executive Director, Academic Consortium for Complementary and Alternative Health Care

Emerging Themes and Initiatives

NED leaders took advantage of the depth of experience among meeting participants by urging them to identify their interests as educators that the meeting was not addressing. Planners then provided time for subsets of participants to meet in small groups on these topics. Four areas in particular drew interest:

1) CAM Access for the Underserved

The sector of the conventional healthcare delivery system with the most significant clinical integration presently is in provisions of services to underserved communities. For example, the NED survey on inter-institutional relationships found that up to 48% of respondent accredited CAM programs have some kind of formal relationship with clinics that serve Medicaid recipients. Institutions with programs in traditional Oriental medicine, naturopathic medicine, chiropractic medicine and massage often offer clinical education programs through relationships with community health centers. Many of these clinics also have conventional medical school affiliations, creating the potential for third-party sites where clinical education of conventional and CAM healthcare professional students could be explored. Public health schools were also viewed as under-utilized in stimulating dialogue between conventional and CAM fields.

Recommendations:

- 1. Increase awareness in conventional academic health centers and community clinics that CAM schools may be willing to create preceptorship sites where student clinicians donate services as a part of their educational mission. Financial constraints restricting development of clinical education opportunities might thereby be overcome.*
- 2. Explore schools of public health as a venue for bringing together CAM and conventional providers, including a survey of existing public health programs in relationship to goals stated in two recent IOM reports — one on CAM and one on public health.*
- 3. Explore third-party clinical sites such as community health centers and other programs that care for the underserved as locations for developing quality clinical education in integrated healthcare practices.*

2) Collaborative Continuing Education

Exploring the role of NED in providing collaborative continuing education was set as a second-year project by NED leaders in their July 2004 planning retreat. With more than a million health professionals in various disciplines currently in practice, the NED vision of a more integrated and collaborative healthcare delivery system clearly implied some re-education of current clinicians. The survey of NED

“What’s interesting in our work with one mobile community clinic is we have physicians and residents from the University of Arizona and naturopathic physicians and fourth-year students from Southwest College. It really gives people an opportunity to work together at a ground level.”

Paul Mittman, ND
President, Southwest College
of Naturopathic Medicine and
Health Sciences

participants strongly affirmed this direction, with 56% believing work in this area “very important” in advancing integrated health care. Participants noted that such education as currently exists is typically delivered in forums, such as professional association meetings, which target just one practitioner type. While the subject matter may be integration, the audience typically represents just one silo. Optimally, conferences will be planned to draw a multidisciplinary audience.

Recommendations:

1. *Use the multidisciplinary NED network as a basis for creating mixed sponsorship of continuing education programs that practice integration in the process of teaching about integration.*
2. *Consider a video combined with an onsite moderator, or an interactive video experience, where people gather at several locations around the country and interact with the presenters.*
3. *Structure the educational experience so that afterward people understand how to model collaborative care in their own institutions.*
4. *Empower local practitioners and local institutions to maintain the principal focus of offering the greatest benefit to the patient.*

3) Assessment of Competencies

Healthcare education currently tends to focus on teaching and assessing cognitive and psycho-motor skills. However, interpersonal affective skills are also essential to the healing process. Practitioners of integrative medicine, both MDs and CAM professionals, need to develop special skills in how to collaborate and how to refer. Many tools are available, such as self-assessments and role-playing, but developing these skills is an ongoing process. The group chose to prioritize an interest in affective processes.

Recommendation:

1. *Collect best practices on teaching and assessment in the affective domain.*

4) Working with “Shadow Issues” Between Disciplines

In sponsoring dialogue between parties that have existed separately and in relative ignorance of each other, NED stimulated the expression of historic and present fears, prejudices and concerns each party has developed about the other. NED organizers began viewing this in the Jungian sense of outing, facing and embracing “shadow issues.” Will CAM providers weaken medical standards? Will conventional physicians “cherry pick” therapies from CAM providers but never value the separate disciplines? NED leaders hoped that the web of their prior years of collegial relationships on diverse projects would allow them to deepen this dialogue and enter into these difficult zones. How can NED admit more contentious issues into the room in order

“This is the first experience I’ve ever had with so many CAM and integrative practitioners in the same room on the same page. My professional life is based in the conventional world. While I do go to CAM meetings, they’re all MD-oriented, so this has been hugely educational for me.”

John Pan, MD
Director, Center for Integrative Medicine, George Washington University School of Medicine

“There’s an elephant in the room and it doesn’t fit on 3x5 cards, and it’s not going away on a list packed in our briefcases. NED as an organization, and all the organizations within NED, need to look responsibly at our own assumptions and beliefs.”

Karen Lawson, MD
Past President, American Holistic Medical Association

to establish a deeper understanding and a more secure foundation for collaboration? Phone meeting agendas included discussions of core “shadow” concerns. Side conversations entered tough areas. Humor helped.

At the NED meeting, time was allotted on the first day for participants to privately jot down their own sense of issues in the culture of their own institution, or that of the “other,” which might restrict development of quality inter-institutional relationships. These were circulated to all participants on the second day. Responses noted jealousies, turf battles and judgments—not only between CAM disciplines and conventional disciplines, but also between different CAM professions. All noted the lack of resources and time to pursue relationship building and institutional change. A small group chose to focus on shadow issues the final morning of the meeting.

Recommendation:

1. Consider a smaller meeting, perhaps under NED sponsorship, to specifically look at the often hidden emotional, cultural and economic barriers to integration in an effort to find strategies for overcoming them.

Assessment, Next Steps and Closing

Assessment

The onsite survey of NED meeting participants affirmed the priorities set by the NED planners. Roughly nine out of ten of respondents viewed each of the four core work areas—enhancing inter-institutional relationships, developing educational resources, clarifying shared values, and leadership development—as “very important” or “somewhat important” for advancing the future of integrated healthcare education. The face-to-face meeting was judged “highly valuable” by participants. Of respondents, 92% felt the meeting met their personal and institutional objectives in attending and 93% that the meeting met the NED’s stated goals. Nearly three-fourths said they would certainly, or very likely, attend a similar, future meeting.

Next Steps

NED planners and meeting participants affirmed the multi-year commitment required to fulfill on identified projects. On the final day, NED meeting participants considered the first-year business model and ideas about how to sustain this work between and across disciplines. The basic funding model for the \$150,000 budget, which carried the initiative through the first 15 months and three face-to-face meetings, consisted of the following:

“Our breakout group [at the NED meeting] felt that all the disciplines and institutions are working well together, but they want to do more. The problem is lack of funding. There’s not enough NIH funding for all the schools. We need more foundation money or private funding to get some of these collaboration projects in education started.”

Kory Ward-Cook, PhD
CEO, National Certification
Commission on Acupuncture
and Oriental Medicine

“The message is clear that NED can not just foster new relationships and provide educators with tools for change. We must also engage the more fundamental work of raising consciousness. We must elevate to core mission the preparation of students for participating in the kinds of team health care that will most benefit patients.”

John Weeks
Director, National
Education Dialogue

- *Significant initial funding from one private foundation (\$70,000), which anchored the work*
- *A match of smaller grants (\$2500–\$10,000) from a diverse set of 11 participant organizations and an additional significant foundation grant*
- *An unsustainably high level of volunteerism*

How can the NED mission, and the recommendations of the IOM report that NED reflects, be sustained? Some participants recommended an association model, with those educational institutions that value the work paying a membership fee. All acknowledged that to engage the significant projects identified by participants, NED will also require substantial investment from private foundations or public funds above and beyond anything the individual institutions could contribute.

NED participants have created a roadmap for NED’s future. Interest in additional meetings is strong. Yet final decisions about what can be accomplished in subsequent years will be fundamentally shaped by the availability of funding.

Recommendations:

1. *Continue to seek ongoing support from participant organizations.*
2. *Seek philanthropic partners for specific NED initiatives.*
3. *Underscore NED’s role as a vehicle to advance IOM recommendations.*
4. *Explore public funding options.*

Closing

A closing session among participants honored the meeting as historic in their individual and collective professional experience. Participants agreed that the most valuable aspect was the informal and small-group sharing of information and experience among educators from diverse disciplines who rarely have opportunities to work on shared educational issues face-to-face.

Closing comments of participants embodied the value in the NED vision and mission. The recommendations support an ongoing and expanded NED network as fertile ground for seeding and hosting diverse projects that will enhance the kind of integrated healthcare education and practice recommended by the report on CAM from the Institute of Medicine.

While NED’s future remains to be determined, NED planners continue to hold that “this great collaborative work,” to again quote the IOM’s report chair Stuart Bondurant, “is one of the most important things anyone can do to implement the [IOM] report.” That guiding document for health care in the United States urges us all toward a healthcare education system that will promote care that is comprehensive, patient-centered, evidence-based and cost-effective — the heart of the NED vision and work to *create common ground*.

“What changes people is proximity. Really getting to know each other is what changes attitudes and behavior. This really, in the long term, is the answer.”

Janet Kahn, PhD
Executive Director, Integrated
Healthcare Policy Consortium

“When I began my integrative medicine work at the university, they drew a circle and excluded me. So I drew a different circle and included them.”

Jeanne Drisko, MD, CNS
Program Director, Program in
Integrative Medicine, University
of Kansas Medical Center

Acknowledgements: Clement Bezold and William Rowley of the Institute for Alternative Futures provided essential assistance to the NED at a critical juncture. Thanks to Melanie Edwards, Raven Bonnar-Pizzorno, Elaine Zablocki, Joan Leach and the staff at the New York Beth Israel Center for Health and Healing for their distinct contributions to moving the NED forward.

Thank you: The NED benefitted from additional donations by the Council of Colleges of Acupuncture and Oriental Medicine; Seek the Frontier Clinicians Network; New York Beth Israel Center for Health and Healing; David O'Bryon, JD; Adi Haramati, PhD; and Synthia Molina.

Special thanks: The NED team extends an especially profound thank you to Lucy Gonda, whose vision and generosity helped birth and then sustain this work from early 2004 until the end of 2005.

Appendix 1

National Education Dialogue Process Elements

Out of respect for the cultural differences between the diverse disciplines involved, the NED has sought to follow inclusive processes. Some elements of this inclusion are noted here:

Development of the NED Planning Team

The core participants in the NED planning team were representatives of the Consortium of Academic Health Centers for Integrative Medicine (CAHCIM) and experienced leaders of key CAM education institutions. The group of conventional healthcare representatives was enhanced by including educators from public health, behavioral health, holistic nursing and holistic medicine. For CAM educator representatives, NED focused on those CAM disciplines that have succeeded in gaining federal recognition of their educational accrediting bodies (see ACCAHC below). This group was enhanced by adding a few representatives of CAM fields which do not have this level of self-regulation and formal recognition in the United States. The whole team was brought together under the direction of John Weeks, a long-time national leader in creating collaboration between the diverse parties to integrated health care.

Clarifying Vision, Mission, Goals and Deliverables for NED

The Vision, Mission, Goals and Deliverables of the NED process were drafted during a July 2004 retreat by a 14-member subset of the 25-member, multidisciplinary NED Planning Team. These were amended and then endorsed by the full NED team in September 2004.

Vision of Integrated Health Care

- NED envisions a healthcare 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.

Mission of the National Education Dialogue

- NED fosters new and continued development of innovative multi- and cross-disciplinary educational experiences, training and guidelines for all licensed healthcare practitioners, through a series of conferences on integrated healthcare education.
- NED supports participant efforts to be successful change agents within their respective communities by offering them appropriate tools and models.
- NED articulates a compelling blueprint for effective inter-institutional relationships that supports integrated healthcare education.

Goals of the June 2005 NED Meeting

1. Build on relevant common ground established by the NPD and WHCCAMP, as well as successful experiences in integrated education.
2. Offer networking opportunities to facilitate effective collaboration among NED participants and their organizations.

3. Create action plans based on common understanding of core issues in integrated education.
4. Assess the effect of the NED and related experiences on participants' knowledge, attitudes and activities regarding integrated healthcare education.

Deliverables for the June 2005 NED Meeting

Educational Guidelines

1. Establish both a process and commitments for developing a compatible set of core competencies and values across disciplines.
2. Create a process for distinguishing and describing portable, shared and adjunctive competencies.
3. Prepare and deliver a glossary to support the use of common language.

Enhancing Inter-Institutional Relationships and Mutual Support

4. Provide designated program time for exchange of information on successful programs and tactics in current working models of integrated healthcare education.
5. Collect and disseminate to participants samples of existing inter-institutional agreements and relationships that advance integrated healthcare education.
6. Offer designated program time on strategies of interdisciplinary teaching.

Ongoing Work

7. Complete a meeting report that includes agreed-upon positions and talking points for participants' use.
8. Create plans for continued communication among participants, including subsequent meetings.
9. Interweave the development of strategies and skills for fostering institutional change throughout the work.
10. Establish both a process and commitments for collaborating on fundraising to advance the work.

Project and Meeting Development

NED advanced projects through monthly phone conferences of typically 10–15 members of the whole team, and, through additional conferences as needed, of members of project-based working groups. The multidisciplinary working groups included two survey teams, and separate projects related to developing educational resources, creating shared definitions, exploring common values, skills and attitudes, and surveying educators on the extent of inter-institutional relationships.

Invitee Group

Develop recommendations for the June 2005 invitee list and consider changes to NED Planning Team make-up.

Mary Jo Kreitzer, RN, PhD
Adi Haramati, PhD
Linnea Larson, MSW, MFT
Paul Mittman, ND
John Weeks

Program Group

Digest diverse suggestions and shape the program.

Sheila Quinn
Pamela Snider, ND
John Weeks
Dale Lick, PhD
Adi Haramati, PhD
Linnea Larson, MSW, MFT
Adam Perlman, MD, MPH
Carole Ostendorf, PhD

Inter-Institutional Survey Group

*Develop and carry out Internet-based survey of accredited CAM schools and CAHCIM programs for baseline data on current inter-institutional and interdisciplinary relationships/best practices.**

Ben Kligler, MD, MPH
Michael Goldstein, PhD
Yi Qiao, LAc, MPH
John Weeks
Adam Perlman, MD, MPH
Karen Lawson, MD
Pamela Snider, ND
Adi Haramati, PhD
David O'Bryon, JD

*Thanks to CAHCIM and ACCAHC members for their work in promoting participation from their respective disciplines. *Note:* New York Beth Israel-Continuum Health loaned research services to support this research project.

Facilitator Selection Group

Solicit nominations for facilitators, develop and carry out selection process.

Linnea Larson, MSW, MFT
Sheila Quinn
John Weeks

Values, Knowledge, Skills and Attitudes Task Force

Develop working draft of a document which described shared values knowledge, skills and attitudes for all healthcare profession students

Carla Mariano, RN, PhD, Chair
Michael Goldstein, PhD
Ben Kligler, MD, MPH
Karen Lawson, MD
David O'Bryon, JD
Dawn Schmidt, LMP
Pamela Snider, ND
Don Warren, ND, DHANP
John Weeks
Note: Mark Seem, LAc, was also a contributor.

ACCAHC-NED Glossary and Terms Task Force

Work with NPD definitions, disciplines' definitions, and other sources toward shared glossary of terms. Most work in ACCAHC.

Jan Schwartz, LMT, Chair
Morgan Martin ND, LM
Dawn Schmidt, LMP
Victor Sierpina, MD (NED)
Pamela Snider ND
(Also: David O' Bryon, JD;
Liza Goldblatt PhD, MPA/HA;
Catherine Niemiec JD, LAc)

ACCAHC/OCCIM Task Force on Response to CAHCIM Article

Develop, working with an Oregon Collaborative for Complementary and Integrative Medicine (OCCIM) team, a formal and proactive response to the CAHCIM-endorsed article on core competencies in integrative medicine published in the June 2004 Academic Medicine.

Reed Phillips, DC, PhD, Chair
Patricia Benjamin, PhD, LMT
Morgan Martin ND, LM
Don Warren, ND, DHANP
Suzanne Nelson Myer, RD, MS, CD
Catherine Niemiec, JD, LAc
Sonia Ochoa, MD (Mexico)
David O' Bryon JD
Pamela Snider, ND
John Weeks

Group associated with OCCIM and the integrative medicine work at Oregon Health Sciences University (OHSU).

Richard Barrett, ND
Tim Chapman, PhD
Richard Hammerschlag, PhD.
Mitch Haas, DC, MA
Robert T. Kaneko, LAc
David H Peterson, DC
Catherine Salvesson, RN, PhD
Anne Nedrow, MD

ACCAHC-NED Educational Resources and Curriculum Task Force

Develop a model template for collaboratively developed educational resources and curriculum models for integrated health care. Began in ACCAHC.

Liza Goldblatt, PhD, MPA/HA, Co-Chair
Dan Seitz, JD, Co-Chair
Frank Zolli, DC
David O' Bryon JD
Adam Perlman, MPH, MD
Pamela Snider ND
Don Warren ND
John Weeks

The teams below have begun work but not yet realized work product.

Federal Grant/HRSA-AHRQ Team

Explore potential of federal government funding of NED activity, in particular HRSA programs.

David O'Bryon, JD
Pamela Snider, ND
John Weeks
Adam Perlman, MD, MPH
Adi Haramati, PhD

Multidisciplinary CME/CEU Project Group

Viewed as a second-year project which could be kicked-off in a session at NED June 2005.

Scott Shannon, MD, Initiator
Pamela Snider, ND
Liza Goldblatt, PhD, MPA/HA
Sheila Quinn
Linnea Larson, MSW, MFT

Clarifying the CAM Educator Role in the NED: A New CAM Consortium

To manage and clarify the issues at stake in the broader dialogue, NED developed a separate but interlinked consortium of CAM educators and institutions. The core membership includes representatives of the councils of colleges and federally recognized accrediting agencies of the leading CAM professions (chiropractic, massage therapy, naturopathic medicine, acupuncture and Oriental medicine, and direct-entry midwifery). This 20-member group, the Academic Consortium for Complementary and Alternative Health Care (ACCAHC), offers a forum for CAM academic institutional leaders and educators across CAM disciplines. ACCAHC leaders met in retreat at Southern California University of Health Sciences in February 2005 to clarify its future and its role in the NED process (see Member List below). A subset of ACCAHC members is also part of the NED Planning Team. Typically, task forces have included representatives of both ACCAHC and the NED Planning Team. The team was organized and is directed by Pamela Snider, ND, a national leader in integrative healthcare education, policy who has taken a lead in numerous initiatives to strengthen understanding and collaboration between the disciplines.

Academic Consortium for Complementary and Alternative Health Care (ACCAHC) Member List

Acupuncture and Oriental Medicine

ELIZABETH GOLDBLATT, PhD
Past President, Council of Colleges of
Acupuncture and Oriental Medicine;
Provost, American College of Traditional
Chinese Medicine

LIXIN HUANG, MS
President, Council of College of Acupuncture
and Oriental Medicine; President, American
College of Traditional Chinese Medicine

CATHERINE NIEMIEC, JD, LAC
Vice President, Council of Colleges of
Acupuncture and Oriental Medicine;
President and Founder, Phoenix Institute of
Herbal Medicine and Acupuncture

YI QIAO, MPH, LAC
Member, Accreditation Commission for
Acupuncture and Oriental Medicine; Clinic
Director, Emperor's College of Traditional
Oriental Medicine

Chiropractic Medicine

FRANK ZOLLI, DC, EDD
President, Association of Chiropractic
Colleges; Dean, University of Bridgeport
College of Chiropractic

DAVID O'BRYON, JD
Executive Director, Association of
Chiropractic Colleges; Chair, IHPC
Education Task Force

Massage Therapy

JAN SCHWARTZ, LMT
Immediate Past Chair, Commission on
Massage Therapy Accreditation; Vice
President for Education, Cortiva
Education, Inc.

DAWN SCHMIDT, LMP
Secretary, Commission on Massage Therapy
Accreditation; Director of Education,
Brenneke School of Massage

CYNTHIA RIBEIRO, LMT
Representative, Council of Colleges, American
Massage Therapy Association; Founder,
Western Institute of Neuromuscular Therapy

PATRICIA BENJAMIN, PHD, LMT
Member, ACCAHC/Oregon Collaborative
for Complementary and Integrative Medicine
Task Force

Midwifery-Direct Entry

MORGAN MARTIN, ND, LM
Chair, Naturopathic Midwifery Program,
Bastyr University

SONIA OCHOA, MD (MEXICO)
Board Member, Midwifery Education
Accreditation Commission

Naturopathic Medicine

PAUL MITTMAN, ND
President, American Association of
Naturopathic Medical Colleges; President,
Southwest College of Naturopathic Medicine

DON WARREN, ND, DHANP
President, Council on Naturopathic
Medical Education; Owner, Centerpoint
Naturopathic Clinic

DAN SEITZ, JD
Executive Director, Council on
Naturopathic Medical Education; Past
Chair, Accreditation Commission for
Acupuncture and Oriental Medicine

Interdisciplinary CAM Universities

REED PHILLIPS, DC, PHD
Past President, Council on Chiropractic
Education and Association of Chiropractic
Colleges; President, Southern California
University of Health Sciences

Subcommittee on Emerging Professions, Traditional Medicines and Modalities

VIVEK SHANBHAG, ND (MD, AYUR-INDIA)
Director, Ayurvedic Academy & Natural
Medicine Clinic

CAM and Conventional Academic Medical University Partnerships/ International

STEPHEN MYERS, ND, MD, PHD
Director, Australian Center for
Complementary Medicine Education and
Research, University of Queensland and
Southern Cross University Collaborative
Department

Other/Staff

PAMELA SNIDER, ND
Executive Director, Academic Consortium for
Complementary and Alternative Health Care;
Vice President, Board of Directors, Integrated
Healthcare Policy Consortium

JOHN WEEKS
Director, National Education Dialogue;
Executive Advisor, Lucy Gonda Foundations

Appendix 2

The Status of Inter-Institutional Relationships between CAM Disciplines and Conventional Integrative Medicine Programs

Task Force: Ben Kligler, MD, MPH; Michael Goldstein, PhD; Yi Qiao, LAc, MPH; John Weeks; Adam Perlman, MD, MPH; Karen Lawson, MD; Pamela Snider, ND; Adi Haramati, PhD; David O'Bryon, JD

The following were among the findings of a NED Internet-based survey of leaders of 158 institutions and programs. This included leaders of 28 integrative medicine programs in conventional academic health care and 130 leaders of accredited CAM programs. The survey was assisted by a loan of research staff from the New York Beth Israel Center for Health and Healing. *Note:* Numbers in parenthesis () represent total respondents.

Extent of Formal Classroom and Clinical Relationships

CAM Program/Institutions: To the best of your knowledge, note whether your program has any formal classroom or formal clinical connection with any of the following types of programs.

	CAM ALL		Acupuncture		Chiropractic		Massage		Midwifery (Direct-Entry)		Naturopathic Medicine	
	Class	Clinic	Class	Clinic	Class	Clinic	Class	Clinic	Class	Clinic	Class	Clinic
Conventional Medicine	34% (26)	39% (30)	35% (7)	45% (9)	50% (8)	50% (8)	28% (8)	35% (10)	30% (3)	30% (3)	0%	0%
Nursing	28% (22)	23% (18)	30% (6)	25% (5)	37% (6)	31% (5)	21% (6)	17% (5)	30% (3)	30% (3)	0%	0%

CAHCIM Programs: To the best of your knowledge, note whether your program has any formal classroom or formal clinical connection with any of the following types of programs.

	Formal Classroom	Formal clinical
Chiropractic colleges	12% (3)	8% (2)
Acupuncture schools	32% (8)	16% (4)
Naturopathic medical schools	8% (2)	4% (1)
Massage Therapy programs	20% (5)	20% (5)
Direct-Entry Midwifery programs	15% (4)	12% (3)

Issues of Perception and Experience

Respondents rate where they strongly agree (SA), agree (A), disagree, or strongly disagree with the following statements.

1. Creating a fully integrated healthcare system will require that programs like ours **develop stronger, multidimensional, inter-institutional relationships** with conventional academic institutions and programs [in the question to the CAM respondents] the independent CAM institutions [for the CAHCIM respondents].

CAHCIM		CAM ALL		Acupuncture		Chiropractic		Massage		Midwifery (Direct-Entry)		Naturopathic Medicine	
SA	A	SA	A	SA	A	SA	A	SA	A	SA	A	SA	A
44% (12)	41% (11)	49% (37)	37% (28)	50% (9)	39% (7)	67% (10)	13% (2)	31% (8)	50% (13)	0% (0)	33% (3)	75% (3)	25% (1)

2. The conventional academic institutions and programs [in the question to the CAM respondents] the independent CAM institutions [for the CAHCIM respondents] in our region/area **would be interested in partnering** with our institution on integrated healthcare projects.

CAHCIM		CAM ALL		Acupuncture		Chiropractic		Massage		Midwifery (Direct-Entry)		Naturopathic Medicine	
SA	A	SA	A	SA	A	SA	A	SA	A	SA	A	SA	A
40% (10)	40% (10)	7% (5)	63% (47)	0% (0)	89% (16)	13% (2)	53% (8)	13% (2)	62% (16)	0% (0)	33% (3)	25% (1)	50% (2)

3. The **availability of additional funding is vital** if institutions like mine are to explore the benefits of greater collaboration with conventional academic schools and programs [in the question to the CAM respondents] the independent CAM institutions [for the CAHCIM respondents]

CAHCIM		CAM ALL		Acupuncture		Chiropractic		Massage		Midwifery (Direct-Entry)		Naturopathic Medicine	
SA	A	SA	A	SA	A	SA	A	SA	A	SA	A	SA	A
73% (19)	23% (6)	59% (45)	34% (26)	74% (14)	26% (5)	53% (8)	40% (6)	54% (14)	35% (9)	56% (5)	44% (4)	75% (3)	0% (0)

4. **Opposition within my institution** has prevented our institution/program from pursuing more institutional relationships with conventional academic schools and programs [in the question to the CAM respondents] the independent CAM institutions [for the CAHCIM respondents]

CAHCIM		CAM ALL		Acupuncture		Chiropractic		Massage		Midwifery (Direct-Entry)		Naturopathic Medicine	
SA	A	SA	A	SA	A	SA	A	SA	A	SA	A	SA	A
8% (2)	15% (4)	1% (1)	9% (7)	50% (9)	16% (3)	0%	13%	4% (1)	4% (1)	0%	0%	0%	25%

Most Useful Resources to Help You Optimize Inter-institutional Relationships

Please note which of the following would be useful to you in establishing or developing optimal relationships with conventional academic schools and programs [in the question to the CAM respondents] the independent CAM institutions [for the CAHCIM respondents]

	CAHCIM	CAM ALL	Acupuncture	Chiropractic	Massage	Midwifery (Direct-Entry)	Naturopathic Medicine
Written materials on best practices of other institutions	73.1%	76.3%	60%	75%	76%	60%	75%
Opportunity to participate in conference calls or telephone-based presentations on this subject	15.4%	38.2%	40%	31%	38%	10%	75%
Examples of formal collaborative agreements between CAM educational institutions and conventional academic medical centers/ delivery organizations	73.1%	76.8%	70%	81%	86%	70%	100%
Conference/meeting which focused on current best practices in inter-institutional relationships	61.5%	73.7%	70%	69%	66%	60%	75%
Strategies in developing internal institutional support for such collaboration	57.7%	69.7%	75%	69%	66%	40%	50%
Special funding targeting these purposes	88.5%	78.9%	80%	63%	72%	80%	75%

Appendix 3

Inter-Institutional and Interdisciplinary Relationships Explored at the NED Meeting

The onsite NED meeting included presentations that looked at both collaborations on curriculum development and more general inter-institutional relationships between distinct disciplines and educational organizations. The table is meant to provide a shorthand look at both the variety and depth of current leading projects in this area. In a few instances in the table—Georgetown, Oregon Health Sciences University and University of Minnesota—the program included presentations with partner institutions. In these cases, the linked presentations are captured (and shaded) side-by-side.

Program or Institution	Presenter	Other Institutions and/or Disciplines Involved	Characteristics
Association of Chiropractic Colleges	Frank Zolli, DC, PhD, President	US Veterans Admin. and affiliated medical schools	<ul style="list-style-type: none"> • Congress passed legislation in 2001 to explore inclusion of chiropractic in the Veterans Administration services. With the VA's relationships with medical schools, the VA could be a model site for exploring integrated care. • Took a lengthy process to get the first chiropractor appointed, in 2005. Some chiropractic colleges are beginning affiliation agreements to have their interns work in the hospitals. Considered "a great way to have our interns work with conventional medical interns."
Australian Centre for Complementary Medicine Education and Research	Stephen P. Myers, BMed, ND, PhD, Director	Southern Cross University (naturopathic medicine) University of Queensland (conventional medicine)	<ul style="list-style-type: none"> • Practitioners of all sorts have fundamental right to practice under Australian law, so the context is quite different. • The Centre is a true "joint center" with both institutions providing equal shares of funds for a \$3 million start-up total. University of Queensland is one Australia's oldest and most prestigious universities and Southern Cross the first publicly funded, university-based program in naturopathic medicine in Australia. • Goal is to be a center of excellence for post-graduates, research training and education. Currently 18 post-graduate students are doing research spread across both institutions. • Significant, multidimensional research agenda includes laboratory science, surveys, social research and clinical trials. • Myers holds a chair of complementary medicine across schools of medicine, dentistry, pharmacy, nursing, rehabilitation science (which includes occupational therapy, physiotherapy and speech pathology), and population health (which includes epidemiology, tropical medicine and nutrition). • Both schools have adjunct faculty at the other.
Georgetown University School of Medicine	Aviad Haramati, PhD, Director of Education, Department of Physiology and Biophysics	Potomac Massage Training Institute	<ul style="list-style-type: none"> • Developed under an R-25 NIH NCCAM grant to Georgetown University to give information on CAM therapies to medical students, and develop a peer relationship to clarify roles in an integrated care relationship. • Haramati, PI on the R-25 grant, reflected on the nature and assumptions of the initiative. • Strategically used the school's accreditation self-study process as a way to show the alignment with the school's core mission of caring for the whole person as set by Georgetown's Jesuit founders. • The program is a starting place in a step-wise movement toward deeper integration. Focus has been on what was achievable, rather than a comprehensive program. • Approached the process as not about CAM but as a step in fostering caring and altruistic attitudes in his medical students. Bringing massage therapists in was a way of quietly instilling these values more deeply.

Potomac Massage Training Institute	Cathy Ayers, LMT, Director of Education, PMTI	Georgetown University School of Medicine	<ul style="list-style-type: none"> • PMTI students meet medical students in gross anatomy lab (1.5 hours). Discover MD student strength in identifying structures, massage student strength in palpating structures. • Georgetown students visit PMTI to gain experience of massage and education in application and techniques (4 hours). • Massage students gain in self-confidence, help develop a common language. • Other outcomes: PMTI has expanded curriculum hours in muscular skeletal pathology, body systems pathology and medical terminology. PMTI has also formed a research department. • Challenges: Getting medical students to participate in one-to-one relationships; also, the course is first-year and there is no follow-up.
Muscular Therapy Institute	Mary Ann DiRoberts, MSW, MEd, Executive Director	Harvard University Medical School/Osher Institute Tufts University School of Medicine	<ul style="list-style-type: none"> • Consulted on various research studies with Osher researchers. • Created and taught a 30-hour, hands-on massage therapy course for Osher research fellows. Goals were to spark interest in researching massage therapy, increase understanding of field, and provide an opportunity to perform massage to increase their understanding. • Tufts family practice residents have a half-day at MTI, which is didactic and experiential. MTI also participates in a family medicine clerkship in CAM. • Work is underway with Tufts to start an MTI graduate clinician in a family practice health center for service to low-income patients. • Strength in working with physicians is clearly in the hands-on training and less in the didactic training. A problem with school-to-school exchange is that the medical students get the experience of student massage, which hasn't the clinical focus or developed skill of a seasoned professional. • Often in inter-institutional exchanges, massage is represented by a dual professional (a researcher trained in massage), rather than a deeply skilled clinical faculty member who may not have the language or temperament for the cross-cultural pressures. • Also working with Boston University's Department of Family Medicine to make massage available to low income patients.
New England School of Acupuncture	Peter Wayne, PhD, Director of Research	Harvard University Medical School Tufts University School of Medicine	<ul style="list-style-type: none"> • Began building relationships following the establishment of a research arm in 2000. Aim is to conduct East Asian medicine research that meets the highest standards of science but at the same time maintains the integrity of traditional practices. • Wayne is principal investigator on a NIH-funded acupuncture research collaborative, the first devoted to East Asian medicine. • Involved with 10 clinical trials (8 NIH-funded) with collaborations from both Harvard and Tufts-affiliated teaching hospitals. • Creating a cadre of acupuncturists who are skilled and equipped in the language and practice of research, to participate in integrated • Emphasized the need for CAM practitioners to improve research and evidence-based medicine literacy in order to effectively participate in dialogue. Noted that while many CAM practitioner colleagues appreciate the limitations of randomized controlled trials in capturing a holistic healing experience, few have the vocabulary or basic knowledge to coherently articulate this stance

(continued)

<p>Oregon Health Sciences University (OHSU)</p> <p>Oregon Collaborative for Comp. and Integrative Medicine (OCCIM)</p>	<p>Anne Nedrow, MD, Education Director</p>	<p>National College of Naturopathic Medicine</p> <p>Oregon College of Oriental Medicine</p> <p>Western States Chiropractic College</p> <p>Note: OHSU and these three are the OCCIM partner schools.</p>	<ul style="list-style-type: none"> • R-25 funded projects from the NIH were developed based on pre-existing relationships between personnel at the four Portland, Oregon-based schools. Quickly found a strong community of partners among the four institutions. Relationships have endured despite transitions in institutional and department leadership at all four schools. • Internal challenges in locating the program in a department and finding the people internally who are both leaders and passionate about the integrative field. Also found philosophic differences inside OHSU—some who saw integration as coming through other distinct CAM disciplines; others who viewed it as a build-out of family medicine, an MD acquiring new skills. • Views the key as establishing from the beginning a lateral relationship between all four schools in all of the three dimensions of the relationship -- research, education and clinical. • Developed a formal contract between all the schools on a shared development of an online CME course on CAM, which now has 30 hours and has been taken by diverse groups of medical professionals. • Integrated clinical training program includes a Chinese medicine doctoral student, a naturopathic resident and a faculty member from the chiropractic school. These are all on OHSU faculty as employees at assistant professor level. • Positive developments came despite early restrictions against credentialing CAM providers and against any publicity that suggested to the public that OHSU had partnered with the CAM schools. • Has also sought to include a local massage school in various projects. The school has been involved with a number of research projects. • Notes the significant difference in working with CAM practitioners who are educators rather than merely community practitioners. The language and mission of education is already a shared basis for collaboration.
<p>National College of Naturopathic Medicine</p>	<p>Richard Barrett, ND, Professor</p>	<p>Other OCCIM partner schools</p>	<ul style="list-style-type: none"> • A component of the program viewed as especially beneficial is a grand rounds with representatives from each discipline/institution, plus a mind-body person. Presentation moves from institution to institution, and draws students from each. • Grand rounds has spun off research collaborations through relationships developed through the educational sessions. • Concerns of NCNM faculty were allayed by noting that the goal of the OHSU grant is not to create CAM practitioners who are competent in these therapies but to create “CAM literacy” among conventional practitioners.
<p>Oregon College of Oriental Medicine</p>	<p>Robert Kaneko, LAc, Dean of Clinics</p>	<p>Other OCCIM partner schools</p>	<ul style="list-style-type: none"> • Includes a formal contract under which OCOM students have access to a variety of educational experiences at OHSU. • One of the big issues at OCOM has been integrating all of the pieces—research with curriculum, getting students on board, letting them know what’s going on, and then training faculty for their role as ambassadors.
<p>Western States Chiropractic College</p>	<p>David Peterson, DC, Professor of Chiropractic Sciences</p>	<p>Other OCCIM partner schools</p>	<ul style="list-style-type: none"> • WSCC has had over 10 research projects with OHSU. • The success of the grant is based on the relationships developed (including earlier HRSA grants involving WSCC and OHSU) and Nedrow’s leadership inside OHSU. • An interesting by-product of the grant was that the distinct CAM schools got to know each other more as CAM schools and began to realize they weren’t communicating in ways that could be beneficial. • A good next step would be to involve more of the faculty and administration who are critical of CAM in the processes. Perhaps move the grand rounds from voluntary to required.
<p>Southwest College of Naturopathic Medicine</p>	<p>Paul Mittman, ND, President</p>	<p>Community clinics and hospitals; possible shared residencies</p>	<ul style="list-style-type: none"> • Many CAM educational institutions are providing care through community medicine centers that serve the underserved. Many have medical school affiliations and can be good places to more formally explore integrated treatment. • Work with community health is supported by the need for care, the openness among administrators and frequently the cultural openness to natural healthcare practices among the populations served. • Affiliation with the local community health center association has been especially helpful in developing the relationships and facilitating provision of care. • One challenge is in the formulary issues in community health centers where they might not have any natural medicines.

<p>University of Kansas School of Medicine</p>	<p>Jeanne Drisko, MD, CNS, Director of Integrative Medicine</p>	<p>Naturopathic medicine Community CAM providers</p>	<ul style="list-style-type: none"> • Begun seven years ago. Initiative originally turned down by family medicine, later located in OB-Gyn with a supportive chair. • Research projects brought interest and support of various department heads. • Clinical credentials granted as “integrative/functional medicine” doctor after five years. Has an infusion clinic for “functional medicine” interventions. • Naturopathic physician credentialed five months later. Has clinical, research and educational responsibilities. • Students from diverse departments (nursing, nutrition, medicine) have been given experiential rotations.
<p>University of Minnesota Center for Spirituality and Healing</p>	<p>Mary Jo Kreitzer, PhD, RN, Director Karen Lawson, MD, Director, Integrative Clinical Services</p>	<p>Northwestern Health Sciences University (chiropractic, acupuncture, other natural health care) Five Mountain Medical Community</p>	<ul style="list-style-type: none"> • Work has been supported by an R-25 grant from NIH NCCAM. • Kreitzer sought strong relationships with CAM community for purposes of both creating both “competence and credibility.” • Interdisciplinary and inter-institutional relationships are developed through networking informal relationships, but without formal inter-institutional agreements, particularly with Northwestern. • All first-year U Minn. medical school students go to Northwestern for a half-day immersion course in traditional Chinese medicine. A later 2-hour course has chiropractors come to U Minn. to give medical students an experience of manual therapies. This is the most highly rated course in the medical school. • Collaborations based less on geography than “values, interests and synergy.” • An additional value of the relationship is joint advocacy in the community. Examples are jointly organizing meetings with federal policy makers, and with local insurers, on CAM and IM issues. • Recent spin-off is the development of a CAM program focus for graduate students in the School of Public Health.
<p>Northwestern Health Sciences University (chiropractic, acupuncture, other natural health care)</p>	<p>Chuck Sawyer, DC, Provost</p>	<p>Minnesota Center for Spirituality and Healing (conventional medicine)</p>	<ul style="list-style-type: none"> • NHSU is located near the University of Minnesota, facilitating movement between the two schools. • After years of professional antagonism, this is a “sea change in attitudes and interests and relationships.” • No obstacles between us other than the usual ones, “time and money.” • Views this beginning as establishing a basis for moving into deeper relationships relative to models for integrating care better in the third-party payer context.
<p>Five Mountain Medical Community (community medicine)</p>	<p>Michael Traub, ND, Faculty</p>	<p>Minnesota Center for Spirituality and Healing</p>	<ul style="list-style-type: none"> • U Minnesota has two rotations here. One a three-week rotation that’s an immersion in integrative medicine, the other is a five-week rotation in public health. These are shaped by formal agreements. • The adjunct community faculty includes integrative medical doctors, three naturopathic physicians, two nurses, an osteopathic physician, two acupuncturists, a massage therapist, a cranial-sacral therapist, and a traditional Hawaiian healer. • Students are also introduced to cross-cultural issues in healing and care delivery through immersion, including living with the families. • Focus is not about CAM but immersion in “integrative healing.” • Single most important factor in the development of the programs has been the network of individual relationships. • Agreement was made not with North Hawaii Community Hospital, but with Five Mountain (of which North Hawaii is part) because of certain liability elements which were thereby avoided.
<p>University of Washington School of Medicine</p>	<p>Ron Schneeweiss, MD, Professor of Family Medicine, Principal Investigator on NIH R-25 CAM curriculum grant</p>	<p>Bastyr University (naturopathic medicine, acupuncture, other CAM)</p>	<ul style="list-style-type: none"> • Program has a responsibility to the four-state Washington, Alaska, Montana, Idaho (WAMI) region. Bastyr faculty served on grant committee and have consulted in program development. • Program, supported by an NIH NCCAM R-25 education grant, focuses on integrating CAM curriculum into pre-clinical, required courses and the provision of clinical electives. Interest found among 350 faculty, and keen interest among 200. Developed CAM cases that have been incorporated into the Objective Structured Clinical Exam (OSCE) given to medical students. • A mind-body skills elective is one of the few places where nursing and medicine are integrated. • Special focus on integrating student populations from the two institutions, including a quarterly gathering. • Started with education, but realizes that research initiatives and clinical sites are key to binding the initiative to the medical school. • Privileging of CAM practitioners is challenging. • Key issue now is sustainability, especially as the R-25 grant runs out..

Appendix 4

Inter-Institutional Agreements Shared by NED Participants

NED participants and respondents to the pre-meeting, inter-institutional survey indicated that seeing sample inter-institutional agreements would be useful. The following were volunteered and made available to participants. These agreements are available on request from John Weeks at nedcommonground@yahoo.com.

- Bastyr Center for Natural Health-Valley Medical Center Agreement Regarding Training of a [Conventional Medical] Resident in a Non-Hospital Setting
- Remote Training Site Operating Agreement—Community Health Centers of King County and Bastyr University
- Bastyr University Template: External Clinic Operating Agreement between Host Clinic Site and Bastyr University
- Memorandum of Understanding (between Oregon Health Sciences University, National College of Naturopathic Medicine, Oregon College of Oriental Medicine and Western States College of Chiropractic) on Electronic Curriculum Development—Oregon Collaborative for Complementary and Integrative Medicine (OCCIM)
- Resolution (between Oregon Health Sciences University, National College of Naturopathic Medicine, Oregon College of Oriental Medicine and Western States College of Chiropractic) regarding the Oregon Collaborative for Complementary and Integrative Medicine (OCCIM)
- Affiliation Agreement for Education between Oregon Health and Science University, University Hospital and Clinics and Oregon College of Oriental Medicine
- Clinical Affiliation Agreement between Sojourner Center and Southwest College of Naturopathic Medicine and Health Sciences
- Agreement of Institutional and Program Affiliation between the Regents of the University of Minnesota and Five Mountain Hawaii, Inc. (for educational and training purposes, including an integrative medicine rotation)

Appendix 5

Model Outline for Educational Resources to Enhance Delivery of Collaborative Health Care

Task Force: Liza Goldblatt, PhD, MPA/HA, Co-Chair; Dan Seitz, JD, Co-Chair; Frank Zolli, DC; David O' Bryon JD; Adam Perlman, MPH, MD; Pamela Snider, ND; Don Warren, ND; John Weeks

National Education Dialogue Program Goals:

- Endorse the value in development of resources which help us better understand each other.
 - Identify a range of potential educational resources about healthcare disciplines, including a model survey course curriculum and a list of individuals with expertise in curriculum development.
 - Define practical uses of such resources (book, website, course materials, curriculum guidelines, syllabi, etc.) and potential audiences.
 - Have NED and involved healthcare professions commit to collaborative work on these resources in 2005–2006.
-

Introduction and Overview

Practitioners of one healthcare system cannot effectively collaborate with practitioners of other systems unless they possess knowledge and understanding about the various healthcare disciplines that exist. The more knowledgeable a healthcare practitioner is about other disciplines, the more effectively he or she will be able to collaborate, as well as assist patients who are accessing multiple healthcare treatments. Well-developed resources that aid this type of knowledge and collaboration will facilitate quality patient care. A well-formulated survey course, or set of courses, would provide an important basis for encouraging collaboration in order to better serve patients.

We recognize the challenges that all educational programs—including programs in conventional as well as complementary and alternative medicine—have in incorporating new content. However, if healthcare students from various disciplines were to take similar, collaboratively developed survey courses as part of their required didactic education, they would have a foundation for collaborating more easily with one another. Training together as interns in integrative care settings would further enhance future collaboration. This project provides a practical step in this direction by bringing together the leading disciplines with an interest in effective integration to create quality educational and curriculum materials, which each can shape for use inside their separate disciplines and institutions.

Reasons for a Model Survey Course Curriculum on Disciplines

Why should every healthcare student, regardless of his or her field, learn how to converse and collaborate effectively across disciplines? Students educated in this way enhance their abilities to:

- Discuss with patients treatments they may already be receiving from other healthcare practitioners.
- Discuss with patients healthcare options outside of the practitioner's own field.
- Communicate about cases with practitioners of diverse disciplines.
- Understand the range of healthcare disciplines in the U.S.
- Cross-refer patients to practitioners of other healthcare fields.
- Develop openness to other medical cultures and paradigms.
- Understand the mind-body-spirit connection in health care.
- Work in collaborative healthcare settings and on collaborative research projects.

Often the best healthcare plan involves a combination of treatments provided by diverse practitioners from various disciplines. A multidimensional approach to health care that includes expertise from across disciplines may be the most beneficial to many patients.

Collaboration: Resources, Guidelines, Text and Syllabi

We propose the development of resources that would provide information on disciplines for all healthcare educators. The information, produced in a printed form, would allow educators or healthcare students to extract information as necessary and could be offered to students as part of a professional program's core curriculum or as electives. Additionally, the information could be provided to practicing professionals as continuing education, whether in classroom settings or online.

We recognize that many healthcare educational programs face curriculum constraints, and there are always more skills to teach and useful information to provide than time allows. The amount of education a program can offer concerning other healthcare disciplines will necessarily vary, based on the institutional mission, the requirements of accrediting bodies and testing agencies, faculty perspectives and other factors. Despite the challenges of working new information into an established curriculum, we believe that a survey course introducing students to a single healthcare discipline (e.g., naturopathic medicine) should be, at a minimum, two or three credits in length (30 or 45 contact hours). This would respect the depth and breadth of the discipline and be sufficient to enable collaboration at a beginning level. If a more immediate goal is to simply introduce students to the various healthcare systems in the U.S., a single three-credit survey course covering a number of systems might suffice. Given that there are cultural and curriculum challenges involved in thoroughly integrating new material into existing programs, other avenues to explore are certificate courses and leadership education for exceptional students.

Elements of a Collaborative Curriculum

We envision that educators within each healthcare discipline would develop a model syllabus based on the outline drafted below. These syllabi would also cover recommended bibliographies, including current journals, and relevant research articles. Because the success of this endeavor rests, like all education, on the qualifications and abilities of faculty members, the materials developed would also include recommended faculty qualifications. Ideally, the faculty member best suited to present material on a specific topic would combine a license and practice experience in his or her field with enough understanding to convey concepts in a language familiar to the listener. For example, a faculty member teaching about acupuncture to medical students would be an experienced, licensed acupuncturist well-versed in conventional medicine.

Possible Topics for a Model Syllabus

Each survey course or resource on a given discipline could potentially include the following topics and activities:

Topics

- History and current status of the field
- Credentialing in the field: educational training requirements (hours/credits), accreditation and certification processes, professional licensure, etc.
- Scope of practice and competencies of trained practitioners
- Basic philosophy about health and healing/core values of the discipline
- Basic theory of the discipline and understanding of its unique terminology (glossary)
- Strengths and limitations of the healthcare system in preventing and treating conditions, and promoting health
- Introduction to research in the field, including a bibliography of research literature, evidence-based material, cultural issues which may restrict or enhance research, and current status of the research effort
- Co-management and referral strategies

Activities and Educational Formats

- Panel discussions on conditions, with two or more fields represented, regarding how each discipline approaches specific cases (“best practices,” strengths/weaknesses, working alone, working collaboratively)
- Lecture and case demonstrations
- Students directly experiencing different forms of health care (such as receiving acupuncture and Oriental medicine treatments, chiropractic adjustments, nutrition and diet assessments, massage therapy and treatments in naturopathic and osteopathic medicine) or observing practices (such as direct-entry midwifery [natural childbirth] evaluation and management)
- Joint case discussions in which specific cases are presented from the perspectives of a variety of disciplines
- Grand rounds-type observations in clinics
- Learning a few “simple” techniques that can be incorporated into self-care
- Examples of how to work collaboratively and/or refer to another healthcare provider

In addition to the ideas presented thus far, we believe it is important that healthcare programs include information on public health, mental health and environmental medicine. Another important subject matter to be aware of is emerging healthcare disciplines.

This survey curriculum on healthcare systems and practices would serve as a foundation for, and companion piece to, a related set of educational resources that specifically provide students of healthcare professions with knowledge and skills that enhance their practical abilities to operate collaboratively in an integrated care environment. We believe that these educational resources begin to address the gap in educational, accrediting and testing standards developed at a time when many of these disciplines operated in relative isolation from one another.

Discussion Questions for NED

- Are there other elements that should be included in a survey course curriculum that trains students for successful collaboration in integrated health care? Should some elements in the model curriculum above be taken out? What competencies would we like collaborative healthcare students to develop?
- What are the shortcomings of existing survey courses in healthcare programs? Is there value in offering a curriculum on healthcare collaboration in which all relevant disciplines agree on core elements of the content?
- What do we need to know about each other's disciplines to best work together?
- If one discipline teaches about the other, who determines the content and who presents the content? Who should be involved?
- What is the case for collaboration? How do we know that medical care will be improved by collaboration? Are there different levels or types of collaboration?
- What are the communication, collaboration and leadership skills involved in sharing patient care with other practitioners? Are there other examples of multidisciplinary collaboration we can learn from?
- Are there considerations regarding insurance, payment, record keeping, management and liability that need to be discussed?
- What do we know about the value of differing models of integrated care delivery?
- Are there specific issues or problems that practitioners who work in collaborative clinics face routinely? Have differing medical paradigms posed unique challenges to collaboration?
- What leadership skills do individuals need to implement new healthcare models in environments that may be unreceptive? Should leadership training be a specific component of training?
- If collaborative educational resources are deemed useful by the participants of NED, what are the next logical steps in developing these resources?

Appendix 6

Draft Glossary of CAM Disciplines Terms

Task Force: Jan Schwartz, LMT, Chair; Morgan Martin, ND, LM; Dawn Schmidt, LMP; Victor Sierpina, MD (NED); David O' Bryon, JD; Liza Goldblatt, PhD, MPA/HA; Catherine Niemiec, JD, LAc; Pamela Snider, ND

This glossary was developed through the Academic Consortium for Alternative and Complementary Health Care (ACCAHC) for NED. The terms were developed in response to the NED goal of delivering “a glossary to support the use of common language.” ACCAHC asked its member disciplines to provide glossaries of terms as used by their own professions. Below is the table of contents. The glossary is available on request from Pamela Snider at plsnider@comcast.net.

Chiropractic Medicine

- Primary Terms
- Organizations
- Practitioner Designations

Eastern, Oriental Medicine and Acupuncture

- Primary Terms
- Secondary Terms
- Organizations
- Practitioner Designations

Direct-Entry Midwifery

- Primary Terms
- Organizations
- Practitioner Designations

Massage, Body Work and Somatic Therapies

- Primary Terms
- Secondary Terms
- Organizations
- Practitioner Designations

Naturopathic Medicine

- Primary Terms
- Secondary Terms
- Organizations
- Practitioner Designations

Appendix 7

Core Shared Values—Draft Working Document

Task Force: Carla Mariano, RN, EdD, AHN-C Chair; Michael Goldstein, PhD; Ben Kligler, MD, MPH; Karen Lawson, MD; David O’Byron, JD; Dawn Schmidt, LMP; Pamela Snider, ND; Don Warren, ND, DHANP; John Weeks. Mark Seem, LAc, was also a contributor.

This document was developed by the task force prior to the onsite meeting in June. The seven values listed here followed a restatement of NED’s vision and mission.

1. Wholeness and Healing

We acknowledge and value the interconnectedness of all people and all things. We believe that healing is an innate, although sometimes mysterious, capacity of every individual, which provides a meaningful opportunity for growth and balance, even when curing may not be possible.

2. Clients/Patients/Families

We value our clients/patients/families as the center of our practices. We act in service to validate individuals’ full experience of their wellness and illness, provide education about the possibilities for change, diminish dependence, bolster resilience, support the mobilization of their full resources and reinforce self-reliance as important to optimal healing.

3. Practice as Combined Art and Science

We value competent, compassionate, relationship-centered practice that honors intuitive knowledge, stimulates creativity in the face of divergent circumstances, and appropriately utilizes a network of diverse practitioners as integral to the practice of the healing arts. This approach is informed by in-depth education, critical thinking, reliable evidence from well-designed quantitative and qualitative research and by respect for diverse theories and world views.

4. Self-Care of the Practitioner

We value a practitioner’s commitment to self-reflection, self-care, and to his or her personal growth and healing as being essential to one’s humble ability to provide the most effective and enduring health care to others.

5. Interdisciplinary Collaboration and Integration

We embrace the breath and depth of diverse healthcare systems and value collaboration of all providers within and across disciplines and with clients/patients and their families. We believe that fostering integrative and collaborative practice is essential to the creation of health, the advancement of health care and the well-being of society.

6. Our Healthcare System

We value the recognition that all practitioners have responsibility to participate in activities which contribute to the improvement of the community, the environment and the betterment of public health. We support access for all populations to competent client/patient-centered care, which is focused on health creation and healing. We believe that advancement and promotion of health and the prevention of disease are fostered by aligning resource investment with these values.

7. Attitudes and Behaviors that Promote Health, Wellness and Change

We value attitudes and behaviors which demonstrate respect for self and others and which are informed by an abiding humility, in light of both the individual care and system challenges that we face. We value authentic, open and courageous communication. We believe that such traits are important for all participants in health care, whether practitioner, client/patient/family, educator, administrator or policymaker.

Appendix 8

CAM Educator Response to Integrative Medicine Curriculum and Values: Excerpt on Key Outcomes of the Delphi Survey Process

Task Force: Reed Phillips, DC, PhD, Chair

Lead authors: Patricia Benjamin, PhD; Reed Phillips, DC, PhD; Don Warren, ND, DHANP; Catherine Salveson, RN, PhD; Richard Hammerschlag, PhD; Pamela Snider, ND

ACCAHC group—Patricia Benjamin, PhD, LMT; Morgan Martin ND, LM; Don Warren, ND, DHANP; Suzanne Nelson Myer, RD, MS, CD; Catherine Niemiec, JD, Lac; Sonia Ochoa, MD (Mexico); David O’ Bryon, JD; Pamela Snider, ND; John Weeks

OCCIM group—Richard Barrett, ND; Tim Chapman, PhD; Richard Hammerschlag, PhD; Mitch Haas, DC, MA; Robert T. Kaneko, LAc; David H Peterson, DC; Catherine Salveson, RN, PhD; Anne Nedrow, MD

Members of the Academic Consortium for Complementary and Alternative Health Care (ACCAHC) worked together with members of the Oregon Collaborative for Complementary and Integrative Medicine (OCCIM) in an exploration of the core values in integrative medicine as endorsed by the members of the Consortium of Academic Health Centers for Integrative Medicine (CAHCIM). The report, “Response to a Proposal for an Integrative Medicine Curriculum,” was written after reviewing the “Core Competencies in Integrative Medicine for Medical School Curricula: a Proposal.” The ACCAHC/OCCIM team used a modified Delphi survey process to explore core, shared responses. The following are their chief findings:

1) Definition of Integrative Medicine (IM)

Five highly rated items from the Delphi process address the basic concept of IM itself. The concerns are expressed a little differently, but all address the core issue of the definition of IM.

- The definition of IM in the CAHCIM article leaves the impression that conventional medical physicians may simply incorporate into their practices what they perceive to be good CAM therapies rather than referring to or co-managing and collaborating with CAM providers.
- The CAHCIM article does not include the option of integrated care with MDs and CAM practitioners as partners, and seems to propose that CAM simply be an add-on to conventional medical care.
- In the CAHCIM article, Knowledge Competency #5 (“Describe the distinction between IM and CAM”) 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.
- It appears from the article that conventional medical institutions want to include CAM, but not 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 doctor.

2) Goals of an IM Curriculum

Another major concern is the lack of clarity about the overall goal of the proposed IM curriculum guidelines. Specifically, 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. While 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 article. 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 MD who trains at a CAM school for acupuncture and Oriental medicine. That was considered a different situation than including CAM within an IM curriculum.

3) Breadth of Whole Systems of Health Care

The Task Force also noted the lack of recognition in the CAHCIM article of the time it takes to gain competency in CAM knowledge and skills. This perhaps reflects 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. Omission of these comprehensive systems and disciplines in the proposed knowledge competencies was rated highly as an area of concern.

In a similar vein, there was concern about the lack of clarity around the use of terms like 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, or therapeutic disciplines, like massage therapy, reflects a lack of understanding of the complexity of the theory, knowledge and skills inherent in their practice.

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 article 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 #3 calling for physicians to “demonstrate skills to communicate effectively...with patients and all members of the interdisciplinary healthcare team in a collaborative manner to facilitate quality patient care” was rated highly as a point of agreement with the CAHCIM article.

5) Partnership in Developing Integrative Care

Several highly rated items indicated a desire for partnership between conventional medicine and CAM in the future development of integrative health care. The CAHCIM article did not acknowledge that this partnership is not presently a reality. The Task Force also noted the following items as missing from the CAHCIM article:

- 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 inter-institutional 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 role in decision-making
- 5) Developing collegial relationships with CAM providers

The five major areas of concern mentioned above revolve around the concepts of recognition, inclusion, collaboration and partnership between conventional medicine and CAM professionals in the future development of IM biomedical school curricula.

Appendix 9

Characteristics of Inter-Institutional, Intra-Institutional and Interdisciplinary Relationships Which Enhance Integrated Education for Healthcare Professional Students

These characteristics were developed via small group work by participants at the onsite meeting, who explored the topic while sitting, where possible, in geographically linked groupings.

Strong personal relationships

- Authentic, constant and caring communication
- Finding shared interests and win-win connections
- Joint steering committees and decision processes

Champion(s) for getting it done

- Have a highly placed sponsor in top leadership
- Leadership-to-leadership communication

Shared values and mission

- Mutual respect
- Equitable and just treatment of all participants
- Clarity on the outcomes and long-term commitment
- Clarity on clear mutual benefit, including financial

Continuity of leadership and commitment over time

Formalizing the relationships through contracting or agreements

- Collaborative development of agreements
- Appropriate funding, grants and rewards

Commitment to continuous education

- Experience of the culture and practices of the other
- Investment in leadership and faculty development

Appendix 10 – Eight Disciplines as Presented on Wall Posters

Acupuncture and Oriental Medicine

Basic Philosophy/Mission Statement

The mission statements of the major acupuncture and Oriental medicine (AOM) national organizations vary in content according to their specific professional focus but in general seek to promote standards of excellence and integrity in the practice of the profession; high quality health care, education, and research; public safety; and excellence in AOM education.

Data on the Profession

Although there is some evidence to the contrary, acupuncture appears to have originated in China several thousand years ago and experienced a renaissance in the U.S. in the early 1970s. There are about 22,671 active AOM practitioners in the U.S. The following are the principle national organizations (in alphabetical order):

- American Association of Oriental Medicine (AAOM)
- Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM)
- American Organization for Bodywork Therapies of Asia™ (AOBTA)
- Council of Colleges of Acupuncture and Oriental Medicine (CCAOM)
- Federation of Acupuncture and Oriental Medicine Regulatory Agencies (FAOMRA)
- National Acupuncture Detoxification Association (NADA)
- National Acupuncture Foundation (NAF)
- National Acupuncture and Oriental Medicine Alliance (AOMAlliance)
- National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM)
- Society for Acupuncture Research (SAR)

Regulatory Status

Practice acts authorizing comprehensively trained acupuncturists to practice acupuncture exist in 40 states and the District of Columbia. Administrative agency structure varies widely among the states.

Research

A leading organization for AOM research is the Society for Acupuncture Research (SAR), most of whose board members are NIH grant awardees. The mission of SAR is to promote scientifically sound inquiries into the clinical efficacy, physiological mechanisms, patterns of use, and theoretical foundations of acupuncture, herbal therapy, and other modalities of Oriental medicine.

Integration/Collaboration

A recent survey of the CCAOM membership indicated that AOM colleges are providing AOM services in over 100 off-site clinics. The clinical categories of practice include general hospital-based practice, urgent care centers, multi-specialty centers, research-based centers, end-of-life palliative care, long- and short-term rehabilitation centers, primary care at family practice clinics, nursing homes, out-patient geriatric centers/assisted living for seniors, out-patient institutions, prison-related out-patient facilities, drug treatment centers, HIV/AIDS treatment facilities, pediatric centers, cancer centers, clinics addressing the needs of specific community groups (e.g., women, students, low income/indigent/American Indian patients, inner city/low income, multi-racial patients, Native Asian community, new immigrants, homeless youth), and sports medicine.

The national accrediting body for the AOM field (ACAOM) has initiated a formal process of collaboration among major AOM stakeholders to explore the possible content of a first-professional doctoral degree for the AOM field.

For additional initiatives regarding integration/collaboration, contact the various professional associations in the AOM field noted above.

Scope of Practice

The scope of practice varies considerably from state to state. Some statutes simply refer to the “insertion of needles,” but many laws are complex and may reference “Oriental medicine” broadly, including Chinese herbs, Oriental massage, dietary advice, and therapeutic exercises.

Educational Status

- Currently there are 52 AOM institutions or programs that are either fully accredited (42) or in pre-accreditation/candidacy status (10) with the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM), the national accrediting body recognized by the U.S. Department of Education for the AOM field.
- The entry-level standard of training and education is either the first-professional Master’s Degree or the first-professional Master’s level certificate or diploma. The degree is variously denominated by the colleges; e.g., Master of Acupuncture, Master of Science in Traditional Chinese Medicine, Master of Science in Acupuncture and Oriental Medicine, Master of Science in Oriental Medicine, Diploma in Acupuncture, Master in Traditional Oriental Medicine, etc.
- Several colleges have been approved by ACAOM to offer a post-graduate clinical doctorate degree in AOM. This degree is designated as the D.A.O.M.
- The Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) is the national membership association for accredited and candidate institutions and programs and currently has a membership of 48 colleges. The Council’s primary mission is to advance the AOM profession by promoting educational excellence within the field. The Council also administers a national Clean Needle Technique course that is required by NCCAOM for national certification in acupuncture.

Key Challenges 2005–2010

- Need for greater consensus concerning the most appropriate entry-level standard for the AOM profession (i.e., current Master’s or a future Doctorate degree) and the content of course work, if Doctorate
- Need for greater public awareness of the skill limitations of other healthcare providers who practice acupuncture without having completed a full three- or four-year AOM curriculum at an accredited AOM institution or program.
- Need for greater reciprocity among states in recognizing the credentials of AOM providers
- Need for an appropriate response to increasing professional and public expectations for integrated health care
- Regulatory uncertainty concerning FDA restrictions on the use of Chinese herbs
- Need for reimbursement for AOM treatments by HMOs, Medicare, and third-party payors, and for identification of practitioner qualifications/standards for obtaining such reimbursement
- Need for greater emphasis on AOM research, training of AOM researchers, and increased funding for AOM research

Key Opportunities 2005–2010

- Ongoing work of ACAOM’s Doctoral Task Force may produce a consensus curriculum eventually leading to a first professional entry-level doctorate in AOM
- Work of ACCAHC focusing on interdisciplinary healthcare education
- Growing commitment within several major AOM organizations for greater collaboration within the field, including joint projects
- Increased marketing activities to develop public awareness of the benefits, safety, and cost-effectiveness of AOM

Prepared by: David Sale (Executive Director, CCAOM), in consultation with Lixin Huang (President, CCAOM), Catherine Niemiec (Vice President, CCAOM), and Elizabeth Goldblatt (Immediate Past-President, CCAOM). **Disclaimer:** The information presented here is a portrait of the profession/discipline. It does not necessarily reflect endorsed statements of agreement by the profession or discipline portrayed.

Chiropractic

Basic Philosophy/Mission Statement

The Association of Chiropractic Colleges provides worldwide leadership in chiropractic education, research and service. The Association of Chiropractic Colleges includes and represents all CCE accredited colleges and programs which serves its institutions and their students, the profession and its patients, and the public by advancing chiropractic education, research and service.

Data on the Profession

Chiropractic was founded in America by D. D. Palmer just over 100 years ago. There are approximately 65,000 practitioners. The Association of Chiropractic Colleges (www.chirocolleges.org) represents accredited colleges around the world. The Council on Chiropractic Education–USA is the accrediting body in the U.S. and recognized by the U. S. Department of Education (www.cce-usa.org).

Regulatory Status

Doctors of Chiropractic are regulated in all fifty states and U. S. territories. There are licensing boards in each state that belong to the Federation of Chiropractic Licensing Board (www.fclb.org).

Educational status

There are 16 accredited colleges in the U.S. that grant the “Doctor of Chiropractic” degree after studying approximately 4,200 in this clinical doctorate program. There are four national exams students take in order to apply for licensure (most states accept the National Board of Chiropractic Examiners (www.nbce.org)). The Part IV Exam is a practical exam that has gained international attention from other disciplines.

Research

Chiropractic colleges have had a consortial agreement that included a NIH Center located on one of our campuses. For the last ten years we have had a Research Agenda Conference that has been partially supported with federal grants. The profession has also supported the Foundation for Chiropractic Education and Research (FCER’s web site is www.fcer.org).

Integration/Collaboration

Leading initiatives include the expansion and integration of doctors of chiropractic in the Veterans and the Department of Defense healthcare delivery systems.

Key Challenges 2005–2010

Further expansion in federal healthcare delivery systems and the VA internship agreements with all colleges.

Key Opportunities 2005–2010

New opportunities include major changes to our healthcare delivery system and transformation of delivery of that care.

Other Valuable Information: The Association of Chiropractic Colleges’ address is 4424 Montgomery Ave., Ste. 202, Bethesda, MD 20814

Prepared by: David S. O’Byron, J.D., CAE, ACC Executive Director **Disclaimer:** The information presented here is a portrait of the profession/discipline. It does not necessarily reflect endorsed statements of agreement by the profession or discipline portrayed..

Direct-Entry Midwifery

Basic Philosophy/Mission Statement

Midwifery care encompasses the normal childbearing cycle of pregnancy, birth and postpartum care. The primary national organizations that support direct-entry midwifery have all endorsed the following statement:

The Midwives Model of Care is based on the fact that pregnancy and birth are normal life events. The Midwives Model of Care includes:

- Monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle
- Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
- Minimizing technological interventions
- Identifying and referring women who require obstetrical attention

The application of this model has been proven to reduce to incidence of birth injury, trauma, and cesarean section.

Data on the Profession

There are approximately 1,000 Certified Professional Midwives in the U.S. today. Estimates of the total number of direct-entry midwives in the U.S. vary widely ranging from 2,000 to 5,000 practicing midwives. In addition to these direct-entry midwives, there are approximately 7,000 Certified Nurse-Midwives practicing in the U.S. today. The Midwives Alliance of North America (MANA) is the main national organization. MANA does not require that members be certified and has an ongoing commitment to be an umbrella organization open to all midwives (<http://www.mana.org/index.html>). The National Association of Certified Professional Midwives (NACPM) was incorporated in 2000 to empower and care for women as they make choices about their pregnancies and births through the development and growth of the profession of midwifery. NACPM adopted Standards of Practice in 2004 (<http://nacpm.net>).

Educational Status

The Midwifery Education Accreditation Council (MEAC) is recognized by the U.S. Secretary of Education as the accrediting agency for direct-entry midwifery education programs. There are currently twelve MEAC-accredited schools and programs, including three degree-granting institutions, two programs located within universities, and seven schools offering certificate programs. Three of the free-standing schools and both of the university-based programs participate in U.S. Department of Education Title IV financial aid programs (<http://www.meacschools.org>). Approximately one-half of all applicants for NARM certification are graduates of accredited programs. Most others obtained their education through apprenticeship. NARM uses a portfolio evaluation process and skills examination as well as the written examination.

Integration/Collaboration

MANA is a member of the Coalition for Improving Maternity Services, a broad-based coalition of over 50 organizations, representing over 90,000 members. The coalition promotes a wellness model of maternity care. MANA is also a partner in the Safe Motherhood Initiatives-USA, whose goal is to reduce maternal mortality. The American Public Health Association adopted a 2001 resolution supporting the profession (<http://cfmidwifery.org/pdf/apha.pdf>). In 1999, the Pew Health Professions Commission and the UCSF Center for the Health Professions called for expanding educational opportunities for direct-entry midwifery, health policies that facilitate integration of midwifery services, and research (http://futurehealth.ucsf.edu/pdf_files/midwifery.pdf). Midwifery services have frequently been honored for meeting the needs of underserved populations.

Regulatory Status

The North American Registry of Midwives (NARM) is the certifying agency for CPMs, independent practitioners who have met the standards for certification and are qualified to provide the Midwives Model of Care. The NARM certification process recognizes multiple routes of entry into midwifery. The CPM credential requires training in out-of-hospital settings (<http://www.narm.org>). NARM is accredited as a certifying agency by the National Commission for Certifying Agencies (NCCA), which is the accrediting body of the National Organization for Competency Assurance (NOCA). The written examination developed by NARM—one element in the certification process—is now used as the licensing examination in all 22 states that license or otherwise regulate direct-entry midwives (except New York). Most states that regulate midwifery also reimburse midwives for services provided to women on Medicaid. Many midwives are also reimbursed by private insurance plans and contract with managed care organizations.

Scope of Practice

NACPM defines the midwives scope of practice as providing expert care, education, counseling, and support to women and their families throughout the caregiving partnership, including pregnancy, birth and postpartum. NACPM members provide ongoing care throughout pregnancy and continuous, hands-on care during labor, birth and the immediate postpartum period. They are trained to recognize abnormal or dangerous conditions needing expert help outside their scope and to consult or refer as necessary.

NARM recognizes that each midwife is an individual with specific practice protocols that reflect her own style and philosophy, level of experience, and legal status, and that practice guidelines may vary with each midwife. NARM does not set protocols for all CPMs to follow, but requires that they develop their own practice guidelines in written form. Some states include well-woman care in the midwives' scope of practice, and some allow midwives to administer specific drugs and devices.

Other Valuable Information

Citizens for Midwifery is a volunteer, grassroots organization whose goal is to see that the Midwives Model of Care is available to all childbearing women and universally recognized as the best kind of care for pregnancy and birth. Their website contains useful information for activists and policy-makers (<http://www.cfmidwifery.org>). The Foundation for the Advancement of Midwifery is a non-profit organization dedicated to the midwifery model of care as the quality health care option for women and families (<http://www.formidwifery.org>).

Key Challenges 2005–2010

- Respond effectively to the increasing medicalization of pregnancy and birth, particularly the rapidly rising rate of Cesarean sections
- Promote licensure, employment and third party reimbursement
- Expand midwifery education and build capacity of professional organizations
- Preserve and promote the principles and practices of midwifery within the context of continuing professionalization.

Key Opportunities 2005–2010

- Launch national public education campaign
- Foster ongoing data collection and new research projects
- Provide leadership in healthcare reform based on values and proven effectiveness of midwifery model of care

Prepared by: Jo Anne Myers-Ciecko, Sonia Ochoa, and Morgan Martin **Disclaimer:** The information presented here is a portrait of the profession/discipline. It does not necessarily reflect endorsed statements of agreement by the profession or discipline portrayed.

Massage and Bodywork

Basic Philosophy/Mission Statement

Facilitation and access of body, mind, spirit and emotions, through touch, manual manipulation of tissues, movement, presence, intention and collaboration, enabling the client's ability to achieve and maintain whole being health and wellness.

Data on the Profession

The use of massage dates back to ancient times with Ling and Metzger often considered the founders of modern massage therapy. However the profession has many deep roots which are not so well defined. The exact number of practitioners in the US is unclear and estimates vary from 150,000 to 250,000. The profession is represented by several general and specialized professional organizations, which include: **AMTA—American Massage Therapy Association** is a national professional member association which was formed in 1943 to be the unifying force for American massage therapists who are committed to high ethical and educational standards, and a well regulated profession to ensure the safety of the public (info@amtamassage.org).

COS—Council of Schools (council of AMTA) is a national schools association which was formed in 1982 to be the unifying force for American massage and bodywork schools and educators who are committed to high ethical and educational standards. It also provides networking opportunities for massage therapy educators and school owners.

ABMP—Associated Bodywork and Massage Practitioners is a national privately owned professional association to be the unifying force for American massage and bodywork practitioners who are committed to high ethical and educational standards, and a regulated profession (not yet fully defined).

Federation for Therapeutic Massage, Bodywork and Somatic Practice Organizations is a non-profit membership organization in the massage, bodywork and somatic practice field intended to support individual disciplines while also strengthening their value as a collective group. The Federation was formed to carry out this new vision of mutual support and cooperation, in 1991 (www.federationmbs.org).

Discipline specific organizations include:

AOBTA – American Organization for Bodywork Therapies of Asia™ (www.aobta.org)

ISMETA - International Somatic Movement Education and Therapy Association (www.ismeta.org)

Educational Status

Only 76 of 1400+ massage schools/programs accredited by COMTA at this time, with more schools seeking initial and re- accreditation annually. COMTA has profession-specific, competency-based educational standards and requires at minimum 600 hours for achievement of those standards. There are 337 schools with massage programs, which are accredited by institutional accreditors (those without profession-specific educational standards).

For non-COMTA accredited programs, a minimum of 500 hours is the most common expectation. National Certification is available. Many states use the national exam as their regulatory exam, though regulatory reciprocity is not consistently available between states. Both AMTA and ABMP, the two major professional organizations, each have approximately 50,000 members. Each has school forums or councils which provide schools and school owners opportunity to network and learn about school/profession-specific issues.

Research

The **Massage Research Foundation** engages in fundraising and funding with the intention to facilitate development of research capacity and to further a profession driven research agenda. The **Massage Research Consortium** is a union of ten top massage schools initiated in 2003, with the intention to develop research capacity within member schools. Several schools across the country are engaging in collaborative research with colleges and universities. In addition, many individual practitioners privately consult with researchers on a contractual basis.

Prepared by: Dawn M. Schmidt, Jan Schwartz and Cynthia Ribeiro. **Disclaimer:** The information presented here is a portrait of the profession/discipline. It does not necessarily reflect endorsed statements of agreement by the profession or discipline portrayed.

Regulatory Status

The number of states that require licensing, certification or registration to practice have grown from four in the late seventies to thirty-five as of this year. There are two states with freedom to practice acts and the remaining states rely on counties, cities, and municipalities to regulate the practice of massage.

COMTA—Commission on Massage Therapy Accreditation. The only federally recognized (U.S. Dept. of Ed.) accreditation agency exclusively specializing in the accreditation of massage and bodywork institutions and programs. COMTA provides institutional and programmatic accreditation. COMTA also works with other institutional and specialty accreditation agencies of other disciplines to accredit massage and bodywork programs. Accredited institutions may apply for Title IV funding for their students.

NCBTMB—National Certification Board of Therapeutic Massage and Bodywork provides certification to massage and bodywork practitioners who have completed educational or practice requirements and an examination process assessing their knowledge base to provide safe client care.

NCTMB—National Certified Therapeutic Massage and Bodywork Practitioner or Therapist. This is the designation conferred on massage and bodywork practitioners who have taken and passed the national exam for Therapeutic Massage and Bodywork. Many states use the national exam as their written exam for licensing; however, being nationally certified does not supercede state regulatory requirements. Most states have specific education requirements along with other state specific requirements, which must also be met in order to practice legally.

Scope of Practice

The scope of practice varies state by state and may include:

- Manual manipulation, pressure or movement for therapeutic purposes
- Manual manipulation, pressure or movement for wellness
- Manual manipulation, pressure or movement for treatment/remediation of specific injuries, conditions, and pathologies for which massage is indicated
- Manual manipulation, pressure or movement for other general or therapeutic intentions
- Access includes external soft tissue
- Access includes epithelial tissues found in body orifices
- Use of hot and cold
- Use of water, lubricants, salts and/or other therapeutic agents (including nonprescription topical applications)
- Incorporation of movement, stretches, neuromuscular re-education, etc.
- Use of mechanical or electrical assistive devices

The scope of practice tends not to include:

- Diagnosis
- Adjustment or manipulation of articulations/joints by the use of thrusting force

Key Challenges 2005–2010

- Leadership development in the areas of Healthcare Policy, Research, and Higher Education
- Identifying common language and ground within the profession
- Further development, definition and refinement of common terminology, including scope of practice
- Addressing ethical and educational issues associated with non-accredited schools, and mediate fragmentation of the whole profession
- Advance the development of nationwide credentialing, eligibility, accreditation and regulatory standards and requirements with the intention of having nationwide reciprocity for the profession

Key Opportunities 2005–2010

- Continued advancement of benchmarking activities nationwide.
- Increased media exposure and acknowledgement in the media for the benefits of massage
- Participation in national dialogues for health care.

Holistic Medicine

Philosophy/Mission Statement

Holistic Medicine is the art and science of healing that addresses care of the whole person—body, mind, and spirit. The practice of holistic medicine integrates conventional and complementary therapies to promote optimal health and to prevent and treat disease by addressing contributing factors.

Principles

Optimal health is the primary goal of holistic medical practice. It is the conscious pursuit of the highest level of functioning and balance of the physical, environmental, mental, emotional, social, and spiritual aspects of human experience, resulting in a dynamic state of being fully alive. [Other principles include] The Healing Power of Love; Whole person; Prevention and Treatment; Innate Healing Power; Integration of Healing Systems; Relationship-Centered Care; Individuality; Teaching by Example; Learning Opportunities.

Data on the Profession

Holistic Medicine was conceived and practiced by medical doctors as early as the 1950's, building on a strong foundation of natural medicine in the U.S. for over 100 years. The **American Holistic Medical Association (AHMA)** was founded in 1978 as a membership organization for physicians seeking to practice a broader form of medicine than what was (and is) currently taught in allopathic (MD and DO) medical schools. For 27 years the AHMA has nurtured and educated physicians making this transition. Current membership is nearly 1,000 physicians, medical students, residents, and allied health professionals who seek to make the holistic model available to patients and practitioners alike (www.holisticmedicine.org). 12101 Menaul Blvd, NE, Ste C, Albuquerque, NM 87112; Phone: (505) 292-7788; Fax: (505) 293-7582

Research

Currently, there is a broad spectrum of research being done nationally on specific modalities and therapies, but little research looking systematically at the practice of holistic medicine and its impact. The membership organization AHMA is currently not engaged in research; however, we hope to be supportive collaborators with anyone doing such research on systems of practice.

Integration/Collaboration

- Facilitating cross-discipline discussions via the Summit in Humanistic Medicine and NED
- Increased involvement of non-MD practitioners, both in presenting and attending our annual conference
- Collaborative conferences (e.g., with the AHNA in 2006)
- Consideration of new CME approach to specialty CAM education
- Continuing presence of an Associate (non-MD) member of our Board of Trustees

Regulatory Status

Board certification has been available via examination since 1999 (www.holisticboard.org). Holistic Medicine is not yet recognized by the American Board of Medical Specialties. No existing residency programs exist as of yet in holistic medicine, although a pilot combined Family Medicine/Integrative Medicine residency is being currently piloted at six major academic medical centers. However, most physicians will receive their post-graduate training in another field, then dual board in Holistic Medicine.

Scope of Practice

Scope of practice is as defined by conventional medical licensing agencies within a given state. Some states have special legislation which provide guidelines for health professionals practicing unconventional medicine, including therapies such as chelation, energy work, and acupuncture.

Educational Status

Conventional MD or DO training and licensing is the prerequisite for board certification in Holistic Medicine. Most education in this area is being obtained in the post-graduate arena. Several post-graduate fellowships are available in Integrative Medicine (closely related practice), and a new residency in holistic medicine is being explored. A pilot combined Family Practice/Integrative Medicine residency is underway through the University of Arizona at institutions nationally. Practitioners who are trained as nurse practitioners, physician assistants, nutritionists, pharmacists, nurses, and other licensed health professionals are eligible for associate member status in the AHMA.

Key Challenges 2005–2010

- Outcomes documentation for the system of holistic medicine as an effective intervention
- Advancing the principles of holism in the dominant conventional model of techno-industrial, reductionistic medicine
- Maintaining economic stability of the organization and the field
- Providing equitable access for patients and practitioners alike
- Providing adequate educational opportunities
- Establishing legitimacy amid the current medical hierarchy
- Working through the CODEX legislation
- Establishing clear definitions and practices within this rapidly evolving field

Key Opportunities 2005–2010

- Through a major educational campaign, AHMA seeks to significantly increase membership over the next five years, as we reach out to conventional physicians who are ready to incorporate new perspectives in health care into their clinical work.
- Increase the understanding and stability of the field of holistic medicine through the strengthening of interdisciplinary and inter-organizational relationships, and the increasing education of healthcare consumers.
- Increase the number of physicians who are adequately trained and board-certified in Holistic Medicine through the ABHM.

Prepared by: Karen Lawson, MD, Past-President, AHMA; Lawrence Pawlevsky, MD, President, AHMA; Mary P. Guerrero, MD, Co-chair, Education Committee, AHMA; Scott Shannon, Past-President, AHMA, Trustee ABHM **Disclaimer:** The information presented here is a portrait of the profession/discipline. It does not necessarily reflect endorsed statements of agreement by the profession or discipline portrayed.

Holistic Nursing

Holistic Nursing Description

- Embraces all nursing which has enhancement of healing the whole person from birth to death as its goal
- Recognizes the interrelationship of the unified bio-psycho-social-spiritual dimensions of the person
- Views the nurse as an instrument of healing and a facilitator in the healing process
- Honors the individual's subjective experience about health, illness, health beliefs, and values
- Acknowledges the therapeutic partnership with individuals, families, and communities
- Draws on nursing knowledge, theories, research, expertise, intuition, and creativity
- Encourages peer review of professional practice in various clinical settings and integrates knowledge of current professional standards, laws, and regulations governing nursing practice.
- Focuses on integrating self-care, self-responsibility, spirituality, and reflection in personal/professional life
- Emphasizes awareness of the interconnectedness of self, others, nature, and God/Life/Absolute/Transcendent

Data on the Profession

- 2.3 million nurses in the U.S.
- 5–8 thousand identify as Holistic Nurses
- 2,700 members of American Holistic Nurses Association (AHNA)
- Professional Organization: AHNA (founded 1982); Phone: (800) 278-2462; Email: infor@ahna.org; Website: www.ahna.org

Research

Quantitative: Outcome measures of various holistic therapies (e.g., therapeutic touch, prayer, aromatherapy; instrument development to measure caring behaviors and dimensions; spirituality; self-transcendence; cultural competence, etc.); client responses to holistic interventions in health/illness

Qualitative: Explorations of clients lived experiences with various health/illness phenomena; theory development in healing, caring, intentionality, cultural constructions, empowerment, etc.

Educational Status

Nursing Programs in the U.S.

- 79 Doctoral (PhD, EdD, DNS)—90 credits
- 375 Masters (MA, MS, MEd)—24-48 credits
- 600 Baccalaureate (BS, BSN)—128 credits
- Associate Degree (AD)—30 credits

Nursing Accrediting Bodies

- American Association of Colleges of Nursing (AACN)
- National League for Nursing (NLN)

Certifying Organizations

- American Nurses Credentialing Center (ANCC),
- American Holistic Nurses Certification Corporation (AHNCC)

AHNCC Endorsed Academic Programs in Holistic Nursing

- 5 Masters
- 7 Baccalaureate

Regulatory Status

- National Licensure Exam (NCLEX) for all nurses through National Council of State Boards of Nursing
- 25 (47%) State Boards of Nursing with a formal policy, position or inclusion of holistic/complementary therapies in the scope of practice of nurses
- National Board Certification in Holistic Nursing at the basic (HN-BC) or advanced (AHN-BC) levels through the American Holistic Nurses Certification Corporation (AHNCC)
- Published Standards of Holistic Nursing Practice at the Basic and Advanced levels through the American Holistic Nurses Association (AHNA)

Scope of Practice

Holistic Nurses:

- Integrate holistic and alternative/complementary modalities (CAM) (e.g., relaxation, meditation, guided imagery, breath work, biofeedback, aroma and music therapies, touch therapies, acupressure, herbal remedies and natural supplements, homeopathy, reflexology, Reiki, journaling, exercise, stress management, nutrition, and prayer, etc.) with traditional nursing interventions
- Draw on nursing knowledge, theories of wholeness, research and evidence-based practice, expertise, caring, and intuition to become therapeutic partners with clients in a mutually evolving process toward healing, balance, and wholeness
- Conduct holistic assessments, select appropriate interventions in the context of their client's total needs, evaluate care in partnership with the client
- Assist the clients to explore self-awareness, spirituality, and personal transformation in healing
- Work to alleviate clients' signs and symptoms
- Concentrate on the underlying meanings of symptoms and changes in the client's life patterns
- Provide health counseling, health promotion, disease prevention, and education
- Guide clients between conventional medicine and complimentary/alternative therapies
- Collaborate and refer to other healthcare providers/resources as necessary
- Advocate to transform and provide access to the healthcare system
- Practice in numerous settings, including private practitioner offices, ambulatory care, acute care, home care, wellness and complementary care centers, women's health centers, psychiatric mental health facilities, and schools. Holistic nurses with advanced education can become advanced practice nurses, faculty, and researchers.

Key Challenges & Opportunities 2005–2010

Education

- Integration of holistic content into nursing curricula nationally
- Recognition, support, and legitimization of integrative nursing practice in licensure and credentialing processes

Research

- Identification and description of outcomes of holistic therapies such as healing, well-being, harmony
- Funding nurses for CAM research
- Dissemination of nursing research findings to broader audiences (e.g. other health disciplines, media)

Practice

- Influence and change the healthcare system to a more humanistic orientation
- Collaborate with diverse healthcare disciplines to advanced holistic health care

Policy

- Reimbursement for holistic nursing practices and services
- Education of public about array of healthcare alternatives and providers
- Increase focus on wellness, health promotion, access and affordability of health care to all populations
- Care of the environment

Prepared by: Carla Mariano, RN, EdD, AHN-C, Coordinator, New York University, Advanced Practice Holistic Nurse Practitioner Program; President-Elect, American Holistic Nurses Association (AHNA) **Disclaimer:** The information presented here is a portrait of the profession/discipline. It does not necessarily reflect endorsed statements of agreement by the profession or discipline portrayed.

Integrative Medicine

Consortium of Academic Health Centers for Integrative Medicine

About Us

The Consortium of Academic Health Centers for Integrative Medicine (CAHCIM) is supported by a grant from the Bravewell Collaborative for Integrative Medicine. Our membership currently includes 29 highly esteemed academic medical centers.

Mission

...to help transform medicine and health care through rigorous scientific studies, new models of clinical care, and innovative educational programs that integrate biomedicine, the complexity of human beings, the intrinsic nature of healing, and the rich diversity of therapeutic systems. The goal, at its essence, is to make a qualitative difference in people's health by advocating an integrative model of health care, incorporating mind, body, and spirit. As an organization we are committed to sharing information and ideas, meeting challenges together in a process grounded in the values of integrative medicine, supporting member institutions and providing a national voice for integrative medicine.

The Consortium of Academic Health Centers for Integrative Medicine represents a tremendous opportunity to affect the direction, assumptions, and outcomes of health care. Given the involvement of strong academic institutions and their representatives, which include deans and chancellors, we are poised to provide a forum for those committed to the values of integrative medicine.

Education Working Group

The Education Working Group's main focus is to incorporate the field of integrative medicine into the curriculum of medical schools across the country. The Education Working Group is developing a user guide to integrative medicine that will define specific goals and objectives for undergraduate medical education. This user-friendly guide will provide pertinent information, which every physician should attain prior to graduating from medical school. This guide will not only outline goals and objectives, but it will also offer a sample curriculum that will exhibit exactly how the goals and objectives can be implemented. Another focus of the Education Working Group is to advance integrative medicine with mainstream medicine by sharing and teaching through clinical cases. The group, as a whole, is developing approximately 20 cases that can be used in medical schools, residencies, fellowships, and allied health programs. The goal is to develop situational cases that will show through example how integrative medicine can be applied in every day clinical settings. The group has developed a "Curriculum In Integrative Medicine: A Guide for Medical Educators," which is available to all for downloading from their site.

Policy Committee

The Policy Committee of the Consortium was formed January 2005 with the goal to develop a Consortium public policy agenda at a federal level. The group developed concrete, obtainable action steps that serve as effective short-term goals which will eventually pave the way in reaching the ultimate objectives on a federal level. The policy committee is led by James Dalen, MD, MPH, University of Arizona and Senior Advisor, and Paul Vick, Duke University. The White House Commission and the Institute of Medicine reports have thus far served as the primary guides on how the Consortium can implement policy.

Definition of Integrative Medicine

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.

—Developed and adopted by the Consortium, May 2004; edited May 2005

Steering Committee

The steering committee of the Consortium of Academic Health Centers for Integrative Medicine is comprised of one representative from each of the 25 member institutions; most often it is the institution's director who sits on the steering committee. The steering committee members share the same goals, visions, and principles in regard to the advancement, awareness, and acceptance of integrative medicine. The steering committee was established with the authority to make decisions on behalf of the Consortium. While each member has a vested interest at their own schools and clinics, Consortium members recognize the importance of advancing the field of integrative medicine. As an organization, the steering committee members are committed and willing to step away from their own personal agendas, and work together to advance integrative medicine in the areas of education, research, and clinical practice. Susan Folkman, Ph.D., director of the University of California, San Francisco Osher Center for Integrative Medicine is chair; Mary Jo Kreitzer, RN, Ph.D. of University of Minnesota, Center for Spirituality, is vice chair. The steering committee holds the voting rights and power of the CAHCIM.

Clinical Care Working Group

The Clinical Care Working Group has a goal of creating a collaborative atmosphere among institutions that currently have integrative medicine clinics and those planning to develop clinical practices in the future. The CAHCIM has the capability to develop a model that can serve as a guide in developing a functional working clinic in integrative medicine. In order to create such an atmosphere, information and strategies regarding issues such as clinic administrative structures, credentialing, privileging, operational issues, as well as billing and insurance, will be addressed. The

The Clinical Care Working Group also has a goal to define key components that constitute an integrative medicine clinic, such as process issues, philosophy, and function.

Research Working Group

The aim of the Research Working Group is to develop standard measures to which integrative medicine can be applied or compared with mainstream research standards. The group's focus includes engaging scientists from diverse disciplines, joining integrative medicine researchers in finding new ways to study integrative medicine and its effects, identifying qualified reviewers for private foundation and National Center for Complementary and Alternative Medicine grant applications, and developing research networks to facilitate multi-site studies.

Membership

Institutions who wish to be considered for membership in the Consortium must meet the following eligibility requirements:

- Meet the criteria of an Academic Health Center
- Have an established program in integrative medicine that includes ongoing work in more than one of the three areas of research, education, and clinical activity.
- Have the commitment of the Health Center in institutional movement in the field of integrative medicine, evidenced by expressed support of this institutional commitment from the senior leadership (chancellor or dean) of the Health Center.

Prepared by: The NED from information on the website of the Consortium for Academic Health Centers for Integrative Medicine (<http://www.imconsortium.org>)

Disclaimer: The information presented here is a portrait of the profession/discipline. It does not necessarily reflect endorsed statements of agreement by the profession or discipline portrayed.

Naturopathic Medicine

Basic Philosophy/Mission Statement

Naturopathic medicine is a distinct method of primary health care—an art, science, philosophy, and practice of diagnosis, treatment, and prevention of illness. Naturopathic physicians seek to restore and maintain optimum health in their patients by emphasizing nature's inherent self-healing process, the *vis medicatrix naturae*. This is accomplished through education and the rational use of natural therapeutics.

Naturopathic medicine is defined by its principles. Methods and modalities are selected and applied based upon these principles in relationship to the individual needs of each patient. Diagnostic and therapeutic methods are selected from various sources and systems, and will continue to evolve with the progress of knowledge.

Data on the Profession

The number of licensed or licensable naturopathic physicians in North America is estimated at 3500. Each year approximately 400 students graduate from the six recognized institutions. The Association of Accredited Naturopathic Medical Colleges (AANMC) represents institutions that have been accredited or are in candidate status for accreditation by one of the regional accrediting agencies approved by the U.S. Department of Education. In addition, all of the naturopathic medicine programs of the member schools have been accredited (or are candidates for accreditation by the Council on Naturopathic Medical Education (CNME), the recognized accrediting body for naturopathic medical programs in North America. The American Association of Naturopathic Physicians (AANP) is the national association for the profession (www.naturopathic.org).

Education

There are six North American schools offering doctorates in naturopathic medicine. Each school is a four-year, doctoral-level, residential program consisting of roughly 4100 hours of coursework, more than 2000 of which is clinical in nature. During the first two years of study, the curriculum focuses on basic and clinical sciences. Students learn virtually all the modalities of proven natural therapies, including clinical nutrition, botanical medicine, homeopathy, acupuncture and oriental medicine, lifestyle counseling, massage, and hydrotherapy. Graduates of the recognized schools are eligible to sit for the national licensing exam, the Naturopathic Physicians Licensing Examination (NPLEX). The Council on Naturopathic Medical Education (CNME) (www.cnme.org) is recognized by the U.S. Department of Education as the profession's programmatic accrediting agency.

Research

Naturopathic physicians and academic institutions have grown over the past two decades. Publications to date have focused on specific naturopathic medical treatments such as *Urtica dioica* for the treatment of Allergic Rhinitis, and *Echinacea purpurea* for the treatment of respiratory tract infections in children. In addition to pursuing biomedical research in individual treatments, the NIH funded the Naturopathic Medical Research Agenda process from 2002–2004, which identified the following areas of study: Type II Diabetes, Health of the Elderly, and Outcome Studies in Naturopathic Practice.

Regulatory Status and Scope of Practice

In North America, a naturopathic physician must be licensed to practice in fourteen states, four Canadian provinces, the District of Columbia, the U.S. territories of Puerto Rico and the U.S. Virgin Islands.

- The license is typically broad, allowing naturopathic doctors (NDs in some jurisdictions, NMDs in others) to diagnose any disease and treat using any natural means.
- In Arizona and British Columbia, acupuncture is a part of the regulated practice; elsewhere, naturopathic physicians must obtain an additional license to practice acupuncture.
- Legend drugs are permitted in some jurisdictions, and minor office surgical procedures and midwifery are permitted in most.
- The term “naturopathic physician” or “doctor of medicine” is used to describe a practitioner in licensed jurisdictions.
- In these jurisdictions, naturopathic doctors are required to graduate from an accredited naturopathic medical school that requires four years of full-time study and to pass an extensive post-doctoral board examination (NPLEX) in order to receive a license.
- Licensed naturopathic physicians must fulfill state-mandated continuing education requirements annually.
- Naturopathic physicians also practice in at least 28 states that have no licensure laws (Hough et al., 2001). The Federation of Naturopathic Physicians Licensing Authorities represents the various licensing authorities nationwide (http://www.fnpla.org/Master_Framset.htm).

Contact information for licensing authorities by area: <http://www.naturopathic.org/licensure/licensing.html>

Integration/Collaboration

Naturopathic Physicians are sought out to provide expertise in the field of complementary medicine, including policy development, medical training, medical research, and clinical applications of natural therapies. Naturopathic Physicians have participated in collaborative activities with the Federal Government, federal scientific and research panels, major universities, state and local public health departments, and private research institutes. The following is a partial list of notable collaborative activities between the naturopathic and conventional medical establishments. A full list of appointments, affiliations and collaborations is contained in the document Naturopathic Medicine: Collaborative Events.

Key Challenges 2005–2010

- Small number of licensed states
- Thriving internet-based program of study graduating “unlicensable” NDs
- Opposition to professions advancement (further state licensing) from organizations supported by “unlicensable” NDs

Key Opportunities 2005–2010

- Potential for the development of bridge programs in naturopathic medicine for other healthcare professionals
- Increased demand for naturopathic physician services
- Active licensing initiatives in 10 states
- Significant opportunity to increase awareness at the federal level on the potential to address chronic illness in underserved areas

Appendix 11

Outline of Materials Supporting the NED Onsite Meeting

This outline is included here to show the depth of preparatory work engaged prior to the May 31–June 3, 2005, NED meeting. Many of the materials will be posted on the IHPC website (www.ihpc.info) or will be available by contacting John Weeks at nedcommonground@yahoo.com.

Introductory Materials

- Program Schedule—At a Glance
- Welcome from NED Planning Team
- Table of Contents
- Leading to NED—A Timeline of Recent Influences
- Calls to Action: Our Common Ground
- White House Commission, National Policy Dialogue, IOM Report
- NED Vision, Mission, Goals, and Deliverables
- Key Personnel: NED, ACCAHC, IHPC, IAF
- NED and ACCAHC Project Task Forces and Groups
- Honoring Our First-Year NED Sponsors
- Finding Your Way into the Woods: IHPC Acronym Chart

Program Materials

Session 1: The IOM Report and the Moment of Our Meeting

Session 2: Finding a Common Language

- Ground Rules in Relationships
- Integrative Medicine Definitions
- Common Healthcare Terms
- Draft Taxonomy: Healthcare Approaches, Systems, Disciplines, Modalities, and Therapies
- Draft Taxonomy: Massage Therapy
- Draft Taxonomy: Naturopathic Medicine
- Draft Taxonomy: Naturopathic Medicine—Physical Medicine Modality

Session 3: Enhancing Inter-Institutional Relationships

Data Charts from NED Survey of CAHCIM Institutions and Accredited CAM Programs/ Institutions

- University of Minnesota Programs—Kreitzer/Lawson
- University of Minnesota Integrated Healing Rotation—Hawaii
- Hawaii State Consortium on Integrated Health Care
- Topics Covered by the Tai Sophia/University of Pennsylvania Agreement
- Tai-Sophia Institute-Overview of Institutional Relationships
- New England School of Acupuncture-Tufts University Medical School
- Muscular Therapy Institute
- Southwest College of Naturopathic Medicine—Extended Sites for Clinic Training
- Southwest College of Naturopathic Medicine: Notable Research

Session 4: Leadership: Conceptual Issues and Direct Application

- Leadership for Change—Presentation by Dale W. Lick

Session 5: Toward Shared Values, Knowledge, Skills and Attitudes

- American Holistic Nurses' Association Standards of Holistic Nursing Practice
- Academic Medicine CAHCIM Values and Competencies
- ACCAHC-OCCIM Response to a Proposal for an Integrative Medicine Curriculum
- NED Core Values—Draft Working Document

Session 6: Challenges and Potential in Endorsing Shared Values

Session 7: Recent Experience in Collaborative Educational Program Development

- University of Washington CAM/IM Program
- Informal Explanatory Note on Agreements Provided by Bastyr
- Australian Centre for Complementary Medicine
- A Cooperative Case Study: Potomac Massage Training Institute-Georgetown School of Medicine
- University of Kansas Medical Center Program in Integrative Medicine/Functional Medicine/Complementary and Alternative Therapies

Session 8: Collaborative Development of Educational Resources

New York University Advanced Practice Holistic Nursing Program and Curriculum
Sample Curriculum Map for Incorporating Holistic Content—Basic Core Content
Model Outline for Educational Resources to Enhance Delivery of Collaborative Health Care

Session 9: Toward Best Practices in Inter-Institutional Relationships

Overview: Oregon Collaborative in Complementary and Integrative Medicine
Oregon College of Oriental Medicine: Overview of Inter-Institutional Relationships
Resolution Regarding the OCCIM Web-Based Curriculum Affiliation Agreement for Education between OHSU University Hospital and Clinics and OCOM
Western States Chiropractic College (WSCC): Overview of Research
Seven Characteristics of Highly Effective Inter-Institutional Relationships

Sessions 10/11: Advancing Our Work and Setting 2005–2006 Plans

Appendices

Note on Sample Inter-Institutional Agreements and Contracts of Participating Organizations
Table of Contents in Related NED Resource Booklet
ACCAHC Vision, Mission, Goals and Deliverables
Descriptions of Professions as Provided by the Disciplines
 Acupuncture and Oriental Medicine
 Chiropractic Medicine
 Direct-Entry Midwifery
 Holistic Medicine
 Holistic Nursing
 Integrative Medicine
 Massage and Bodywork
 Naturopathic Medicine
Glossary of Terms — CAM Disciplines (Developed by ACCAHC for the NED)
 Chiropractic Medicine—Common Terms
 Eastern, Oriental Medicine and Acupuncture—Common Terms
 Direct-Entry Midwifery—Common Terms
 Massage, Bodywork and Somatic Therapies—Common Terms
 Naturopathic Medicine—Common Terms
Samueli Conference on Definitions and Standards in Healing Research:
Working Definitions and Terms
Participant Optional Program/Organizational Descriptions
 The Australian Centre for Complementary Medicine Education and Research (ACCMER)
 American Medical College of Homeopathy
 Bastyr University
 Center for Complementary Medicine at Lutheran General Hospital
 Council on Naturopathic Medical Education
 Goshen Health System
 Hawaii State Consortium on Integrated Health Care
 Institute for Functional Medicine
 International Association of Yoga Therapists
 Mayo Complementary and Integrative Medicine Program
 Muscular Therapy Institute
 National Certification Commission for Acupuncture and Oriental Medicine
 New England School of Acupuncture (NESAs)
 New York University Advanced Practice: Holistic Nursing
 Oregon Collaborative in Complementary and Integrative Medicine (OCCIM)
 Oregon College of Oriental Medicine
 Potomac Massage Training Institute, Washington, DC
 Tai Sophia Institute, Laurel, MD
 University Of Bridgeport College of Chiropractic
 University of Connecticut Integrative Medicine Programs
 University of Kansas Medical Center Program in Integrative Medicine/Functional
 Medicine/ Complementary and Alternative Therapies
 University of Minnesota Center for Spirituality and Healing
 Western States Chiropractic College (WSCC)
 Yoga Alliance
Memo on Specialty-Based Collaborative Continuing Education
NED Participants Professional Bios
NED Participants—by Educator Discipline or Grouping
Inside back cover: Untitled Poem
Back cover: List of First-Year NED Sponsors

Participants in the NED Onsite Meeting

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PETER WAYNE, PhD
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CATHERINE NIEMIEC, JD, LAC *
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Allied Health Educators

LINNEA LARSON, MSW, MFT
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Clinical Professor, Chair, Department of
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Director, Director Dietetic Internship,
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Middle Row: David O'Bryon, Gerald Monk, Jim Berg, Ivan Zador, Richard (Muz) Anseno, Mary Ann DiRoberts, Barbara Dossey, Mike Dyer, Joseph Kaczmarczyk, Sonia Ochoa, Jim Giordano, Joanne Myers-Ciecko, Anne Nedrow, Suzanne Myer, David Peterson, Mike Goldstein, Catherine Niemiec, Sheila Quinn, Janet Kahn, Peter Wayne, Dale Lick, Elaine Zablocki, Adi Haramati, Joan Leach

Seated Row: Frank Zollli, Kory Ward Cook, Veronica Zador, Sherman Cohn, Marc Diener, Jan Schwartz, Cynthia Ribeiro, Mary Guerrero, Vic Serpina, Chuck Sawyer, Carla Mariano

In Front: Melanie Edwards, John Weeks, Whitney Lowe, Pamela Snider

National Education Dialogue Vision

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

September 2004

Institute of Medicine Rubric

The level of integration of conventional and CAM therapies is growing. That growth generates the need for tools or frameworks to make decisions about which therapies should be provided or recommended, about which CAM providers to whom conventional medical providers might refer patients, and the organizational structure to be used for the delivery of integrated care. The committee believes that the overarching rubric that should be used to guide the development of these tools should be the goal of providing comprehensive care that is safe and effective, that is collaborative and interdisciplinary, and that respects and joins effective interventions from all sources.

January 2005

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