Integration of Complementary and Alternative Medicine Services in the Hospital Setting in Israel*

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The recent emergence of integrative practice of complementary and alternative medicine and conventional medicine has resulted in a variety of integrative medicine frameworks within healthcare services. This raises several questions: what is integrative medicine; why did it emerge; what are the desirable settings for professional interactions, and what are the expected benefits for the patients, the healthcare providers, and the medical system.

It should be noted that the terms "integrative medicine" or "integrative healthcare" are now largely used within different areas of health sciences. We have witnessed the evolution of terms that shifted away from separate "mainstream" and "alternative" categories via a complementary approach of CAM towards integrated medicine or integrated healthcare [1]. This is reflected in numerous manuscripts and medical conferences. The Consortium of Academic Health Centers for Integrative Medicine has issued a definition of integrative medicine: "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" (2004).

The development of Integrative Medicine in Israel was influenced by the following factors:

- National health insurance – providing mainstream medicine services, through health management organizations and their vast public services.
- Mixed cultural ground – a country of new immigrants with a wide spectrum of health traditions, from ancient Hebrew and Arab medicine, via Mediterranean, African, Eastern Europe, and western types of practice and medicines.
- Demands for other approaches – the conservative mainstream medicine in Israel, strongly influenced by western medical concepts, was challenged by a demand from the public for other approaches in medicine. This demand allowed alternative methods to flourish outside public services providing mainstream medicine. The medical establishment was compelled therefore to evaluate these needs through a governmental committee that later issued recommendations to include CAM.
- Concomitant privatization processes of governmental hospitals – enabled initiation of CAM services.

CAM in the hospital

We would like to share our experience by analyzing the mode of function of two of these services. Assaf Harofeh Medical Center was the first to take this step, followed by Sheba Medical Center. Although both facilities are government university hospitals, they differ in their infrastructure: Sheba is a major and conservative hospital, whereas Assaf Harofeh is smaller and more dynamic. Subsequently, CAM integration processes were adapted according to the needs and interactive ability of each institution.

Incentives for integration

The objective of both facilities was to explore the therapeutic options of CAM and include them in a comprehensive treatment program of the patients. While this incentive was similar in both, the developmental steps varied according to the needs of the institutions.

The process of integration

The initial stages of integration were facilitated by the sympathetic and open-minded hospital director and a highly motivated and accomplished CAM team. Both services are headed by physicians who are also qualified CAM therapists. Only very experienced and skilled professionals (some of them with previous medical education) were recruited. Also essential is a suitable environment for the integration of CAM, according to the particular needs and interests of each institution. Assaf Harofeh designed a separate (free-standing) outpatient clinic that has gradually developed collaboration with the hospital departments. The CAM clinic at Sheba was established within the rehabilitation facility. The therapeutic focus of this service therefore became treatment for chronic pain and disability.

Multi-professional teams

Both services share a similar mode of function: teamwork of CAM and conventional practitioners with the emphasis on communication between the patient, the CAM practitioner and the physician. This format allows effective case management, which includes full medical evaluation and integrative intake, selection of treatment modality, and assessment of follow-up.

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CAM = complementary and alternative medicine

The integration of these concepts was achieved by eradicating myths and prejudices via exposure of physicians to CAM methods, physicians to CAM therapists, and CAM therapists to conventional medicine

Education

Since enhanced communication between CAM practitioners and physicians is vital to the well-being and safety of patients [2,3], both services designed programs for mutual learning. These included the apprenticeship of CAM students in the hospital environment, and teaching CAM methods to medical personnel. This process of continued communication, interaction and learning led to a mutual understanding of therapeutic options as well as a recognition of the benefits and limitations of the methods. The services implemented two concepts of integration: a) mainstream medicine & CAM, and b) various types of CAM.

Both services have earned the trust and respect of the medical staff. Curently 60–65% of patients receiving CAM services are referred by the medical staff. Another achievement is the clinical collaboration that now exists, whereby CAM services are integrated to varying degrees within various departments, such as orthopedic surgery, dermatology, rehabilitation, oncology, pediatrics and gynecology. While the process of integration during the early years was initiated by CAM clinics, in recent years, with the accumulation of research data and clinical experience of co-managing patient care, such initiatives are advanced by hospital departments. Finally, research collaboration and initiatives are underway, usually based on clinical observations and further processed by means of appropriate methodology [4-12].

Discussion

Our practical experience supports previously published reports [2,4] that developing a common language and good relations with hospital physicians are crucial to the success of integrated medicine. Since integration of CAM is in its early stages, there is still a lack of sound evidence that could support further implementation of IM models. As various systems of IM are already offered worldwide, scientific and clinical evaluation of these models is of outmost importance. University hospital settings may provide important insight into the practice of integration [13].

Outcome measures should reflect the expected benefits for the patients, the healthcare providers, and the medical system [2]. Evaluation of IM models requires research designs that take into account the complexity of the intervention, and may include randomized controlled trials, randomized pragmatic designs, observational research, and qualitative methods or case studies. In addition, the selected outcomes of the studies need to reflect the intent and purpose of the IM model [14].

Our clinical experience indicates that the most important factors in the true process of integration are high levels of professional skills (which, in the absence of professional regulation, will be difficult to define), commitment of the staff to the idea of integration, mutual respect, and recognition of the benefits and limitations of the other's capabilities. After all, the definition of IM, provided by the Consortium of Academic Health Centers for Integrative Medicine, is simply a definition of a good medicine.

IM = integrated medicine

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Every increased possession loads us with new weariness

John Ruskin (1819-1900), British author, art critic and social reformer