מאיירס - ג'וינט - מכון ברוקדייל
MYERS - JDC - BROOKDALE INSTITUTE
مايرس - جوينت - معهد بروكديل

SMOKLER CENTER FOR HEALTH POLICY RESEARCH

Perceptions of Physicians, Patients and Policymakers of Integrating Alternative and Conventional Medicine

Revital Gross ◆ Yael Ashkenazi ◆ Irit Elroy
Leora Schacter ◆ Judith T. Shuval

The study was funded by the Israel National Institute for Health Policy and Health Services Research

RESEARCH REPORT

RR-571-11

Related Myers-JDC-Brookdale Institute Publications

Brammli-Greenberg, S.; Gross, R.; Matzliach, R. 2007. ***Supplemental Insurance Plans Offered by the Health Plans – Analysis and Comparison of Baskets of Services in 2006***. RR-495-07 (Heb)

R. Gross, S. Brammli-Greenberg, R. Waitzberg. 2009. ***Public Opinion on the Level of Service and Performance of the Health-Care System in 2007 and in Comparison with Previous Years.*** RR-541-09 (Heb)

To order these publications, please contact the Myers-JDC-Brookdale Institute,
P.O.B. 3886, Jerusalem, 91037;
Tel: (02) 655-7400; Fax: (02) 561-2391;
E-mail: brook@jdc.org.il

The report is also available on the Institute website. www.jdc.org.il/brookdale

Executive Summary

1. Introduction

In recent years, a new pattern of Integrated Care (IC) has been developing in Israel and other countries, with physicians learning and applying the methods of complementary and alternative medicine (CAM) to treat patients in conjunction with conventional medicine. This trend stems from the greater demand from patients for CAM, the marketing efforts of manufacturers of natural remedies and food additives, the increasing number of studies on CAM, the accumulation of evidence as to the effectiveness of some treatments and the growing legitimacy for CAM in the medical establishment. Nonetheless, a review of the literature reveals that IC poses medical, legal, ethical and financial dilemmas, among them: the safety and effectiveness of the treatments; the training, licensing and supervision of the care providers and the question of remuneration. Little research has been done on the way that physicians combine conventional and alternative treatment, the effect of IC on the provision of conventional care, and the way that physicians, patients and policymakers cope with the dilemmas raised by IC.

2. Study Goals

The study aimed to describe and analyze the practice of IC in Israeli primary-care settings from the perspective of IC physicians, their patients and policymakers. More specifically, it examined a number of aspects:

1. IC's implementation, its advantages, the difficulties it causes and how these are addressed by physicians;
2. Physician perceptions of the effect of using CAM methods on their medical decision-making, on the way they provided conventional medicine (CM), and on the quality of care;
3. Patient perceptions of the process and quality of care, and the reasons for choosing this type of physician;
4. Policymaker perceptions of IC, its advantages, inherent difficulties and regulatory issues.

3. Study Methods

The study employed a qualitative approach. We interviewed a purposive sample of 15 IC physicians, 14 of their patients and 16 senior policymakers from the health plans, the Ministry of Health and the Israel Medical Association who wield influence on the field's regulation. In-depth interviews of one-to-two hours were conducted using a semi-structured interview protocol adapted to each group. Interview content was recorded manually and fully transcribed. Data analysis was based on classification and categorization to identify patterns, trends and conceptual categories.

4. Findings

4.1 Implementation of IC

Three patterns of care provision emerged from the patient interviews:

a. Patients receiving IC from their family physician at a health-fund clinic, without payment.

b. Patients receiving IC privately (with payment) from their family physician, at a private clinic.

c. Patients receiving IC privately from a physician other than their family physician.

According to the patients, both conventional medicine and CAM methods were used in all stages of diagnosis and treatment.

The physician interviews also revealed a number of patterns of providing integrated care. On the organizational level, there are different degrees of separation between public and private patients: from a complete separation in time and space (separate clinics) through partial separation to no separation (private and public patients at the same clinic during the same hours).

Concerning the types of treatment given, IC is sometimes offered to public as well as private patients, either with or without payment. The type of treatment they give is determined by the problem presented and by the patients' willingness to accept the treatment.

4.2 The Perspective of IC Physicians

According to the physicians interviewed, the IC approach addresses problems created by conventional medicine as regards both the treatment offered and the organization in which it is provided. The integration of CAM methods in patient care offers more opportunity to take initiative, think independently, connect with patients better and devote more time to them. Moreover, IC enables more humane care and a holistic approach that keeps sight of the person rather than the illness, as they believe the practice of medicine should do. Thus, in their opinion, IC is not a substitute for conventional medicine; rather, it broadens the range of treatment alternatives and helps cope with difficulties such as burnout that often affects practitioners in mainstream frameworks.

The responses raised ethical questions about remuneration for CAM treatments (which are not in the basket of health services) to IC practitioners who work in the public system. The patterns of care employed by the physicians, be they altruism (waiving payment for health-plan patients) or setting boundaries of time and place between private and public practice, are their way of dealing with this problem. However, the boundaries themselves cause another sort of difficulty, restricting physicians from offering IC to all their patients even though they believe in its effectiveness.

With respect to the field's regulation, some of the physicians interviewed saw a need to set CAM training standards for physicians in order to ensure quality of care. Others claimed that standards are both unnecessary – as physicians may be trusted – and may infringe on a physician's autonomy. Moreover, the claim was made that the healthcare system lacks the knowledge to set and enforce standards in this field.

4.3 The Perspective of Patients

Patients regarded IC as preferable to conventional medicine and CAM alike. Its perceived advantage over CAM lay in the physicians' knowledge and use of conventional diagnostic and treatment methods as well, when needed. Its perceived advantage over conventional medicine lay in the physicians' approach (holistic, personal, respectful, attentive) and the use of CAM methods which, in their view, respond not only to the symptom but to the cause of the problem, thereby reducing the chances of recurrence.

The difficulties reported by patients relate chiefly to accessibility: the waiting time for an appointment, the distance from the clinic, the cost of private care and the restrictions barring physicians from offering IC to patients applying to them through a health plan. Alongside their trust in, and high level of satisfaction with, the treating physician, some patients mentioned the need to license CAM practitioners (including physicians) so as to prevent charlatanism; others considered this measure unnecessary.

4.4 The Perspective of Policymakers

The policymakers expressed a good deal of faith in the professionalism and integrity of physicians. The predominant view, therefore, was that physicians need not be restricted and decisions regarding type of treatment may be left to their discretion, including when they chose to practice CAM. According to the Physicians Ordinance, they may offer any type of care, but are liable for the consequences. Their legal responsibility and the terms of their professional insurance assure that they exercise professional, informed and cautious judgment. Several policymakers nevertheless did voice the concern that charlatanism and/or avarice could tempt some physicians to offer ineffective treatments or those whose effectiveness is either marginal or uncertain.

The attitude to IC itself was not uniform due, mainly, to variant perceptions of CAM's effectiveness. Some policymakers stressed the advantages of IC: the variety of tools, a holistic approach, helping patients and responding to their needs. Others noted the impropriety of offering CAM since there is no proof of its effectiveness. Others, still, feared that the diversion of treatment towards CAM would be detrimental to the physician's competence in conventional medicine. Yet another claim was that it is inefficient for physicians to practice CAM in view of the costly medical training they undergo; the implication was that even if CAM is a useful modality it could be provided more efficiently by other types of professionals. The holistic approach (bio-psycho-social) practiced by IC physicians was perceived as beneficial but attributed chiefly to the length of patient visits rather than to inherent features of IC. Many policymakers noted that a holistic approach could be applied in conventional medicine if there were sufficient time, and several claimed that many physicians indeed already do so.

The mix of private and public practice was perceived as the chief danger of IC; most of the interviewees supported a pattern of IC with clearly-defined boundaries (the separation of time and place between public and private care). Opinions on the desirability of regulating IC regulation were not unanimous. Proponents of licensing, training and supervision argued that

these were necessary for the patients' good: to avoid both misleading patients (even if innocently) and greed-driven charlatanism on the part of physicians. Opponents claimed that since physicians are trustworthy and there is insufficient knowledge of CAM to set standards, it is impossible to supervise IC as it includes the provision of CAM.

In all three groups of respondents, the attitude towards regulation revealed a high degree of trust in the physicians' professionalism and integrity; nevertheless, some patients and policymakers felt that there is a danger of charlatanism from which patients need to be protected. Some of the physicians and policymakers, however, recognized that the insufficiency of knowledge as to setting standards for CAM poses an obstacle to regulation.

5.Implications for Policy and Recommendations for Decision Makers

The study findings shed light on the complexity of IC, its advantages and its difficulties as perceived by the interviewees. The study revealed various patterns of IC provision that differ in terms of the boundaries set between conventional, public and complementary medicine administered by one and the same physician. The complexities also emerged in the attitudes of physicians, patients and policymakers towards the field's regulation. The claims against regulation cited trust in a physician's professional integrity as well as the unfeasibility of regulation (e.g., the absence of standardized tools for CAM). The claims in favor of regulation cited a need for training physicians in CAM methods and a clear separation between CAM, which is paid for privately, and publicly-funded conventional medicine, which is provided to health-fund members.

Based on the insights emerging from the study, it is recommended that a number of policy directions be explored:

a. ***Regulating the CAM training*** required of physicians who provide IC to health-plan members, by means of policymakers and IC physicians together setting self-imposed threshold requirements;
b. Regulating ***"the rules of the game"*** for the provision of IC to health-plan members by addressing two issues separately: defining which patients the physicians may treat and how the latter are to be remunerated for treatment;
c. ***Implementing features of IC in conventional medical frameworks*** to increase both physician and patient satisfaction: lengthening patient visits, broadening the use of the holistic approach and developing additional areas of expertise that can be provided privately;
d. ***Encouraging research*** to support policymaking on issues identified by the current study; e.g. how training for IC physicians is regulated in other countries.

The study was funded by the Israel National Institute for Health Policy and Health Services Research.

Table of Contents