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VIEWPOINTS

Connecticut's Integrative Medicine Center Offers a New Conventional Medicine Model: An Interview With David L. Katz, MD, MPH, FACPM, FACP, and Ather Ali, ND, MPH

Andrea McCloud

David L. Katz, MD, MPH, FACPM, FACP, is founder and director of the Integrative Medicine Center (IMC) at Griffin Hospital in Derby, Connecticut. He is also an associate professor, adjunct, of Public Health and director of the Prevention Research Center (PRC) at the Yale University School of Medicine in New Haven, Connecticut. He earned his MD in 1988 from the Albert Einstein College of Medicine in Bronx, New York, and his MPH from the Yale University School of Public Health in 1993. A board-certified specialist in both internal medicine and preventive medicine, he has served as an advisor on obesity control to the US Secretary of Health, the Commissioner of the US Food and Drug Administration, the ministries of health in Canada and Israel, and the National Governors Association. Dr Katz has authored more than 100 scientific papers and book chapters and 11 books.

Ather Ali, ND, MPH, is co-director of the IMC and assistant director of Integrative Medicine at the PRC. He supervises complementary and alternative medicine (CAM) research, naturopathic clinical care, and residency training. Dr Ali also teaches research methodology at the University of Bridgeport in Connecticut. He earned his ND in 2003 from Bastyr University in Kenmore, Washington; his MPH in chronic disease epidemiology from Yale University in 2006; and did his residency training in integrative medicine at Griffin Hospital/University of Bridgeport. He is completing a 3-year National Institutes of Health/National Center for Complementary and Alternative Medicine postdoctoral fellowship focused on research in integrative medicine. He serves as Yale's clinical representative to the Consortium of Academic Health Centers for Integrative Medicine.

IMCJ: The Integrative Medical Center has a research arm, a clinical care arm, and an education arm. Will you explain the structure of the center and how each component fits into that structure?

Dr Ali: The research arm is Yale's Prevention Research Center, funded by the Centers for Disease Control and Prevention (CDC). In keeping with the CDC, The PRC is focused on chronic disease prevention and control. It has a wide portfolio of research interests, including cardiovascular disease and type II diabetes prevention, endothelial function research, nutrition, and obesity control. It also has been home to a number of clinical trials and systematic reviews in CAM topics. The PRC is housed in Griffin Hospital, a community hospital and teaching affiliate of the Yale School of Medicine.

The IMC, the medical practice where we see patients, is the clinical arm**.** The IMC shares staff, resources, and physical housing at Griffin Hospital with the PRC, but the 2 are otherwise financially independent. It also serves as a breeding ground for research hypotheses that are implemented at the PRC.

The educational arm at the IMC is our residency program, a Council on Naturopathic Medical Education (CNME)-accredited program focusing on integrative medicine. The PRC also hosts interns interested in learning about CAM research. These interns include NDs, MDs, MPHs, PhDs, PAs, and nursing students, as well as MD and ND residents.

Dr Katz: There are 3 basic approaches to integrative medicine. The founding approach—and I think Andrew Weil, MD, gets the lion's share of credit for establishing the concept—is training conventional practitioners in complementary disciplines. So take a pediatrician, a family practitioner, and an internist and teach them how to do acupuncture and herbal medicine.

The second approach is a high-overhead approach, something I refer to as "architectural integration." That's when you have a big facility and you put everybody in there. Kind of like the Noah's ark of medical care. You have 2 massage therapists, 2 chiropractors, and 2 acupuncturists. You have to spend a lot of money because you have a big space and lots of people waiting around to see patients.

And then there's our approach, which I think is the least common and, frankly, has the most potential to make integrative medicine the standard practice—that is, to create collaboration, to integrate allopathic and naturopathic medicine in just the same way conventional medicine integrates the care of generalists and specialists. To establish that model, we have a clinic where 2 conventionally trained practitioners and 2 naturopathic physicians work side by side, see patients either jointly or sequentially, talk over every case, and put their heads together to generate what we think is the best possible treatment plan across the full spectrum of complementary and conventional options.

IMCJ: What modalities do you offer?

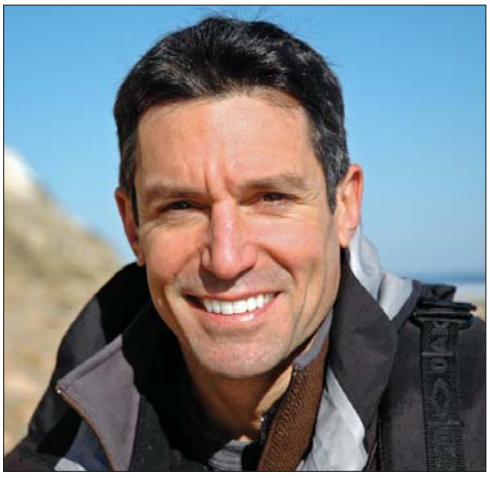
Dr Ali: We offer conventional internal medicine and preventive care along with more alternative therapies such as general naturopathic care, herbal medicine, homeopathy, nutritional counseling, therapeutic touch, and other services based on the interest and training of our residents. For example, our current resident has strong interests in classical homeopathy and massage therapy.

Other residents have had experience in acupuncture and traditional Chinese medicine.

Dr Katz: Ultimately, we want a seamless collaboration and that's how our clinic operates. Dr Ali ran through the services we offer right on site, but we also have identified an array of practitioners who can do just about anything you can think of—from Reiki to acupressure to craniosacral therapy to osteopathy—and we refer out to them. Basically we practice holistic care just the way I practiced internal medicine for years, which is to say I can take care of just about anything, but if your joint problem is severe enough that you really ought to see a rheumatologist, I'll stay involved in your care, but I'm also going to refer you to someone who does nothing but rheumatology. We function just that way. That model of referral is really the template of what I'd like to see spread to the medical community at large.

IMCJ: What is the business model for the center?

Dr Katz: For billing, whenever possible we are reimbursed by insurance, but if a patient doesn't have insurance or if insurance doesn't cover a procedure then there is an out of pocket expense. As far as the business structure goes, we use mid-level providers—so while I'm overseeing the clinic, a nurse practitioner does much of the hands-on care for the patients. And similarly, on the naturopathic side, Dr Ali is the director, but we also have a naturopathic resident. The hiring of a resident offers an array of benefits. To be blunt about it, doctors in training are inexpensive labor. You spend a lot less money on a naturopathic resident than you would on an experienced practitioner.



David L. Katz, MD, had the vision to create a center that integrates allopathic and naturopathic medicine in the same way conventional medicine integrates the care of generalists and specialists.

But more importantly, the graduates of our resident program, including Dr Ali, are in the vanguard of what really should be the revolution in clinical care. Namely, they are practitioners trained in naturopathic medicine along with complementary and alternative modalities who also understand science and clinical trials and have spent an entire year working intimately with their allopathic counterparts. We save money on the cost of the medical care by employing a resident, but we also expand the impact of the clinic by training the kind of practitioner we think is necessary to help change the way healthcare gets done.

Another financial element that mitigates the cost of much of this is grant support. We use the IMC as a crucible to generate testable hypotheses that we can study at the PRC, which is grant supported. As Dr Ali mentioned, we tap into the resources of the PRC to develop the hypotheses into protocols and to secure the necessary funding to carry out the study.

The final financial component is the hospital, which absorbs costs when they exceed revenue.

IMCJ: Dr Ali, will you share a little bit about your experience as a resident?

Dr Ali: The residency program was a tremendous opportunity to hone clinical skills and gain experience in areas beyond my ND training. Structurally, I spent half of my time with the University of Bridgeport College of Naturopathic Medicine, both in their teaching clinic and in a number of community clinics focusing on underserved populations. These clinics fostered the use of "nature cure" in a place where expensive supplements are in short supply and comprehensive lifestyle changes are beyond the means of most. The other half of my time was divided between the IMC, PRC, and rotations at Griffin and Yale-New Haven hospitals.

The IMC aspect had me really focused on honing my clinical judgment and learning to be systematic in my therapeutic choices. The PRC portion exposed me to the world of clinical research in an active, federally funded lab with projects spanning my areas of interest, from pure CAM to general preventive medicine. The hospital portions consisted of hands-on work in a variety of specialties, including cardiology, emergency medicine, gastroenterology, OB-GYN, pediatric critical care, and radiology. The experience fosters an appreciation for the marvels and limitations of modern medicine. It also strongly solidified my commitment to the principles of naturopathic medicine and the beauty and gentleness of nature cure.

IMCJ: How did the IMC come to exist? Was it born of the PRC?

Dr Katz: They developed independently. I founded both, and the IMC did come later, but that's really just historical happenstance. I went to Griffin Hospital as a preventive medicine residency director is 1996 and, early on, started having discussions with administration about their very strong interest in complementary and alternative medicine. I'm a CAM practitioner more by accident than design. I became involved in it not because of any particular calling, but because of the extensive overlap with what preventive medicine is all about—lifestyle practices and healthy diet.

I was interested in developing a model that was in equal parts responsive to the needs of patients and responsible about the use of scientific evidence. It took several years of dialog and mapping out concepts and cost and revenue projections before we were ready to actually open the IMC. That happened in 2000. It was the culmination of several years of effort to operationalize a concept. Scientific evidence is important, high standards of

medical care are important, and patients need and want holistic care that typical practice models don't provide. We thought we could do better, and the IMC was born.

IMCJ: What might be the typical experience of a new patient?

Dr Katz: A new patient is seen sequentially by our 2 teams. They spend roughly 45 minutes either with 1 of our conventionally trained practitioners or 1 of our naturopaths. Then the whole team—the MD, ND supervisor, ND resident, and NP—meets briefly to discuss the patient, in essence, to hand over the baton. "I just saw this patient. Here's the principal issue. Here are the salient elements in his history. Here are some things I didn't fully understand. Here's the part I think you're better qualified to handle." And then the second practitioner goes into the room and picks up where the previous practitioner left off. That's another 45 minutes. At the end of that, everyone reconvenes to do a full presentation of the case, have a full discussion, and generate an array of treatment recommendations.

A guiding paradigm called an *evidence hierarchy* governs the recommendations we provide. The evidence hierarchy is fundamentally a thought process that we teach our residents—basically, a systematic way to evaluate the appropriateness of a therapeutic choice. It's easy when a treatment is safe, efficacious, confluent with a patient's desires, and no alternatives exist. However, most treatments are in a gray area where these choices aren't so clear. The evidence hierarchy is a means by which to choose a therapy that is systematic yet allows for individualized, holistic care. Thus, we can be systematic when we assess whether an herb, drug, nutritional supplement, homeopathic remedy, or a combination is the most prudent choice for a particular patient.

Ather Ali, ND, performed his residency training at the Integrative Medicine Center, allowing him to hone his clinical judgment and make systematic therapeutic choices.

After the team meets together, they then meet with the patient again and go over the recommendations, explain them, give the patient a chance to ask questions, and revise the plan if necessary. And then all team members generally see patients for follow-up visits at intervals dictated by the particular needs of the case.

IMCJ: How do patients find out about the IMC? Have they been referred? Do you market the center?

Dr Ali: Our patients come from all over. Some are referred by Griffin Hospital doctors. Some are referred by local physicians or specialists. Some have seen our website. There are naturopathic doctors in the area who sometimes can't provide services their patients need due to licensing laws; the most salient example is intravenous nutrient therapy. They are referred to us because we can provide those services under the licensure of our MD or NP providers. Occasionally we get patients who come from far away because they've heard of the model of care or they've seen Dr Katz lecture or appear on TV.

IMCJ: What challenges have you encountered through the process of developing the IMC?

Dr Katz: There are 2 fundamental problems. One is paying the bills. We are providing care that is at the margins of what insurers pay for. They want to see evidence. The problem there is that we have an absence of evidence. But absence of evidence is not evidence of absence. A patient in need deserves a trial of things that may not be the product of a randomized controlled trial, but insurers won't necessarily pay for those. Generating sufficient revenue without catering to the rich and famous is a real problem. There's no way around that. We need more science. We need more evidence.

The second big challenge is purely clinical. Most of the patients we get are really tough. They've been everywhere. They've tried everything. They're at the end of their tether because they can't get satisfaction. We become the de facto clinic of last resort. It's the rare patient who comes to us before having seen anyone else. They have chronic fatigue. They have chronic Lyme disease. They have advanced cancer. They have some cryptic neurological condition. On a good day, despite all of that, we're able to help people, and they're immensely grateful and we're immensely gratified. On a bad day, we're scratching our heads. What can we offer that they haven't already tried? We are much more adept at helping these folks than just about anyplace else, but it can be very intimidating and humbling.

IMCJ: Are there any particular success stories that you'd like to share?

Dr Katz: We have many, but there's 1 that is a clear-cut case of the value of integrative care. A male professional in his early 40s had an abdominal trauma that required surgery. In the aftermath of that surgery, he developed adhesions and abdominal pain. When he came to see us, he had had unabating abdominal pain for 10 years. He had been to every conceivable conventional practitioner but had not been to any alternative practitioners. He thought conventional medicine was the way to go and didn't have faith in alternative practices. But after having put up with debilitating pain for a decade, he saw that we offered something new and were under the supervision of a conventionally trained doctor, so he decided to give it a shot.

At the time he came to us, his conventional treatment was suboptimal. He was on short-acting narcotics, and our history revealed something that other doctors had overlooked: He had not slept through the night in years. It's very well established that the quality and quantity of sleep affects your pain threshold. The reason he hadn't slept in years was because the short-acting drugs wore off in the middle of the night and his abdominal pain woke him up. The first thing we did was put him on a long-acting narcotic. After a week of the long-acting narcotic, he was dramatically better. He'd slept for the first time in years. It was a combination of the pain relief from the drug and the elevation of his pain threshold from the normalization of his sleep pattern. We immediately started him on a course of acupuncture, and within 2 to 3 weeks had weaned him off the narcotic completely. At this point, he was pain-free just from the acupuncture treatments. Since he was a busy professional, he didn't have time to continue to come in for acupuncture treatments, so we gave him a homeopathic remedy. Within 3 months of his initial visit, he was absolutely pain-free for the first time in more than a decade. In his case, we needed to follow a conventional treatment for the acute relief he needed but were able to use 2 alternative and more benevolent approaches to reach the long-term goal.

IMCJ: Do you see the older, more-traditional medical doctors opening their minds to CAM, or is it still a battle?

Dr Katz: The notion that everything in nature is benign or that everything in CAM is good is what turns conventional practitioners off. We need to get past that and admit that there's some stuff we're doing in conventional medicine that's highly effective, and there's some stuff we're doing that doesn't work and should be abandoned. The world of CAM is the same. There's some baby and some bath water. If we can all admit that it's a work in progress, then we can embrace one another's practices with open minds.

I needed to find that baby-bath-water formula to feel comfortable. I don't think that dialog has taken place for others. Most conventional practitioners have the view that CAM is voodoo. But they're being pushed by their patients who are using it, so there's this gradual enlightenment. If we can start to describe integrative medicine in terms of being this work in progress, it will accelerate the acceptance process. There's a lot of stuff out there that we simply don't know. That doesn't mean it doesn't work.

Dr Ali: The fact that we have a strong research foundation is a big plus. The conventional medical establishment respects that. And results speak. When our colleagues see patients getting better using therapies they may not have heard about, they become curious. I don't believe in the notion of a vast conspiracy by the medical-industrial complex to suppress CAM. Most people I encounter just want the best for their patients. In the end, it's about relationships and individuals. Never underestimate the impact of being professional, collegial, and true to your foundations.

IMCJ: Any closing thoughts?

Dr Katz: As long as integrative medicine is the stuff of interviews, we have miles to go before we sleep. Only when it's no longer worth talking about because it's just the way healthcare is will the mission be accomplished. My sincere hope is that our model helps to advance that mission.

Dr Ali: I'm aware of many models of integrative care, and my obviously biased opinion is that our model truly allows for the blending of the best of conventional and alternative medicine.

Editor's Note: For more information on the evidence hierarchy see: Katz DL, Behrman A, Girard C, Adelson H, Schiller-Liberti L, and Williams A. Teaching evidence-based integrative medicine: description of a model programme. Evidence Based Integrative Medicine. 2003;1(1): 77-82.

Andrea McCloud, a freelance writer who reports regularly on health and wellness, conducted this interview. Her book series, the "Glow Guides," including *Meditation, Yoga*, and *Spa*, is published by Chronicle Books. Most recently, she was a contributing writer for the revised edition of *Arthritis: An Alternative Medicine Definitive Guide* (Alternativemedicine.com Books, January 2006). She is currently earning her MFA at the University of California, Los Angeles, and lives in Brentwood, California.