Balancing the Scales for Drug-Herb Interactions . . . and more

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Tieraona Lowdog, MD, chair of the US Pharmacopeia Dietary Supplements Information Expert Committee, notes that too much attention has been given to adverse interactions between herbs and nutrients and that not enough has been given to beneficial interactions.

Reframing the Debate on Drug-Herb Interactions

Herbs and natural products are typically viewed by consumers and practitioners of "alternative medicine" as having fewer adverse effects than conventional pharmaceuticals. Thus, it has been an irony of their migration into the medical mainstream that the principal dialogue around natural medicines relates to their potentially detrimental outcomes, particularly when they are used concurrently with conventional pharmacy. Concern about drug-herb interactions has prompted numerous investigations and publications. An early entrant into serving this need for information was the *Interactions* software database developed with a multidisciplinary team led by Mitchell Stargrove, ND, LAc, and published in 2000.

This year, Stargrove, with a coauthor team that includes a medical doctor and an herbalist, brought some useful balance to the drug-herb dialogue. In a forward to the authoritative 930-page *Herb, Nutrient, and Drug Interactions: Clinical Implications and Therapeutic Strategies* (MosbyElsevier, 2008), Tieraona Lowdog, MD, chair of the US Pharmacopeia Dietary Supplements Information Expert Committee, notes, "With the primary emphasis [for herbs and nutrients] on adverse interactions, the topic of beneficial interactions has received little attention." Lowdog then goes on to assert that "An integrative approach would utilize therapies that reduce or mitigate the adverse effects of medications deemed necessary for the patient whenever possible." In other words, while beneficial interactions of herbs and nutrients with drugs are as important to note as adverse ones, a doctor's main goal should be to pursue strategies that limit the need for more-powerful pharmaceuticals that may have significant adverse effects.

To support an even-handed, integrative approach, Stargrove and his team developed a range of measures that guide readers to the appropriate use of both natural agents and pharmaceuticals. The focus is practical information for clinical strategies. Thus, readers confront categories of interactions that are delightfully upside-down to the current views and heretofore not considered. For an individual agent, the reader will find the following types of interactions evaluated: Adverse Drug Effect on Herbal Therapeutics; Drug-Induced Adverse Effect on Nutrient Function; Bi-Modal or Variable Interaction Drug-Induced Nutrient Depletion; and Supplementation Contraindicated, Professional Management Appropriate. In an interview, Stargrove noted the volume's guiding view that "herbs and nutrients are not second-class citizens." Writes Lowdog, "The authors demonstrate an appropriate balance between recommendation and risk based on the overall strength of the scientific evidence and their own clinical experiences. The text is well-referenced, balanced, and objective, and the use of icons and summary tables allows the clinician to quickly identify areas of potential risk, as well as potential benefit." Marketing materials include quotes from a range of physician leaders including *IMCJ*'s own Joseph Pizzorno, ND.

Comment: I am neither trained nor skilled to evaluate the literature or the clinical perspectives presented in this book. What I did immediately recognize is that this team has walked fearlessly, and with as much objectivity as can be mustered, into the gray zones around evidence in which clinicians work. They acknowledge that, whether mixing chemotherapy cocktails or selecting a set of herbs and nutrients in and around conventional pharmaceutical administration, clinicians are always working in realms of partial evidence. The editorial line of the authors is succinctly captured by reference to the conventional mindset that can only too comfortably, as Stargrove states, "counsel patients to avoid healthy behavior on the basis of the possible risk of disrupting predictable drug levels."

IAYT Executive Director John Kepner searched some 2-dozen yoga therapy training programs to begin determining the role that yoga therapy might play in healthcare.

Advancing Clarity on Standard for Training a Yoga Therapist

The International Association of Yoga Therapists (IAYT) distinguishes between "yoga therapists," which IAYT represents, and the literally tens of thousands of "yoga teachers." The former functions with a healthcare and medical focus, though there remain debates inside IAYT on exactly how to frame the relationship. But what education is required to take on

this additional level of responsibility and become a "yoga therapist"? This spring, one IAYT board member, Claire Collins, RN, PhD, and the program's executive director, John Kepner, MBA, identified roughly 2-dozen yoga therapy training programs. They surveyed the group on their standards and hours. The results, posted on the IAYT site (www.iayt.org), show a wide range of programs—from a low end of just 50 to100 hours to a high end of more than 1000 hours. Most cluster in the 250- to 500-hour range.

The survey was engaged as preparation for an IAYT-sponsored invitational meeting of program leaders that took place at its March 2008 Symposium on Yoga Therapy and Research. Involved were program leaders from many of yoga's diverse traditions. Participants heard from a representative of the Academic Consortium for Complementary and Alternative Health Care (ACCAHC) on the education-related maturation patterns from other conventional and complementary healthcare disciplines. They considered the potential value of ongoing communication and collaboration and ultimately resolved, with IAYT's guidance, to explore the creation of a council of programs or schools that might eventually be an organizational force in shaping yoga therapy education.

Comment: Under Kepner's able direction, IAYT has walked with great sensitivity into the debate about a more-integrated role that yoga therapy might play in healthcare delivery in the United States. If the evolution of other healthcare professional education is a guide, this convening of schools could be a critical step in advancing the field. As the ACCAHC representative at the meeting, I shared how the formation of a council of schools or programs typically involved some contentious processes regarding setting standards. (For instance, can a person rightfully declare him- or herself a therapist, of any kind, based on 50 hours of training?)

Such councils typically foster creation of a specialized accrediting agency that gains clout if it, in turn, secures recognition from the US Department of Education as the educational standard-bearer for the discipline. Such an agency then becomes a key reference point in public or private initiatives for inclusion or even licensure of the related field. IAYT has made it clear that it has not committed to licensing as a professional goal. In fact, yoga's uptake into US healthcare seems to be proceeding rapidly without such formal self-regulation. That stated, IAYT's convening of schools has created a platform for envisioning new futures for this emerging, mind-body world medicine.

SHORT TAKES

▸ Charlie Maguire, the founder of the American Holistic Nurses Association, died on May 15, 2008. Maguire brought 81 nurses together for a gathering she convened in 1981. That meeting has blossomed into a 4000-member association with a Board Certification in Holistic Nursing (BC-HN) that is recognized by the American Nurses Association.

Christine Goertz Choate, DC, PhD, is the principal investigator in an NIH NCCAM award to establish a 4-year, multidisciplinary Developmental Center for Clinical and Translational Science in Chiropractic care.

▸ The Palmer Center for Chiropractic Research received an award to establish a 4-year, multidisciplinary Developmental Center for Clinical and Translational Science in Chiropractic care from the National Institutes of Health National Center for Complementary and Alternative Medicine. Christine Goertz Choate, DC, PhD, is the principal investigator.

▸ The Samueli Institute partnered with the Institute for Family-Centered Care for a spring seminar entitled Hospitals and Communities Moving Forward with Patient- and Family-Centered Care. This strategic move by the Samueli Institute, headed by former National Institutes of Health Office of Alternative Medicine Director Wayne Jonas, MD, marks another extension of Samueli's mission to transform hospital-based care through its Optimal Healing Environments initiative (for more information on this initiative, see www.siib.org). The Institute has also partnered with the American Hospital Association's affiliate in content, Health Forum, to produce Health Forum's 6th Annual Conference on Integrative Medicine for Health Care Organizations, entitled Leadership and Business Strategies for Integrative Health Care.

▸ The Arizona State School of Social Work has announced that it will begin offering a graduate certificate program in the Assessment of Integrative Health Modalities. Target audience is nurses and social workers. The program is meant to increase awareness of integrative approaches.

▸ In mid-May, the *Journal of Chiropractic Education* achieved inclusion by the National Library of Medicine into PubMed Central, the NIH's free digital archive.

Downloading Guided Imagery into US Healthcare

In 1989, in Northeast Ohio, Kaiser Permanente began to deliver little cassettes on guided imagery to assist the healing processes of certain of their patients/members. The cassettes were produced by Health Journeys, an information company founded by psychologist Belleruth Naparstek.

Early use led to a successful Kaiser pilot study involving mind-body tools at Santa Rosa Hospital in California. Promotion of these cassettes, then CDs, within Kaiser slowly expanded until this spring, in a watershed move for the uptake of guided imagery in US medicine, Kaiser began to offer free guided imagery downloads to all its members nationwide. A statement from Health Journeys describes the program: "Members go to their doc's

web page or a pod cast page, and access any of 7 digitized guided imagery recordings: Healthful Sleep, Ease Pain, Pregnancy and Childbirth, Successful Surgery, Mastering Menopause, Weight Loss, and Relieve Stress."

The respect for these inexpensive interventions gained another foothold in the late 1990s when Deborah Schwab, MSN, a Blue Shield of California employee, began a study that not only looked at patient satisfaction but also quality-of-life outcomes. Schwab studied big-dollar issues, including the potential impact of CD-based guided imagery, on length of hospital stays for surgical patients. In a recent issue of *Advances in Mind-Body Medicine,* Schwab reported a reduction of 14% in mean total charges among surgical patients, or $2003 per procedure.[1] Now, according to Naparstek, other routine promoters of Health Journeys' inexpensive interventions include health plans such as United Healthcare and Oxford Health Plans (now part of United); 120 Veterans Administration hospitals; and biotech and pharmaceutical firms such as Boche, Amgen, Ortho Biotech, and Glaxo, who offer the mind-body CDs as a complement to pharmaceutically-supported surgery.

Comment: When I learned of the Kaiser decision, I contacted Naparstek to see to what extent the use of these CDs has made its way into clinical strategies of integrative practitioners who are working in their own outpatient clinics. Do individual professionals sell the CDs in their offices? Health Journeys' response was that sales are growing, but they didn't have readily available data. Massage therapists, spas, wellness practitioners, and social workers are most likely to sell the CDs. Other practitioners, they believe, simply point patients in the direction of their catalogue. (Another catalogue vendor is Healing Mind, founded by another mind-body pioneer, Martin Rossman, MD, LAc.) The question arises as to whether integrative practitioners are missing an opportunity to reinforce healing behavior if they don't promote these mind-body practices in the way, for instance, that they promote use of nutritional supplements.

Rick Kellerman, MD, immediate past president of the American Academy of Family Practice, notes that US regions with more primary care have better health outcomes and lower costs than those that are more dependent on specialists.

The Medical Home Movement and Complementary Practices

Last year, 4 professional organizations representing 350 000 physicians rolled out a joint statement to promote the concept of the "patient-centered medical home" as a major agency for health reform in the United States (http://www.medicalhomeinfo.org/Joint%20Statement.pdf). This is a historic partnership among the American Academy of Family Physicians, the American Osteopathic Association, the American College of Physicians, and the American Academy of Pediatrics.

Patient-centered medical homes are a kind of outpatient care that is technologically linked, team-focused, and based on wellness and preventive options. Supportive data for this healthcare direction are powerful. In a presentation to large employers at the October 2007 meeting of the Institute for Health and Productivity Management (www.ihpm.org), medical home leader Rick Kellerman, MD, the immediate past president of the American Academy of Family Practice, noted that regions with more primary care have better health outcomes and lower costs than those that are more dependent on specialists. Might we not expect even better primary care outcomes through the coordinated teamwork of these medical home models?

After the presentation, I asked Kellerman if the medical home model had any place for complementary and alternative health practitioners. After all, for a significant subset of consumers, their own healthcare "homes" include use of complementary healthcare professionals. In addition, from a practical, political perspective, might it not be smart for these primary care organizations to directly solicit connectivity with the nation's 70 000 chiropractors, 25 000 acupuncturists, 4500 naturopathic physicians, and 250 000 massage therapists[i] whose patients are known for their political action? If proactively included, these practitioners, who also work nearly unanimously in outpatient settings, might be useful in political efforts for change. Kellerman was interested, but noncommittal.

***Comment*:** The medical home movement—which some view as a grab for power by these primary care professions—reminds me of a description of health reform I heard from Robert Duggan, co-founder of the Tai Sophia Institute: "Reform medicine by getting people out of the sick-care system." Diminishing the time people spend in disease and error-riddled tertiary care is a good step. Of course, our hospital-centric leadership of US medicine is not likely to embrace such a concept merely on its merits. Medical home activists would be well served to expand their strategic thinking from their own historic coalition to a broad-based grassroots movement. Given the sad and disempowered condition of primary care of all types in the United States, they'll need all the help they can get.

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Reference

1. Schwab D, Davies D, Bodtker T, Anaya L, Johnson K, Chaves M. A study of efficacy and cost-effectiveness of guided imagery as a portable, self-administered, presurgical intervention delivered by a health plan. *Advances*. 2007;22(1):8-14. Available at : http://www.advancesjournal-digital.com/advancesjournal/2007summer/?sub_id=By33YaCH5SynZ. Accessed June 16, 2008.

[i] These are self-reported numbers from the American Chiropractic Association, the American Association of Acupuncture and Oriental Medicine, the American Association of Naturopathic Physicians, and the American Massage Therapy Association.