

Interview with Marc Micozzi, M.D., Ph.D.

by Daniel Redwood, D.C.

Marc Micozzi, M.D., Ph.D., former director of the National Museum of Health and Medicine and newly named Executive Director of the College of Physicians, is emerging as a major figure in the field of alternative and complementary medicine. Trained as both a medical physician and an anthropologist, he is the editor of the *Journal of Alternative and Complementary Medicine*, which debuted in January 1995. He edited the new landmark textbook, *Fundamentals of Complementary and Alternative Medicine*, published by Churchill Livingstone, and is the series editor for a forthcoming series of texts on various aspects of alternative medicine. He was also the program chair for the First International Congress on Alternative and Complementary Medicine, held in Arlington, Virginia in May 1995.

In this interview with Dr. Daniel Redwood, Dr. Micozzi discusses major issues of concern in the field of alternative medicine, including the fact that the United States lags far behind Europe in the integration of these therapies into mainstream practice. Micozzi says the alternatives that interest him most are those "that represent complete systems of thought and practice, in which the practices are derived from a whole pattern of thought about health." He expresses enthusiasm at the increased scientific attention such subjects are attracting, saying that "science shouldn't use the terms 'mainstream' and 'alternative.' Science is science."

Looking toward the future, Dr. Micozzi calls for "tolerance and medical pluralism," recognizing that this ultimately requires a shift in power relationships between doctor and patient. "Health is not something you grant someone," he says. "Health is something that must be pursued... Every person really has to be responsible to stay healthy, and get well when they're sick, and has to focus on their ability to care for themselves."

Subscriptions to the *Journal of Alternative and Complementary Medicine* are \$89/year personal, \$120/year institutional from Mary Ann Liebert, Inc, Publishers, 1651 Third Avenue, New York, NY 10128.

Dr. Micozzi's mailing address is Marc Micozzi, MD, PhD Executive Director College of Physicians 19 South 22nd Street Philadelphia, PA 19103-3097

Marc Micozzi Interview

DR: Have you been surprised at the seemingly rapid growth of alternative and complementary medicine?

MM: I can't say that I've been surprised by it, but I've been impressed by it. It's not a surprise. When you look at the health care crisis that we're in, it's a crisis for both practitioners and for patients. You know, doctors want to heal, and there are a lot of problems people have for which mainstream medicine has no really good alternative, to use the term in that way. That bothers patients and it bothers doctors.

I think that a lot of doctors are open to looking at things that are going to work, because they want to be healers. I think that's something we can rely on in this crisis, the motivation to find better ways. But the health care crisis, in my view, has been seen as a crisis of cost, and to me the costs are only a symptom. The health care crisis is really a crisis of confidence and conscience. Even if the health care that's available is effective, if it's not affordable, then it's really not effective.

Alternatives, to me, provide an orientation toward self-care and self-cure that can really be an answer to the health care crisis. That's what's optimistic about this whole picture. I feel quite optimistic about our so-called health care crisis. It's not going to get solved in the way the so-called health care

reformers have gone about it. It's not that we have to change how we're paying for what we're doing-we have to change what we're doing.

DR: Do you feel that the United States is in the forefront of the move toward alternative and complementary medicine?

MM: No! Absolutely not! The United States is way behind. That's another thing I've learned clearly and indisputably in my work on these publications in the last couple of years-that the U.S. is way, way behind.

DR: Please expand on that.

MM: Europe is way ahead of us. Our best research papers are coming from Europe. Probably two-thirds of Europeans are using alternatives, as opposed to one-third in the U.S. You've got state supported alternative practice institutes in many countries of Europe that have been around for a long time. We're just barely getting started with that here. So the U.S. is way behind. We think we're ahead in terms of medical technology, and that is the case, but we're not ahead in terms of affordable health care and realistic alternatives to the present system.

DR: Why do you think it's turned out that way? Why is the United States not in the forefront?

MM: One of the binds has been that the biomedical establishment demands scientific evidence, which is very expensive. The federal government spends over \$10 billion a year subsidizing biomedical research in this country, and the sum total of what we've spent on alternative medicine research in all of history is something less than \$20 million. So to demand scientific evidence, knowing the costs of producing that evidence, but at the same time to say we shouldn't spend money on creating that scientific evidence, leaves us in a bit of a bind.

DR: Do you think that the Office of Alternative Medicine of the National Institutes of Health is likely to make a major contribution to the evolution of alternative medicine?

MM: I think that a lot of the focus has been on the Office of Alternative Medicine. I am continually impressed by what's going on elsewhere, other than the Office.

DR: Could you give some examples of things that are heartening to you?

MM: There are larger research efforts underway, at the National Heart, Lung and Blood Institute, the National Cancer Institute, and the Fogarty International Center, which could probably be considered alternative or complementary medicine. All of these are parts of NIH. But all the attention has been on the OAM, which is a pretty small operation in comparison.

DR: Could you give one or two examples from those other programs at NIH?

MM: There are programs using relaxation and meditation to control blood pressure. There is the Natural Products Program at the National Cancer Institute. Some improvements could be made in terms of the scope of the activities that they're looking for among medicinal plants, but nevertheless it's a very large program that is looking at natural products that can be helpful in the treatment of chronic diseases.

DR: Regarding plants as medicine, the United States is at this time a country where there is no nationwide profession that specializes in herbal medicine. Naturopathy is still at this point more of a regional phenomenon.

MM: My own view is that I don't see herbal medicine per se as a specialty in this way, or as a medical system. The use of plants is common to every alternative system . . . Is herbal medicine really a holistic system? Or is it that instead of using a drug for a particular condition, I'll just use an herb? To understand an alternative system, there has to be an entire world view behind it in terms of: Where does health come from? How do I keep it? How do I get well?

Using plants and natural products is part of it. Nutrition is a focus. So is lifestyle. Understanding how to manipulate the body's energy, for example, is part of alternatives, but is there something that is called "energy medicine?" I don't know. What I tend to do is look at the things that alternative systems use that focus on the whole person: the focus on wellness, the use of natural products, nutrition in a primary role, the recognition of bioenergy. These are things that are not any

one system- they are shared among alternative systems.

DR: Do you feel then that health practitioners, whatever their profession, should become knowledgeable in, or at least aware of, these areas so as to be able to use them when appropriate, or refer to those who do?

MM: That's an open question. I think it's a difficult challenge. When you mention naturopathy, I look back at history. A hundred years ago, before the Flexner report [which revamped American medical education, and nearly eliminated many alternatives], we had something called Eclectic Medicine, which used the best of everything, and didn't focus in such a way that everybody who comes in gets a drug, or everybody who comes in gets a spinal manipulation, or whatever.

I look at naturopathy, and my term for naturopathy is "new eclectic medicine." If there's a new system that comes along that has merit, they immediately try to incorporate it. It's very laudable in that respect. That's a viable model, but I think in the end what we're going to evolve to is a system of self-care and self-cure, so that the patient will refer himself, will know enough about their own body and what they need to do for themselves, and what works for them.

DR: The trend in insurance reimbursement in the United States is precisely in the opposite direction, with HMOs and gatekeepers. How is this going to work?

MM: I don't know how it's going to work. Because what happens in managed care is that when we start getting alternatives into the picture, suddenly it's just handled as another referral. It becomes another cost center, and you really haven't accomplished what you set out to do.

I think we should have tolerance and medical pluralism. Just as we have cultural diversity, we should see it as a resource, we should value it. We should let people choose for themselves. Health is not something you grant someone. A doctor cannot grant a patient health. Health is something that must be pursued. It's a path that people have to choose to get on. They can't be given health with a pill or an operation. It goes even beyond lifestyle. It's an issue of philosophy, and every person really has to be responsible to stay healthy, and get well when they're sick, and has to focus on their ability to care for themselves. That's a common element among alternatives. That's the only solution, in the end. No one can give you health.

DR: Can that viewpoint be integrated into the training of health care professionals?

MM: I think it's easier to see how to integrate it into training than into today's health care system. But it's pretty clear that it can be integrated into training. We are now committed to publishing a series of textbooks for medical students. We have a commitment from a major medical publisher to create a complete library of textbooks on complementary and alternative medicine.

DR: Does such a library exist elsewhere now?

MM: No, not in terms of presenting information to medical students and medical professionals in terms that they can understand and relate to. And incomplete terms. In other words, to present these things as systems. What is the underlying world view? What is the philosophy? What's the intellectual framework? In ways that make sense, that are understandable. Not just this technique or that technique, that's hard to place in context and hard to understand. We're trying to recontextualize these alternatives, so they're not just seen as techniques, but in the context of practices, systems of thought, and entire ways of looking at health and medicine that make sense.

DR: What first led to your interest in medicine?

MM: It's pretty clear that I was inoculated at an early age.

DR: In what way?

MM: Well, the usual parental pressure. Both of my parents were immigrants and it was really important to them that I become a doctor. My real interest was in natural science and also in history. I was one of those rare people who had a high aptitude for science, high aptitude for humanities and history, but a low aptitude for math. Usually math and science go together. Also, I loved the humanities and history.

DR: How did that affect the route of your career?

MM: I was very disappointed in my medical training at the complete lack of what we would today call medical humanities... Modern medicine is not grounded in the natural sciences; it's grounded in a very small subset of science. So in that way I find it less scientific. It's an interesting perspective-we talk about being scientific, yet there's a lot of science that doesn't really figure into allopathic medicine and the biomedical model.

DR: So not all science takes place in man-made laboratories.

MM: That's correct. That's exactly the point.

DR: What led you into anthropology?

MM: It was feeling that I needed to learn a lot more about other aspects of human experience that were relevant to health, beyond what I was getting in medical school. After two years in medical school I got a fellowship to study in Asia, and when I came back from that experience I realized that I was not going to learn in medical school what I thought was most important in terms of understanding our health problems. Anthropology gave a perspective that was very important to me. Fortunately the University of Pennsylvania had a combined degree program to do an M.D. and Ph.D. So I ended up doing a masters in epidemiology and a Ph.D. in anthropology at the same time as my medical training.

DR: Did you practice medicine after that, or go into academia?

MM: I pretty much went the academic track. I practiced medicine within a hospital setting, which I did not particularly enjoy. I also found that I was a resource in my neighborhood. I lived in an Italian neighborhood in West Philadelphia at the time, because that's the only place I could afford to live during my prolonged period of training. I found that I was a resource there, basically acting as a primary care physician. Not for pay, but much more along a traditional model where I wasn't making my living at it. It was a blue collar neighborhood, and in exchange people would cook meals for me, they'd invite me to dinner, or the electrician would fix my wiring, the carpenter would do this or that. It was really a very nice experience.

DR: It's interesting to me that you use the word "traditional" to describe that, because I think some of us in this country have gotten so used to contemporary, high-tech Western medicine that we think that's what's traditional.

MM: If we really talk about what's traditional, this modern invasive high-tech tradition is only one or two generations old. When we talk about traditions as anthropologists, we're talking about age-old systems that have been around for a long time.

DR: Which of those age-old systems attract you most?

MM: The ones that are of interest to me are those which represent complete systems of thought and practice, in which the practices are derived from a whole pattern of thought about health... Systems that are well-developed, well-articulated, well-established. These systems are not just random myth, magic and superstition. They're often put down that way, but these alternative medical systems represent complete systems of thought and practice.

They're internally consistent, they make sense, they give people effective ways of interacting with their environment, they've been used for many generations among many different practitioners with many different patients, and they are widely held to have observable benefits. Examples are Chinese medicine, Indian medicine, and, in its own way, curanderismo here in the Americas, which represents rather a syncretic system, a blending between 16th century European medicine that was brought to the New World, combined with indigenous medicine that was already here. Then we have other healing systems that are not in the written tradition.

DR: What would be some examples?

MM: Native American. The indigenous medicine of the Americas is a particular challenge to study, because the knowledge is traditionally held in the oral tradition and not written down. There are symbolic and pragmatic issues in trying to get the knowledge written down in any form. To some extent African medicine would be like this as well.

DR: In this light, are new and different methods needed for studying such systems?

MM: Sure. You've got to take a relativistic approach, and to understand the epistemology of the system in order to really make sense of it. We're trying to establish some of those approaches and some of those standards, and articulate the need for this, through our publication, *The Journal of Alternative and Complementary Medicine*.

By contrast, some of the techniques that we have trouble studying are techniques that have evolved in the last generation, the product of one particular practitioner, that other people don't use. There isn't really a system there; instead it's a technique that is being propounded by certain individuals.

One of the things I've come to realize is that the unusual is not necessarily the alternative. There are some unusual treatments that in effect fit with the allopathic model, in the sense that they involve an intervention, an isolated compound or treatment that is somehow affecting the body. In a sense, these are just an unusual version of allopathic medicine. I don't see them as representing alternative systems. In other words, what's the philosophy behind it? What are the other practices associated with it?

DR: Would you say that the hallmark of the allopathic model is the treatment of symptoms?

MM: Yes. Many unusual treatments are not necessarily alternative in that they don't look at the underlying philosophy. They're focused on treating symptoms. They propose just another magic bullet, with the difference being that their magic bullet may happen to be, say, some sort of cartilage. To me that's an unusual treatment, not an alternative treatment. Because what's the underlying philosophy? It's just a new magic bullet.

DR: The editorial board of the *Journal of Alternative and Complementary Medicine*, of which you are the editor, includes some mainstream figures like former Surgeon General C. Everett Koop, along with international leaders in the alternative medicine field. What kind of interchange are you hoping for? What are your goals for the journal?

MM: The people on the board are interested in science, basically. That's the common denominator we look for, regardless of whether they're "mainstream" or "alternative." Science shouldn't use the terms "mainstream" and "alternative." Science is science. It's based on observation. There are scientists who are interested in observing what the effects of these different [alternative and complementary] systems are. If there are things that can't be explained in the biomedical model, then we need to learn that, and expand the model to account for the observations that are made.