

ACMA

THE AUSTRALIAN COMPREHENSIVE
MEDICINE ASSOCIATION

DIRECTIONS

&

OPPORTUNITIES

POSITION PAPER

VERSION 2.8

The Mission of ACMA

The mission of ACMA is to promote & foster safe & effective Complementary Medical practice within a framework of Total Health Care.

Purpose of this document

This document has been prepared to stimulate ideas and discussion on the structure of ACMA and the directions that it should take, particularly in its relationship with academic bodies in Complementary Medicine. In particular, it proposes a scenario in which there is a clear division between ACMA as a political and organisational body representing the broad range of Complementary Medicine on the one hand, and the various independent academic bodies representing the individual "sub-specialties", or craft groups, within Complementary Medicine on the other. This document is intended as a working position paper, and is expected to provide a framework for further discussion. It has emerged from the National Workshop in Sydney in Sept 94, and is a "living" document, subject to feedback and review.

Update information:

This document (Version 2.8) is current as at Monday, 24 August 1998 , and should replace all previous versions.

Acronyms used in this Document

ACMA	Australian Complementary Medical Association
AMA	Australian Medical Association
BMA	British Medical Association
CM	Complementary Medicine
CME	continuing medical education
CPCMC	Council of the Presidents of the Complementary Medical Colleges
CPMC	Council of the Presidents of the Medical Colleges
HIC	Health Insurance Commission
NEJM	New England Journal of Medicine
PBS	Pharmaceutical Benefits Scheme
PR	peer review
PSR	Professional Services Review
QA	quality assurance
RACGP	Royal Australian College of General Practitioners
SIG	Special Interest Group
WHO	World Health Organisation

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EXECUTIVE SUMMARY

- The Australian Complementary Medical Association (ACMA) was originally created to protect Complementary Doctors from the Professional Services Review (PSR) legislation regarding “inappropriate practice”. The discussions to date have led to concessions that allow for ACMA members to be first reviewed and counseled by their peers through an “internal review” process.
- Protection of ACMA members from referral to the PSR will be dependent on establishing consistent standards across Complementary Medicine for CME, peer review, and QA programs. The establishment of these programs is to be overseen by the Council of the Presidents of the Complementary Medical Colleges (CPCMC), which will work closely with ACMA. The Colleges, with the support and input of ACMA, will implement such programs.
- ACMA will not be directly involved in medical education, but will provide funding and the structure required by the colleges to fulfil their educational obligations, to establish peer review, and to commence appropriate research and outcome studies. External benchmarks and feedback processes are critical for the success of this program.
- ACMA will work with the CPCMC to ensure that members participate in these educational processes. ACMA members must belong to an approved educational body, and participate in the educational programs of that college. Members of participating Colleges must join ACMA to gain protection from PSR referral, to gain a political voice within Complementary Medicine, to benefit from the organizational structure of ACMA, and to participate in many professional opportunities.
- A broad range of new professional opportunities will exist for Doctors wishing to join the growing and maturing field of Complementary Medicine. These opportunities are discussed.
- Research and outcome studies will be undertaken, and will be directed to those areas identified as being priorities on the basis that they are poorly managed by modern medical techniques, and because Complementary Medicine may prove cost-effective in the management of these disorders.
- ACMA will work with its members, the Medical and Complementary Colleges, Government, industry and the medical profession to ensure equitable access to Complementary Medicine by all Australians within ten years.
- ACMA proposes a short term (2 yrs) and long term (10 yrs) plan:
 - Before the end of 1996;**
 - *Colleges within Complementary Medicine will have achieved a consistent, high standard with regards the educational process*
 - *Colleges will define the means to achieve the same high standards in the content of the courses offered*
 - *The CPCMC will be established by July 1995, and will oversee this process*
 - *Protection of ACMA members through the internal peer review process will be established*
 - *Priorities for research and outcome studies will be set with input from external bodies (e.g. RACGP)*
 - *The communications and information systems will be defined, and its core elements established*
 - *ACMA will begin responsible dissemination of information related to Complementary Medicine to its members, to the profession generally, to government and to the public*
 - Between 1997 and 2004;**
 - *ACMA will facilitate the integration of Complementary Medicine*
 - *ACMA will bring the disciplines of Complementary Medicine within a common conceptual framework*
 - *ACMA will establish and promote Complementary Medicine as a part of the undergraduate curriculum at the major Australian Universities*
 - *ACMA will make Complementary Medicine a valid vocational choice for medical graduates*
 - *ACMA will create the links and associations to ensure the establishment of Complementary Medicine, and the long term prosperity and opportunity for its members*

History of ACMA

The Australian Comprehensive Medicine Association (ACMA) was established in April 1994 following a meeting in Sydney of nearly 50 Medical Practitioners from all fields of Complementary and Alternative Medicine. Initially named the Australian Complementary Medical Association, it was originally formed in response to the threat posed to Doctors practising Complementary Medicine by the Professional Services Review (PSR) amendments to the Health Insurance Act. Under these amendments, a doctor in Australia risked prosecution and heavy fines for practising medicine in a way which differed from the majority of their peers. The potential fines were excessive, and Complementary Medicine Doctors did not have peer representation on the panel of the PSR, nominations for which were largely in the hands of the AMA.

The meeting elected a committee to establish ACMA, to enter discussions with relevant bodies, and to make proposals on how the PSR threat could best be managed. Primary support was provided by Dr Brighthope and the Australian College of Nutritional & Environmental Medicine (ACNEM), and Dr Mark Donohoe was elected Acting Chairperson of ACMA. The steering committee comprised thirteen Doctors, representing all States of Australia and many disciplines in Complementary Medicine. The original committee members were:

<i>Dr William Barnes (WA)</i>	<i>Dr Russel Cooper (Tas)</i>	<i>Dr Giselle Cooke (NSW)</i>
<i>Dr Peter Dobie (NSW)</i>	<i>Dr Mark Donohoe (NSW)</i>	<i>Dr Joachim Fluhrer (NSW)</i>
<i>Dr Alan Hadley (Qld)</i>	<i>Dr Nick Goodman (NSW)</i>	<i>Dr Zenon Gruba (Vic)</i>
<i>Dr Mel Sydney-Smith (Qld)</i>	<i>Dr Margaret Taylor (SA)</i>	<i>Dr Jonathan Turtle (ACT)</i>
<i>Dr Emmanuel Varipatis (NSW)</i>		

This group provided the original direction for ACMA, and all members gave valuable and active input. A working group was established in Sydney to meet regularly, and to action the decisions of the steering committee. This led to ACMA successfully raising the issues in the medical and popular media, with articles in *Australian Dr Weekly*, and television stories on *Dateline* and *A Current Affair*. Dr Donohoe opened a dialogue with the Health Insurance Commission (HIC) in early June 1994, resulting in a formal meeting between ACMA representatives (Drs Asher, Cooke, Donohoe and Goodman) and three senior Doctors of the HIC on July 14 in Canberra. This meeting was a turning point in improving the understanding between ACMA, the HIC and the Department of Health. The Minister has subsequently been publicly supportive of the initiatives agreed upon at this initial meeting, and this has allowed for a dramatic improvement in the relationship between these bodies since that time. The HIC and ACMA are now working together to achieve the common goal of better health for all Australians.

ACMA has achieved concessions and undertakings from the HIC, the most important being that ACMA members will not be referred directly to the PSR. Should the ACMA member so request, their case will be referred back to ACMA where an internal review process may be carried out in conjunction with the respective Colleges to which the Doctor belongs. This will provide the Doctor an opportunity for true peer review. The findings will be reached, the Doctor counseled if necessary, and the results of the review will be conveyed back to the HIC. If the matter is to go further, the Doctor may subsequently elect to have ACMA communicate on his or her behalf with the HIC.

A second process of review is proposed, one in which the HIC provides “de-identified data” to ACMA on styles of complementary practice about which the HIC has concerns. ACMA would be responsible for liaising with the appropriate College or craft group, to determine in principle whether the methods or styles were appropriate. The degree of professional and scientific support for such practices would be determined. This would be conveyed to the HIC, and would provide a fair and cost-effective means of determining appropriate practice.

The 1st National Workshop of ACMA

New opportunities for ACMA have now been identified as a result of ACMA’s 1st National Workshop, which was successfully conducted at the Airport Parkroyal Hotel in Sydney in the first week of September 1994. The participants achieved an extraordinary degree of consensus on the issues of the mission and goals of ACMA, and showed unity, vision and an ability to work together towards common goals. These qualities will sustain ACMA through the work ahead, and allow ACMA to become the national body representing doctors using Complementary Medicine in their work.

A 21 member Steering Committee and smaller Executive Committee has been established as a result of the Workshop. The Executive Committee will meet regularly to identify the means by which the goals set at the Workshop can be attained, the timeframes for the achievement of such goals, the associations required to achieve them, and the costs of achieving them. The Executive Committee will keep the Steering Committee informed of progress on a regular basis, and will work towards putting the proposals to the Steering Committee at the 2nd National Workshop in March 1995. At this Workshop, the Steering Committee will review the proposals, set the directions and constitution of ACMA, and prioritise and authorise those actions which will best support the interests of ACMA members.

The significant agreements and proposals reached at the 1st National Workshop, unanimously supported by the members of the Steering Committee, include:

- that the Australian Comprehensive Medicine Association be the national body politically representing doctors practising Complementary Medicine, and the colleges and institutions to whom they belong
- that the Executive Committee be established to gather information in the following areas:
 - a. *The structure and constitution of ACMA*
 - b. *Political issues, especially related to the PSR*
 - c. *Education - Establishing common standards*
 - d. *Quality assurance in Complementary Medicine*
 - e. *Research opportunities and priorities*
 - f. *Information Technology and Communications*
 - g. *External relations - media, public, colleges, medical organisations*

and that the Executive Committee formally present this information and its proposals or preferred options to the Steering Committee at the 2nd National Workshop in March 95

- that ACMA establish an office and budget, and continue its work in representing the interests of Complementary Medicine Doctors until the March 95 Workshop
- that ACMA establish an interim budget to achieve these requirements, and establish a membership fee appropriate to the costs which will be incurred in achieving these goals
- that all members of the Steering Committee immediately contribute \$300 to ACMA as a practical demonstration of support for ACMA, and to create a financial base from which ACMA can progress.

The following Steering Committee was elected at the Workshop, with 2 additional members subsequently added. All Committee members are registered medical practitioners.

Dr Bob Allen(Vic)	Dr Eric Asher(NSW)	Dr William Barnes ..(WA)
Dr Nick Bassal (NSW)	Dr Heather Bassett(NSW)	Dr Ian Brighthope ...(VIC)
Dr Giselle Cooke *...(NSW)	Dr Russell Cooper (Tas)	Dr Peter Dobie *(NSW)
Dr Mark Donohoe * .(NSW)	Dr Joachim Fluhrer *...(NSW)	Dr Nick Goodman *(NSW)
Dr Alan Hadley(QLD)	Dr Andriya Martinovic (QLD)	Dr Margaret Ngu(Vic)
Dr Mel Sydney-Smith (Qld)	Dr Margaret Taylor(SA)	Dr John Turtle(ACT)
Dr Emmanuel Varipatis*(NSW)	Dr Vicki Kotsirilos # ... (Vic)	Dr Stephen Myers #(NSW)

* = Executive Committee Member

..... # = Subsequently added to Steering Committee

ACMA — Mission & Overview

The mission of ACMA is to promote and foster safe and effective Complementary Medical practice within a framework of Total Health Care.

In addition, ACMA holds certain Principles relating to the provision of care by its members, namely:

1. The principle of whole person care (WHO mandate), espousing the betterment of each individual, inclusive of physical, social, psychological, emotional and spiritual well-being, and
2. The declaration of Helsinki (World Medical Organization), that a physician must be free to use the most appropriate treatment if, in his or her judgement, it will result in the alleviation of suffering, the restoration of health, or saving the life of the patient.

To achieve these, an educational program is essential, leading to the processes of quality assurance through peer review and feedback. Information needs to be gained from research and outcome studies, and conveyed to the general profession through peer reviewed journals. Practice methods and educational content must be sufficiently responsive to be varied according to this information.

An infrastructure of communications and information will be provided by ACMA to enable this process. ACMA will thus provide a common “interface” for Government, industry, media, the medical profession and the public. ACMA will work to achieve the vision of a unified discipline of Complementary Medicine in Australia by the year 2000.

Definition of Complementary Medicine

Complementary Medicine is a generic term that encompasses a broad range of diagnostic and therapeutic modalities not commonly taught to medical students in the Australian undergraduate medical course. The term “Complementary Medicine” is used in preference to “Alternative Medicine” because the practitioners are Doctors who combine the techniques of alternative and allopathic medicine, with the aim of achieving an improved outcome for their clients. Since they are first and foremost Doctors, the “alternative” skills are used to augment and support the medical assessment and management of the patient, where appropriate.

Because of the enormous diversity of the styles of practice, it is not possible or useful to provide a “hard and fast” definition of Complementary Medicine, especially one that would satisfy all groups currently under this loose banner. An article in the NEJM (*Physicians & Healers – Unwitting Partners in Health Care* Vol. 326, N° 1, Pp61—64) suggested “alternative medicine” refers to “...a heterogeneous set of practices that are offered as an alternative to conventional medicine for the preservation of health and the diagnosis and treatment of health related problems; its practitioners are often called healers.”

A BMA report on the practice and use of Complementary Medicine has defined CM in terms of “non-conventional therapies”, which it defines as “...those forms of treatment which are not widely used by the orthodox health care professions and are not taught as part of the undergraduate curriculum of orthodox medical and paramedical health care courses.”

While strict definitions are difficult, it is possible to describe certain hallmarks which set alternative and complementary practices aside from allopathic medicine. Complementary Medicine tends to be more concerned with the achievement of optimal health, rather than the treatment of specific disease. The client usually participates actively in the achievement of improved health. There is a tendency to avoid synthetic medications (drugs), and to base therapies on supposedly “natural” and “non-toxic” intervention. There is a commitment to prevention of disease, and a concept that early intervention is useful in such prevention. There is an understanding of the need to treat the person as a whole person, involving support for physical, emotional, mental, and spiritual facets of each person’s life. There tends to be an individualised approach to each person, rather than an attempt to classify people into specific groups to facilitate appropriate general management. There tends to be a greater degree of personal involvement between therapist and client than is commonly found in the Doctor-Patient relationship, and the requests of the clients tend to play a major part in the therapeutic processes utilised.

Thus, Complementary Medicine aims to optimise health using traditional or non-drug techniques, encouraging participation of the client. Personal choice of the individual client is considered of paramount importance in selection of diagnostic and therapeutic modalities, and the clients are empowered to heal themselves and maintain their health after the interaction. Allopathic (“modern”) medicine aims to use the scientific method to enable accurate diagnosis of disease, and to minimise or eliminate that disease through the use of a range of scientifically validated interventions, especially drugs and surgery. Personal involvement with the client (especially emotional attachment) is limited in order to allow for objective decisions to be reached. Patient input and patient preferences do not usually determine the method of treatment chosen. The use of proven technologies tends to be preferred to patient choice, and information provided to the patient is often limited due to the technical nature of the processes and interventions used.

ACMA

ACMA recognises that Complementary Medicine as a whole has had little formal structure in Australia, and that much of the education and accreditation in Complementary Medicine has reflected this lack of organisation and structure. Because of this, many colleges and institutions have been forced to develop their own infrastructure and organisation, often without realising that they are unnecessarily duplicating valuable work already done by their colleagues in closely related fields. Coordination of, and cooperation between the many existing bodies involved in Complementary Medicine is now essential if we are to make optimal use of limited resources. Such cooperation will help to provide common philosophical and educational foundation for all Doctors practising, or wishing to practise, Complementary Medicine. ACMA is a body well placed to help with such coordination, as it has no prior associations with existing bodies or particular practices in Complementary Medicine, is national in its reach and representation, and exists only for the benefit of all its members. Other political groups will be welcomed under the ACMA “umbrella” as Special Interest Groups (SIGs), and will represent the interests of their own members in a way similar to the SIGs within the AMA. This will improve their political “reach”, and will help set the agenda for ACMA, defining the issues and priorities of its members.

Over the past three decades, it would be generally true to say that many, if not most Doctors practising Complementary Medicine have possessed certain personality traits. The archetypal practitioner has tended to be a Jungian introvert, strongly idealistic, convinced of their rightness of their own direction in the face of considerable opposition, less concerned with financial reward than pursuing their dreams and aiding their clients, and something of a loner. This “pioneer” personality type is needed to question and to change the direction of any group or organisation which is becoming self-serving, stagnant, and ineffective, and may represent a rebellious, “adolescent” phase in the emergence of a new paradigm. Such non-conformity may, however, eventually work against the general acceptance of the worthwhile concepts espoused by this group or individual, especially in an ultra-conservative profession such as medicine. The challenge is to maintain the dynamism and questioning of such an organisation within a structure which provides the familiar form and safety of the medicine in which they were trained and work. To help create such a “loose-tight” organisation is one of the real challenges for ACMA, harnessing the energy and vision of the pioneers, and transforming this into a workable, credible and useful structure to attract support from the profession as a whole. It may be true that there are many Doctors who are simply incapable of making this transition. Such resistance is expected where upheavals occur in a comfortable science or profession, and time removes this resistance through attrition, and the admission of new, open and inquiring minds into the profession.

ACMA also recognises that the terms “alternative” and “complementary” suggest a split from allopathic, (modern) medicine, and this often causes distress to people who are ill, as they try to choose between medical approaches. All Australian Doctors should understand the opportunities provided by Complementary Medicine, as well as the risks, and be able to provide the sick person with this information in an unbiased way, looking only to the best outcome for each person. ACMA will ensure that this information is readily available to all Australian Doctors. It is clear that division and specialisation in the provision of health care is related to the needs of the providers (Doctors), rather than the consumers (Patients). Education of Doctors and the public about the benefits and problems in alternative medicine will allow for improvement in continuity of care, and will allow those who are unwell to choose the best options from all fields to manage illness and optimise their health.

Educational & Peer Review - Short Term Structure

To provide safety for members, ACMA Doctors are required to participate in CME, peer review, and quality assurance programs through appropriate Colleges. Determining the best mechanisms for achieving these is currently the work of the Executive Committee, which will report to the Steering Committee by March 1995. The following proposals are made in the meantime.

Structure and Process

Colleges would retain their independence, and would be represented on the Council of the Presidents of the Complementary Medical Colleges (CPCMC). This body would be responsible for the setting of academic standards, the CME, QA, and peer review programs. It would also set priorities for research programs and outcome studies, and oversee the studies carried out by the Colleges. Results of studies, both positive and negative outcomes, will be published.

Smaller Colleges may combine into philosophically homogenous groups to achieve the membership numbers needed for representation on the CPCMC. This would ensure fair representation of the interests of all Complementary Doctors, without the risk of hijacking of the agenda by a large number of small and marginal groups.

The CPCMC will comprise representatives of the Colleges, and will function independently of ACMA. There will be representatives common to both boards to ensure that the common interests of Complementary Medicine are best and most effectively served. ACMA's political and organisational functions are separate from the academic functions of the CPCMC, though the goals and directions of each are entirely congruent.

ACMA will present a single voice for issues related to Complementary Medicine, & will act as an "interface" in dealings with the profession, the Government, the public, industry & media.

Implementation of Peer Review

Peers will be drawn from the appropriate Colleges or craft groups, and will be proactive in implementation of "best practice" principles, rather than simply reacting to the demands of the HIC or the requests of members fearful of PSR referral. The peer review process will allow for an inventory of methods and practices used by ACMA members, and a determination as to the safety, efficacy and appropriateness of the methods used. The separate issue, related to whether a particular method or practice style fulfils the necessary criteria to attract a Medicare rebate, will be addressed in each assessment.

ACMA Doctors must be aware of their responsibilities to the public in the provision of high quality, safe, and cost-effective services. The CPCMC and the Colleges will be responsible for ensuring that all members maintain medical standards at the highest level. ACMA does not directly participate in the setting of such standards, but must ensure that such standards are in place and are being adhered to, in order to protect its members.

Evidence Supporting Styles of Practice

In implementing a process of peer review, it is clear that various fields within Complementary Medicine have varying degrees of scientific support and credibility within the profession. The issue of whether this support and credibility is worthwhile or essential for good client care is a separate question, and one which will need to be addressed by ACMA very early on.

For the sake of simplicity, practices within Complementary Medicine can be divided into three broad categories:

1. Practices in which the majority of scientific and medical evidence is supportive

the aim in these cases is to convey the information to the profession, government and public in order to increase access to and knowledge of the information. New studies are not a priority.

an example may be the value of fresh, clean fruit and vegetables in longevity and disease prevention

2. Practices where evidence is lacking or conflicting, or where the profession as a whole holds a view contrary to the best scientific evidence

this provides an opportunity for novel Australian research and outcome studies with support of the government, especially in cases where there may be a significant cost-benefit to the Complementary Medicine practice in question.

an example may be the use of nutritional supplementation with antioxidants in disease prevention

3. Practices in which the significant majority of evidence identifies the practice as ineffective or dangerous

in these cases it is the responsibility of the proponents of such a practice to provide the evidence of safety and efficacy required to move this back into category 2

an example may be the prolonged use of highly restrictive diets for supposed allergies or sensitivities to food chemicals, especially where such diets lack the nutritional requirements to maintain normal biological function.

It is essential that practitioners do not fall into the difficult position of “being a college of one”. Being in this position does not preclude the practitioner from being correct, but it does make it extremely difficult for ACMA to identify an appropriate peer group to assess and advise in cases which may lead to PSR referral. Such practitioners should identify other colleges, groups or Doctors within Australia using similar approaches, or maintaining a similar philosophical view to the practice or illness being treated. Often, this will ensure the “cross-pollination” which is essential to progress in any field, and may lead to an improved “consensus” view on such practices by this group, ultimately benefiting both clients and the Doctors.

Relationship between ACMA & the Colleges

ACMA is a political and organisational body, and has a duty to establish an infrastructure to link and protect its members. This protection will be most easily achieved if the processes of CME, peer review, and QA are in place, and if relevant trials, outcome studies and cost-benefit studies are under way.

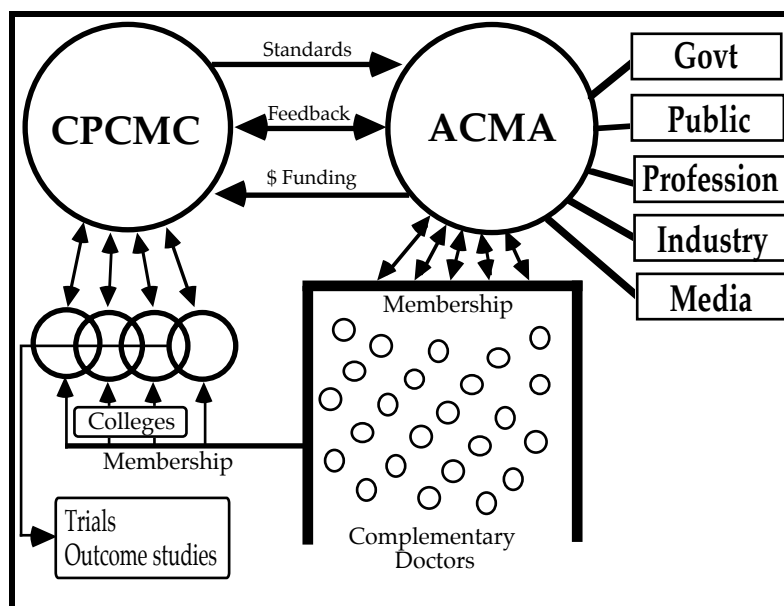
ACMA is not an academic body, and will leave the process of education and standard setting to the CPCMC and Colleges. ACMA provides the structure and a safe medical environment to attract more Doctors into the broad area known as Complementary Medicine. It is ACMA's intention to ensure that all ACMA members become members of the academic body appropriate to their style of practice. In the long term, simultaneous membership of a number of Colleges may be an option within an integrated framework for Complementary Medicine.

Functions of the CPCMC

The CPCMC is responsible for two major areas in Complementary Medicine. The first is the quality of the education provided to members by the Colleges, and the second is in establishing a credible and useful quality assurance (QA) cycle, utilising research trials, outcome studies, and peer review, and feeding the information from these back into the educational process.

The continued success of Complementary Medicine will rely on the respected and credible academic programs of the Colleges, so that ACMA can represent it confidently in interaction with Government, the Profession, industry and the public. The CPCMC will ensure that Colleges provide appropriate, high quality education. A feedback cycle of assessment & review of the educational process will be implemented, resulting in measurable improvements in quality of education and outcomes. These improvements may well to be gained without cost escalation.

ACMA must ensure that uniform standards exist among practitioners of Complementary Medicine, and that these standards evolve to become as uniform as possible. ACMA is not responsible for defining, implementing or reviewing these standards. These functions are properly the domain of the CPCMC, and this Council's decisions are taken back to the Colleges for implementation. Clear benchmarks, some of them external to Complementary Medicine, will be established, and these will be the basis upon which the success of the quality assurance cycle can be determined. Appropriate feedback strategies, with input from consumers, Government and the profession as a whole, will allow for continuing improvements in the quality, safety and efficacy of Complementary Medicine.



Benefits Derived from the Proposed Structure

There are many benefits to be gained by the educational groups and Colleges from the structure described above. There are also certain concessions that will need to be made to gain those benefits.

Membership of Colleges

ACMA will ensure that members join the appropriate College for their predominant style of practice. The Colleges will provide the educational opportunities for their members according to the standards decided upon by the CPCMC. ACMA cannot perform the required assessment of Doctors who may be under investigation by the HIC unless they belong to a College, as the College provides the benchmarks of appropriate practice, and the peers will be drawn from that College for the assessment of the practitioner under threat. The HIC will deal directly only with ACMA, and only members of ACMA will be eligible for assessment via the internal review process.

Funding for research, outcome studies, etc

ACMA will seek financial support from industry, the public and Government. Money earmarked for education will flow directly to the participating academic bodies through the CPCMC to ensure high quality medical education and to support the feedback/ review cycle. The disbursement of these funds would be through the CPCMC. The CPCMC is responsible for prioritising funding for research and outcome studies, consistent with community needs, and with a view to gaining the information required by ACMA, the Colleges, Industry, and Government. These studies should be designed to identify a cost-benefit, if one exists.

Consistency across Colleges

Consistently high standards of education and QA across Complementary Medicine will ensure credibility for the process of internal review of Doctors referred to ACMA by the HIC. ACMA will ensure appropriate peer review by setting up review committees drawn from the Colleges. This will involve the upgrading of many courses to an academically acceptable standard within 2 years, and this upgrading would require significant funding from commercial and Government sources, and from the public. This upgrading of education and facilities for the Colleges may allow for common administrative and educational processes to be identified and shared, improving the quality and consistency of education while reducing costs. This would also aid in the progression to an integration of Complementary Medicine by providing a common educational foundation for all Doctors entering Complementary Medicine.

Obligations of Colleges & Members

Necessity to define appropriate practice within specialties

The academic bodies would need to be prepared to define appropriate practice for their members and associates. They will also need to advise members of their specialty or craft group which practices are appropriate, and which are considered inappropriate. There must be room for review of these practices. Furthermore, of appropriate practices, the decision as to which ones fulfil the necessary obligations to attract Medicare rebates, and which ones are more properly billed privately, must be conveyed to members. Education and persuasion is usually preferable to penalty and confrontation.

External benchmarks & feedback

It is not sufficient to have an internally consistent philosophical framework for assurance of quality of processes and content. External and agreed benchmarks and feedback processes are essential if Complementary Medicine is to avoid the trap of self delusion regarding the efficacy, safety and quality of the services provided. Honest feedback and adjustment is critical to providing the best service for the clients in Complementary Medicine.

Outcome studies provide an obvious means of measurement of success by external standards, and some of these need to be formal prospective, double-blinded trials, with appropriate control groups, and be carried out in association with institutions experienced in the design and running of such studies. Outcome studies should measure the cost (total and taxpayer funded) of the outcomes, in order to determine cost-effectiveness of the various approaches.

Other formal research will need to be performed to assess certain diagnostic and therapeutic techniques and regimens. Given the complexity of the illnesses seen, and the multifactorial nature of the regimens used by Complementary Doctors, help in the design, implementation and costing of such research should be gained from universities and others experienced in such potentially complex protocols. The basic premise being tested in the research should be defined by the CPCMC in conjunction with the Colleges, members, and funding body (industry or Government).

Ethical considerations in such studies and research are paramount, and one or more Ethics Committees will need to be established to ensure the rights of our clients. The composition of these will ensure an external benchmark in ethical matters.

In terms of ensuring medical competence and quality, it would be useful to adopt educational and assessment processes already in place, such as accreditation through the RACGP. While true that Complementary Doctors will not necessarily be training to become specialist GPs, there is a need to ensure that a high quality of medical skills is possessed by members. The CPCMC would liaise with the RACGP to adopt useable standards, and to develop an educational program and accreditation appropriate to the specific needs of Complementary Medicine. Members of Complementary Colleges would be required to participate in this process, ensuring that Complementary Doctors are, first and foremost, good doctors.

Associations will be made with those Colleges and institutions world-wide which provide the "gold standards" of education and accreditation in the Complementary Medicine specialties, and where appropriate, such courses and standards will be integrated into the processes of the appropriate Australian College. Courses and assessments will be designed to satisfy these international benchmarks, so that Australian Drs receive education and accreditation at the highest possible level.

Other external benchmarks and feedback strategies will be identified as the process emerges.

Requirements for Drs to join a specific College

In order to provide protection for members in the short term from PSR referral, members will need to join a specific College in Complementary Medicine that most closely matches their practice style. This will ensure that appropriate peer review can be initiated for any Doctor so referred, using the expertise and standards of that College. It is acknowledged that, currently, Colleges vary widely in the form and content of their educational programs, and that some are clearly more “acceptable” to the medical community and Government than others. The Colleges, under the CPCMC, have an obligation to reach a common, high standard in the form of the education provided to members within 2 years, and this will require support from members by way of membership.

Thus, the required membership of an appropriate College serves two purposes at present. Firstly, it provides the best available peer review, which is important for protection against PSR referral. Secondly, it supports the College in its move towards common academic standards, and ultimately to an integration of the Colleges within Complementary Medicine. Members without a College cannot be fully protected, and Colleges without members cannot participate in the educational process or vision.

Cost in time and money to Doctors and Colleges

The work outlined in this paper is clearly costly in both time and money, yet it is work which must be done if the true value of Complementary Medicine is ever to be appreciated, and if we want Complementary Medicine to become a “normal” part of medical practice in Australia. We currently often use these techniques because of our direct experience of their benefit in improving the health of our clients. This raises the question of the method of entry into Complementary Medicine for the majority of our medical colleagues, most of whom will not use novel approaches until they are “proven” and “safe”. “Safe”, in this context, means that the approach must have medical approval, and use of the technique or treatment should not expose the Doctor to criticism, ridicule or punishment. Most Doctors require such safety before adopting a “new” approach, and the strategies outlined in this paper should achieve such safety within 6 to 10 years. The cost may, thus, be well compensated in the long term by improved professional standing, and possibly even a specialised fee structure.

In the short term, however, it seems all work and study, with little benefit. Participation in these programs takes time, and time spent here is time not spent earning an income.

The most tangible initial benefit is the “insurance” against referral to the PSR, especially with its capacity to disqualify a Doctor from Medicare rebates, & to fine that Doctor retrospectively. The extent of possible penalty is similar in size to malpractice suits, and the money, time and effort can be seen in terms of insurance at fees well below such professional insurance.

ACMA will enter discussion with industry, Government, and medical associations and Colleges, with a view to raising sufficient funds to compensate Doctors for the time and effort they will contribute. Practice Grants, Special Divisional Grants, funding for education, research and outcome studies will all be explored, and ACMA will support such applications by the CPCMC or individual Colleges. Such compensation may take a range of forms.

Any input into the means by which Drs can be adequately compensated, and thus encouraged to join in the educational and QA programs, would be appreciated. Achieving these goals benefits our clients, Government, industry and the profession generally. The beneficiaries are commonly those who would pay for such benefits, so increased fees, practice and divisional grants, research grants, and a flow of financial support and expertise from the Colleges may be forthcoming with strong and persuasive argument.

Benefits from Complementary Medicine

There are a number of perceived benefits in the use of Complementary Medicine, from the perspective of the Government, the profession, and the community. A few of these are listed here to stimulate thought on other benefits, and to provide a framework for demonstrating cost-benefit of Complementary Medicine.

Minimal Pharmaceutical Use

Taxpayer contribution to the cost of pharmaceuticals in 1994 is estimated at \$1.8 billion, and is growing at around 22% pa. By 1998, the supported cost will approach \$3 billion, or one out of every three dollars paid out by Medicare. By contrast, the medical industry apart from pharmaceuticals is growing at around 6% pa. Clearly, the rate of growth of drug costs is not sustainable. The problem is one of determining ways of managing illness with less drugs, or less costly drugs. The Government's (though not the community's) problem could be solved by cutting certain medications from the PBS, or increasing the patient contribution. These would place more of the costs on the unwell, and this is generally not supported.

Complementary Medicine has an excellent opportunity to establish itself as a model for management of illness (especially chronic and degenerative disease) with minimal drug use. Outcome studies focussing on the issues of cost-benefit and quality of life in these illnesses are likely (from the published literature) to be supportive of CM techniques, especially the cost-effectiveness of such approaches. Such benefits to the taxpayer and Government would encourage active support of complementary practices, and would attract significant funding.

Length of Consultation and Quality Care

Recent work has suggested that the single best predictor of quality of care is the duration of the consultation (the time spent face to face with the client). There are reports that time spent with the patient is the best "value measure" for consultation-based work, also. Complementary Doctors tend, on average, to spend considerably more time with their clients than do "standard" GPs, and this may be a major contributor to the apparent success of Complementary Medicine.

The problem for those who do such long consultations is that they must accept a lower hourly rate of pay than their colleagues who tend to push clients through their surgeries more rapidly. There is thus an inherent financial disincentive to provide optimal care. The options for a Doctor who wishes to provide such time include; charging above the schedule fee; gaining income from other sources; reducing overheads in multiple Doctor practices; going broke, or; reverting to shorter, bulk-billed consultations.

It is likely that the HIC and Minister will need to make changes to the rebates over the coming years to reverse this anomaly, and to encourage Doctors to spend more time with their clients. ACMA will actively lobby for this on the basis of overall cost-benefit. Outcome studies to assess total client satisfaction, and client and taxpayer costs over, say, 2 years for chronic illnesses would be likely to support the approach of Complementary Doctors, and may allow for a change in the schedule to be expedited.

Communications and Information Technologies

An early priority of ACMA will be to define and set in place a cost-effective, secure network, or information web, to link all members. ACMA already has the advantage of members and partners with a high level of experience and expertise in these fields, and the network will not need to be bound by constraints of compatibility with systems already in place.

Within three years, members will have access to vast amount of relevant information automatically, using "agent" technologies and "smart" networks, and will be shielded from the technologies behind such information transfer. The ACMA system will provide an "on ramp"

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to the so-called “Infobahn” for all members, and will provide the tools to find the information needed by members, on demand and at the lowest possible cost.

The Communications and IT program promises to be an exciting, empowering and unique opportunity within ACMA, and all can participate in trapping or accessing information, through email, electronic workshops & conferences, and the formal clinical data collection system which will be provided free to members for the work in clinical trials.

Quality of life and opportunities for Doctors

One recurrent theme in Australian Medicine in the past 10 years has been the degree of dissatisfaction among Doctors, relating to their professional careers and public standing. In many ways, the lack of challenging opportunities for Doctors is understandable in an increasingly technical and complex field, especially as the technologies are perceived as taking over from the art of medicine.

Complementary Medicine provides endless opportunities in education and personal interaction with clients. In the long term plan of an integrated field of Complementary Medicine, the Doctor who enters this field can continue to grow and expand his or her knowledge and competence indefinitely. The Doctor would not become more specialised, but more “generalised”, with the broader education linked closely with factors which improve the quality of life for the doctor. The endless variety of modalities, the differing philosophies within CM, the opportunities in non-medical fields, and the support of colleagues would provide significant incentive to stay in Complementary Medicine. Doctors would be provided resources and encouragement to best manage their own health, which is likely to ensure that the Doctors maintain a balance between work and personal and family time.

The result of happier and healthier Doctors is lower costs to the community. Doctors who gain their satisfaction from their work and study are less likely to develop the “rapid turnover” mentality common among many medical (especially procedural) colleagues. Where the work provides no satisfaction, Doctors are tempted to pursue money as their major goal, and may modify their practice accordingly to maximise income. A simple study may be appropriate.

Proposed Timeframe & Planning

The steering committee of ACMA will be responsible for gathering information and opinion from the relevant medical organisations and political institutions over the coming 6 months. As well, basic market research will be performed, assessing the needs and wishes of a range of Complementary Doctors, and of the medical consumers. A basic flowchart and rough costing (money and resources) of the processes will be in place by the time of the next meeting of the Steering Committee in March 1995.

A number of stages are defined in the diagrams which should accompany this document. They show in diagrammatic form the following stages (a graphic describing Stage 2, the short term structure and functions, is included as it is the major short term process proposed):

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| Stage 0 (prior to Sept 1994): | Prior to ACMA |
| Stage 1 (Sept 94 - Mar 95): | Executive Committee construct and cost blueprint for ACMA |
| Stage 2 (Mar 95 - Dec 96): | Establish CPCMC, bring Colleges to common Standards |
| Stage 3 (Jan 97 - Dec 98): | Refine educational programs, outcome studies & research |
| Stage 4 (Jan 99 on): | Integration of Complementary Medicine into respectable medical specialty |

The eventual aim is for the integration of high quality, cost-effective and safe Complementary Medical practices in a single vocational field of Complementary Medicine by the year 2000.