

The Top Ten Challenges Facing Naturopathic Medical Education

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Naturopathic medicine in the United States reached a clear milestone when the National College of Natural Medicine (NCNM) turned 50 years old in 2006. As the first formal educational institution to achieve the half-century mark in our profession, it seems reasonable to examine current trends within naturopathic education and in medical education overall. Naturopathic education, especially *how* we educate as much as *what* we teach, shapes the mold from which develop all other elements of naturopathic practice. From that perspective, let's look towards the future and consider what might be the top ten challenges facing naturopathic medicine both within academic institutions and in the profession as a whole.

Before I present my list, however, a little background information is necessary. In 2003, the *Townsend Letter* published an article I wrote on teaching at naturopathic institutions; that article discussed the demands placed on teachers. Three years later, the need to understand these pressures has increased exponentially. Fueled by incredible growth and interest

in complementary medicine from federal institutions and other agencies funding research as well as from consumers, the volume of peer-reviewed literature available on various aspects of health care germane to naturopathic education (and, subsequently, its practice) is stupendous. In addition, many health services and other governmental agencies have recently begun requiring evidence-based treatments in order for funding to occur or continue.

Furthermore, the quality of knowledge emanating from research is strong enough that there can be no doubts about its growing influence *outside* naturopathic medicine, particularly on allopathic medical education. For example, within the area of my expertise – communication and the physician-patient relationship – allopathic standards for education and outcome assessment have transformed over the last decade. Allopathic institutions now consider communication skills and the quality of the relationship-building skills between patient and physician as essential. In the medical licensing exam, students

are now required to demonstrate competence in these domains using standardized patients.

Understanding how allopathic medical institutions educate and assess their students and residents in these areas is both fascinating and scary. Fascinating because the science is truly remarkable in determining how a learner's performance of something as complex as communication and relationship-building skills can be assessed. (One expert source noted there are over 2000 published articles on Medline between 1998 and 2004 related to teaching communication in medical settings.²) And scary, because the American Association of Naturopathic Physicians (AANP) has long distinguished naturopathic doctors as “physicians who listen to patients.”² Yet the standards at naturopathic institutions for training and assessing students in communication skills is not necessarily well-aligned with the accepted science in these areas.

Indeed, the more relevant query may well be, will this research be able to influence future naturopathic training and course

structure? The question is relevant, especially if one recognizes there is no procedure or clinical skill that will be performed by naturopathic graduates more often than these two essential skills. Could it be that what the AANP emphasizes to distinguish ourselves from other primary care providers is being taught to a higher standard elsewhere?

For those who might still question why is it necessary to follow the literature in medical research or keep tabs on academic medicine in whatever area interests them, I offer the following *sine qua non*: naturopathic medicine years ago decided to become a profession. Since the late 1980s, the AANP has historically been involved in supporting licensure and creating an ethical code for the profession. Most regulatory boards for naturopathic physicians stipulate mandatory self-regulation by requiring practitioners to report unprofessional, unethical, or incompetent care in colleagues. All these aforementioned activities are well-founded methods for creating and defining a profession.

A profession creates standards of care for their practitioners. If standards of care are unwritten, the determination of what a reasonable practitioner (with the same license and training) would do under the same or similar conditions provides the guidance needed in specifying what is adequate or appropriate care. Furthermore, in jurisdictions where naturopathic medicine has a scope of practice that overlaps other primary care professions in function, it becomes a professional duty to recognize the various protocols or standards established relative to these other professions. Failure to do so potentially harms patients by not providing them with all viable alternatives in establishing informed consent.

The other significant factor influencing naturopathic education and practice comes from what is commonly referred to as the

hidden curriculum. Something that can reveal hidden curriculum is understanding what is and is not being assessed in student performance. In other words, the hidden curriculum is the attitudes or behaviors that are unintentionally taught to students through the course of their clinical experience. For example, if a clinical skill is never assessed or tested, even if it is taught in the curriculum, therein lies the unintended message and value that students rarely ignore.

naturopathic education, what is the hidden curriculum revealing about that?

As stated earlier, examining how learners are assessed outside the classroom setting can also expose the hidden curriculum. Therefore, consider how communication and relationship-building skills support lifestyle counseling, specifically the ability to help someone make or maintain dietary and other behavior changes. Beyond assessment of student performance

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Learners gravitate towards and focus on what they perceive is necessary to pass a test to continue their progress in a training program and will move away from what is not tested. Of further interest is that the hidden curriculum often includes the development of student attitudes and behaviors that become what is thought of as professional or unprofessional behavior.³

In regards to communication and relationship-building skills in naturopathic programs, students initially learn these skills in the classroom. The hidden curriculum dictates the importance of learning these skills through the number of students grouped into the course (how many students per section), the course structure, and the course placement within their academic training schedule. Research and expert experience has found communication skills are best taught in a helical structure, in small group settings, and with immediate feedback from trained instructors, in part because they minimize the risks students frequently perceive when learning these complex skills.⁴ If “best practice” methods of teaching are not being supported in

in these skills, how do students observe supervising physicians as they communicate with patients about making these changes? What are clinicians emphasizing or not emphasizing? All these various factors will have a significant impact on the developing attitudes and behaviors of students and give definition to what is considered professional.

Finally, student performance is ideally assessed by the same method in which they are trained. This congruency between academic and clinical training speaks well for a thoroughly integrated learning environment. What is the value of taking a patient-centered approach to history-taking, demonstrating empathy, counseling someone to stop smoking, exploring suicidal ideation with someone depressed, building trust with someone sexually abused when younger, or giving bad news? If these examples of patient scenarios involving good communication skills are not taught to the extent needed for students to have sufficient mastery, can it be surprising if students were to wonder about the importance of communication as a skill essential for practice? ►

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So without further ado, and with a tip of my hat to NCNM turning 50 years old, here is my list of the top ten challenges facing naturopathic medical education today:

1. Although most naturopathic institutions offer continuing education (CE) courses or lectures, there currently is no uniform standard for disclosure by speakers. At NCNM, the Curriculum committee several years ago turned down a suggestion for requiring disclosure when I presented it. Allopathic continuing medical education (CME) providers, including hospitals and universities, generally require presenters to disclose any potential conflicts of interest. The Accreditation Council for Continuing Medical Education (ACCME) requires disclosure of any potential conflict of interest, and most eligible providers of CME consider disclosure an indicator of excellence.⁵

Recently, the Oregon Association of Naturopathic Physicians co-sponsored a conference that met ACCME standards for disclosure, a possible first in naturopathic-sponsored continuing education. A Portland hospital explains that faculty disclosure does not imply that financial interests or relationships are inherently improper or would prevent the faculty from making a presentation. However, they state it is imperative that the faculty identify these relationships so that participants can have these facts *prior* to the presentation and may form their own judgments about the presentation (my emphasis).⁶

2. Developing student exposure to specific proprietary medicinary items in clinical training sites is considered a valuable asset by the nutraceutical industry. Although, to the best of my knowledge, product selection has not been studied,

the thought is that graduates will continue to use products prescribed while they were working as students under supervision. If this thinking is correct, what safeguards are in place to protect this asset in clinical education? Without adequate safeguards, choices made about product selection or variety can more likely become another element of the hidden curriculum in naturopathic education.

Creating standards before products can be approved or placed in clinics (and even involving students in designing standards) will bring out hidden attitudes or other assumptions about a particular product selection or company. Designing a more transparent position relative to the nutraceutical industry safeguards the integrity of product selection and student exposure. Channeling nutraceutical industry interests with educational goals can help support some of the critical-thinking skills necessary for practice.

3. Naturopathic institutions continually influence and define clinical competence through their education and graduation of students. Determining how and when to assess competence in various clinical areas becomes, therefore, a tremendous responsibility. The high stakes involved in passing clinical examinations require institutions to remove factors that lower objectivity or introduce bias. In allopathic education, Objective Structured Clinical Exams (OSCE) have been researched and utilized since the 1990s to assess various clinical skills in medical students. These often utilize standardized patients (actors) with specific clinical scenarios that are intended to allow objective evaluation of clinical skills.

OSCEs are not considered reliable or valid unless they involve multiple scenarios, adequately trained observers and actors, and demonstrated inter-observer reliability.

Subjective evaluations of students on clinical clerkships by attending physicians (which most closely represents how students are involved in patient care on naturopathic clinic shifts) have been criticized because evaluators often do not observe trainees directly, have different standards between them, are subject to halo effects, and may evince particular racial and sex bias.⁷

Yet in spite of these challenges, the upside of establishing objective assessment of clinical skills is extremely worthwhile. Each stage of student assessment can become an opportunity to instill greater confidence through complete observation and immediate feedback of their performance. One challenge lies in carefully considering when in a student's clinical or post-graduate training it is optimal for assessment to occur. In my view, providing assessment of students with attending physicians during a clinical shift does not speak to the potential benefits of objective periodic assessment in a more formal environment.

4. Practicing patient-centered communication improves patient compliance, patient satisfaction, health outcomes, and reduces malpractice claims. A challenge for naturopathic education and clinical training is understanding what this communication style means, particularly in the context of students who are often eager to try new or favorite modalities. Any tendency on the part of students (or supervising physicians) to "practice" certain therapies has to be carefully weighed against serving the patient's concerns, desires, and expectations. It can be considered an abuse of power if a practitioner is proselytizing a point of view in order to change a patient's mind.⁸

5. This leads me to wonder what, if anything, distinguishes patients who visit naturopathic physicians from those who visit

other practitioners. Do naturopathic patients have similar desires and expectations as those patients who choose to visit other types of providers? The benefits of better understanding our patients can be tremendous. For example, Kaiser Permanente sent patient satisfaction surveys to thousands of patients over the course of seven years. Eventually, Kaiser began to interview and study the particular habits of physicians who were consistently ranked in the top ten percent by patients. After gathering this information, Kaiser generated a practice model for physician behavior that they considered best practice. The demonstration of institutional interest in patient satisfaction made such an impression when published that the study itself was later written about in the *Wall Street Journal!*

6. There is a wonderful quote: "It is easier to change the location of a cemetery, than to change the school curriculum."⁹ In naturopathic educational programs are there any periodic, statistically reliable, and valid surveys of what naturopathic physicians are actually practicing in the field? Although such surveys should not be the only influence in determining required vs. elective education, given limited resources, they should certainly be a factor. If anything, this information could help support the relevance of curriculum outcomes. As an example, if the majority of practitioners are using IV therapeutics or less than five percent practice minor surgery techniques, when does this information begin influencing core curriculum content?

Staying current with contemporary practice realities will help inform and assure relevancy of learning outcomes in educational institutions. Regulatory boards have a similar interest in this knowledge, because it will contribute to their ability and responsibility to adequately protect public safety. Joint venture, anyone?

7. Practitioners with more experience are commonly assumed to provide greater expertise compared with recent graduates. Examples of this sort of thinking are relatively easy to find. The Oregon Board of Medical Examiners requires five years of licensure before allowing acupuncturists to supervise acupuncture students. NCNM posted a requirement of five years of clinical experience in order to be approved as a clinical supervisor several years ago. Unfortunately, although experience provides many things, there is little supporting evidence that it will increase medical expertise. In fact, it could potentially do just the opposite.¹⁰

If I could only recommend one article for students and educators to read, the article written by Ericsson and published in *Academic Medicine* in 2004¹⁰ would certainly rank high on my list for consideration. Ericsson incisively describes research and evidence of learning habits and practices consistently found in developing expertise in a variety of non-medical domains (such as music or athletics). He then describes some challenges inherent in establishing evidence of expertise in medicine (interesting points to remember the next time someone is introduced as an expert in some medical field). Finally, he concludes by describing learning practices, relevant for both medical students and licensees, that have the best potential for improving medical skills and discusses tendencies that seem to arrest continuing skill improvement. The challenge for students and practitioners alike is to understand these principles and develop or model educational and clinical practice styles that integrate their use.

8. Naturopathic educational institutions have historic kinship with treating the Mind, Body, and Spirit. At least these were the messages I read in advertisements from naturopathic programs in the

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mid- to late-1970s. This message continues to be implied whenever a student or practitioner advocates "treating the whole person." It's perhaps the perceived differences over the meaning of this role that causes tension between "nature cure" proponents and "green allopaths," especially over defining appropriate guidelines for clinical care treatment. I've personally recognized this debate by reading residency applications from new graduates, reading recent articles in naturopathic journals, and most frequently, engaging in classroom discussions.

Although I believe tension in this context can help inform and improve critical thinking for both elements within our community, one challenge is recognizing the existence of a paradigm shift emerging from within energetic methods of healing. Midge Murphy describes the shift this way: "that the caregiver and what she brings to the therapeutic setting with a client as a person is more important to the outcome of care than the choice of techniques she employs in giving the care."¹¹

Does Murphy's description regarding the therapeutic relationship and paradigm shift affect the training and mindset of naturopathic practitioners? Is it the intention or the modality being used that affects the health outcome? Or is it how the patient perceives either or both from the practitioner? Can intention and the prescribed modality be separated to better understand how best to use them? These questions within the debate between "green allopathy" and "nature cure" may not be addressed very well and can significantly shape the future of naturopathic education and training. ►

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9. Another factor may not be fully recognized in the debate between “green allopaths” and “nature cure proponents” and is also relevant to item number 4 (regarding patient-centered communication, student desires to use certain modalities, and proselytizing). That is, what does the patient want? To leave the patient out of the debate or to presume the practitioner knows what is best for the patient harks back to the paternal attitudes reminiscent of mainstream medicine several decades ago.

Does it need to be repeated that arrogance has been roundly rejected by nearly everyone involved in health care, including consumers? Perhaps some humility can lighten the debate. In addition, demeaning fellow practitioners or the attitudes and values of patients is always unprofessional. Let’s consider ways in which research can create evidence to help inform viewpoints and keep the debate aboveboard!

10. Vis Medicatrix Naturae describes one of the unique principles of naturopathic medicine and refers to nature’s self-healing power. Some key modalities naturopathic physicians use, such as homeopathy, are believed to stimulate this vital force. Some of

these naturopathic modalities don’t always present clear or mutually agreed-upon mechanisms of action. Certain questions raised by Michael Cohen, who has published multiple books on law and ethics in complementary medicine are interesting to consider.¹²

These questions include the following: 1) When has harm occurred when practitioners claim or use modalities to treat the less physical elements of humans? 2) The principle of beneficence is universally recognized as a cornerstone in medical ethics. Beneficence creates a responsibility: what is prescribed must be of benefit (independent of the do-no-harm principle in the first question). Although beneficence is not explicit in the code of ethics adopted by the AANP in 1990, this principle is clearly implied.

Therefore, what acceptable standards for determining a modality are of benefit? Is there an agreed-upon threshold before modalities are acceptable to use in practice? If a modality is proprietary or promoted by only one company, is there an obligation to allow or encourage research utilizing it? Can the naturopathic profession become the authority in establishing appropriate guidelines to address these questions? How naturopathic medicine addresses these questions and others that I’m sure I’ve failed to note will speak

to the quality of its education and growth as a profession over the next 50 years.

Notes

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10. Ericsson K. Deliberate practice and the acquisition and maintenance of expert performance in medicine and related domains. *Academic Medicine*. 2004; 79 (10). October Supplement.
11. Murphy M. Ethics and the law for mind/body healers, A continuing education course. March 2005; 6.
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