

The Potential of Integrative Medicine and Patient-Centric Approaches in Addressing Chronic Diseases

*S R Narahari

*".....Publish each healer that in city lives
Or country houses at the end of drives....."*

'Petition' by WH Auden

When religion was strong and science weak, people mistook magic for medicine; now, when science is strong, and religion no longer controls it, patients mistake medicine for magic.¹ How can a physician turn into a health magician when the treatment and cure are received from the assembly of many sources? The knowledge available in allopathy and complementary and alternative medicine (CAM) shows that the perceived quick response to treatment depends on disease conditions, body constitution (not entirely understood by genetics and epigenetics), and therapeutic approaches. Therapies may react in different ways: suitable and active, repulsive, inactive, practical, and more effective. While some patients may find relief with just a few allopathic drugs, others seek better relief from their illness by combining medicines, lifestyle changes, and procedures from traditional systems of medicine. Holistic health (MeSH term 1979) and Integrative Medicine (MeSH term 2008), as practised now, mainly focus on chronic care and patients who progress to chronic conditions after very satisfying acute care provided by mainstream allopathy.

Integrative medicine assesses the patient's disease rather than focusing on individual organs.

Allopathic healthcare disciplines, in general, treat chronic conditions and acute events, often alongside associated comorbidities that are overlooked during the management of presenting urgent events. In current 'modern medical practice', the focus in the health care environment and among its subscribers is on addressing disease complications. As our hospitals are overwhelmed by patients, often little attention is given to the preventive lifestyle changes and details of what patients should expect when they slip back to a chronic condition after surviving an acute condition. Acute management is often protocol-driven, technology-assisted care delivery, where doctors rely on machines and drugs and become operators in this system-driven 'healthcare industrial routine', and scramble when technology reaches its limitations. Managing a chronic condition requires different

skills from treating an acute condition. As the disease progresses, treatment options become limited; the allopathic doctor's role becomes more advisory. As the disease moves to the chronic and progressive stage, both health care providers and seekers quickly realise that the diagnosis of a disease is only a starting point in patients' journey with chronic conditions. Once patients get this realisation, they start to manage their finances for treatment, treatment adherence, drug adverse effects, nutrition, disease self-care, and coping with their changed routine, including their job and immediate family. In addition, if a severe illness causes disability, patients may become dependent on their family members. Often, personal life can be compromised, such as sexual dysfunction, change in social status, and divorces due to psychosocial stress in visible skin diseases, such as leaking lymphedemas, vitiligo, especially in people of colour. Due to the chronicity of the disease, such developments in patients' lives may cause severe constraints on the family's income and achievement goals. Finally, the compartmentalisation of morbidities by organ system through referrals to other disciplines becomes more complex for patients as the disease gradually affects other organ systems. In the current technology-driven medical practice, when a disease affects all organs, evidence-based allopathic practitioners and health seekers move on a dead-end road of palliative care. Such situations are demanding for patients, and they seek solace in holistic/integrative and patient-centric care services.

Two pandemics brought this realisation to the surface emphatically: Acquired immunodeficiency syndrome (AIDS) in the

* Senior Consultant Dermatologist (Allopathy), Institute of Applied Dermatology

#MP XVII-779, Uliyathadka, Madhur P.O. Kasaragod-671124, Kerala E-mail address: srniad@gmail.com

1990s and COVID-2019. Both diseases involved all organ systems and challenged the compartmentalised care of allopathy. Since antiretrovirals that can give immediate relief were not on the market, international policy-making bodies briefly focused on CAMs as a possible treatment option for symptomatic AIDS patients. They struggled to save lives using whatever treatments were available during the COVID-19 pandemic. Academicians at Ayurveda medical colleges began discussing parallel descriptions of these diseases. Ayurveda is the leading traditional medicine within AYUSH, the acronym for Ayurveda, Yoga, Unani, Siddha, and Homoeopathy. AYUSH junior doctors in many provinces of India undergo short training courses in allopathic hospitals. As a result, numerous English translations of Ayurvedic terminology and accounts of AYUSH practices appeared in India, including as continuing medical education articles for the AYUSH stream, historical translations, and medical textbooks, as well as in several short-term, methodologically questionable clinical trials. However, clinical studies do not always support such claims of traditional literature.² Many AIDS and COVID-19 patients took Ayurvedic or other CAM treatments alongside the available allopathic therapy. Various plant-based products and certain vitamins and minerals showed promise as practical approaches against viral diseases such as SARS-CoV-2, often with minimal adverse effects. The initial lacuna of effective antiretrovirals during the emerging epidemic triggered discussions of integrative medicine and holistic health at many North American and European universities, and during COVID-19, several Indian government initiatives from the Ministry of AYUSH.

Conventional care models tend to focus on disease silos and symptomatic control, rather than adopting a systems biology and whole-person approach to treatment. To manage a significant global health burden due to chronic diseases, with incomplete remission and high recurrence rates, integrative medicine can support modern medicine, which struggles to address them effectively³. There is evidence that combining allopathic and CAM approaches can enhance patient outcomes, reduce healthcare utilisation, and empower patients to manage their conditions.

There are examples in silos of success of integrative medicine. The Institute of Applied Dermatology (IAD) is among the leaders in bedside integrative/holistic dermatology. Its mutually oriented multi-system therapeutic team effectively utilised treatments from various medical systems. Integrating Ayurvedic skin care with modern dermatology improved patient management of skin diseases, achieving better outcomes than single-system approaches². More details can be obtained from several of its international publications^{4,5,6}.

In the IAD model, the integrative medicine team comprises allopathic and traditional medicine doctors, as well as supporting paramedical staff such as nurses, physiotherapists, masseurs and yoga therapists. Each team member records clinical features in detail through written patient notes and photographs, including all required details to provide gold-standard care. For example, each patient has 40+ pages of structured case sheets in lymphoedema.

History-taking is detailed, similar to homoeopathy, because it is a system that asks questions about all aspects of a patient's life. Other systems believe that a careful history is essential, but its practitioners rarely give the time necessary, which is about 30-45 minutes for each chronic patient, as they often come with a heap of old prescriptions. Homoeopathy has its critics, but cannot be faulted for the time made available to the patient. Such a detailed history of the patient's condition aims to answer most of the questions patients and their family members raise. However, it may be difficult for the allopathic practitioner to understand the relevance of some of the questions, as current medical teaching usually suggests that symptoms equate with the presence of pathology. Accordingly, many allopathic doctors cannot recognise symptoms that do not suit the understanding in straightforward pathological terms.

A few such medically unexplained symptoms find their reasoning in traditional Ayurveda. For example, although chronic gastritis (CG) patients could be asymptomatic, many patients complain of gastrointestinal discomfort in clinical practice, such as stomach aches, bloating, nausea, vomiting, and loss of appetite. CG could be due to multiple factors, including eating habits. Therefore, Ayurveda doctors adjust the diet habits of CG patients, such as excessive consumption of sweets, salty foods, meat, spices, and fried foods. In addition, reverting to regular eating habits is a crucial factor in improving CG. Ayurveda describes food digestion and assimilation as agni (sometimes termed Jatharagni; Jathara = duodenum). Similarly, other terms are used, such as ama, which refers to food absorbed into the body without being adequately digested and *kosta* (meaning bowel movements).

Allopathy is beginning to recognise that both nutrients and non-nutritional components of a diet are essential to gastrointestinal health; they may also cause or influence the development of gut pathology (e.g., inflammatory bowel disease, dietary intolerance, sensitivity and/or allergy). The appropriate diet may profoundly affect intestinal recovery and the successful management of chronic gastrointestinal diseases⁷. A proper nutritional assessment and 'diet therapy' are essential in such cases.

Dietitians determine what patients should eat through a lengthy and structured interview, after working with the multi-system team to understand the diseases and the patients.

So, Ayurveda attributes certain 'allopathically unexplained symptoms' to the clinical features not described in internal medicine books; thus, working with AYUSH practitioners brings the patient's perspective to the treatment. Integrative medicine protocols include the patient's features and disease-specific management, as described for gut evaluation. Dysbiosis and gut-brain axis studies are receiving funding, and new publications are emerging every day. Many chronic patients' previous prescriptions often contain histamine blockers and proton-pump inhibitors, and despite such treatments, patients continue to experience uneasiness, bloating of the abdomen, loss of taste, and lethargy. Integrative Medicine treatment helps relieve such patient's, which has been measured by quality-of-life indicators⁸.

Novel interventions, including integrative medicine, can use health-related quality of life (HRQoL) as an outcome measure to monitor their efficacy⁹. HRQoL can be measured by tools such as the World Health Organisation Disability Assessment Schedule 2.0 (WHODAS 2.0) and the Dermatology Life Quality Index (DLQI). The qualitative studies focus on patient-reported outcomes (PROMs). Often, generic measures miss relevant HRQoL contents reflecting local cultures and patients' beliefs. Hence, disease-specific tools are used, for example, to capture the issues faced by lymphoedema patients (Lymphatic Filariasis Quality of Life Questionnaire-LFSQQ¹⁰) because the psychometric properties of health status measures help determine the appropriateness of a particular tool in a specific population. Such instruments inquire about many facets of life affected by the disease, often ignored by allopathic doctors. Life domains used to assess the HRQoL of lymphoedema patients include; mobility (sitting and getting out of the chair, sitting down and standing up from the floor, travelling by public transport), self-care (dressing, bathing, washing clothes, difficulty in using the toilet) usual activities (difficulty in gardening, doing agrarian work) disease burden (foul smell-odor, itching (eczema/ discharge from limb), pain/discomfort (pain in the joints or of the body parts), psychological health (feeling neglected by friends and family members), and social participation (problems in moving around freely without feeling self-conscious, approaching people in the community). LFSQQ, as a PROM introduced to the routine treatment, helped develop patient-centric care for lymphoedema⁵. LFSQQ performed better than other HRQoL tools (WHODAS 2.0, DLQI) in the Lymphatic Filariasis population in the age and gender-matched control group⁹. LFSQQ, which inquires into seven life domains, had missing value rates lower than 10%, suggesting high feasibility, high internal consistency, and discriminant validity. However, one must be careful, as the tick-box approach often fails to build rapport and to reveal why patients consult doctors or their level of satisfaction.

Nurse counsellors' rapport with patients improves when tools to measure PROMs are used routinely in practice and when treatment adherence is monitored. Adherence to a complex and demanding

self-help regimen burdens the individual and the family member who provides support^{5,6}. Home-based self-care requires the support of skilled and time-consuming counselling. Every detail of the proposed therapy is discussed, and an understanding of the disease and its management is ascertained. The information is provided on the pros and cons of treatment options available in allopathy and traditional medicine.

Well-documented clinical studies can only support such conversations. Close family members also attend the counselling sessions. The nurse emphasises that therapy is lifelong and explains what they should expect from the treatment and what happens if treatment is discontinued. Such a long conversation helps the patients. The nurse counsellor in the treatment team greatly supports the medical consultation. Non-verbal communication, such as body posture, eye contact, facial expressions, and other skills, is developed through training and experience and helps win over patients. The first rule in communication is to shut up and listen; the second is to encourage the debate¹¹. Listening to the patient without interruption for 30-90 seconds upon arrival for consultation is essential. The patients tend to narrate most of their symptoms during that period. The clinical communication should elicit the reason a patient is seeking a consultation with the doctor. Such information supports the development of medical treatment protocols for subsets of patients.

Counselling chronic patients using specialised tools or disease-specific PROMs is likely to bring discussion of their health beliefs that may defy scientific reasoning. In this patient-centric approach, the healthcare team always listens to patients, and the objective of the patient's visit to the centre is elicited before drawing up the treatment protocol. The health care culture for chronic diseases among great physicians is to listen to the patient, empathise with them through verbal and non-verbal cues, and perform at least an organ-specific clinical examination. In my personal view, reliance on advanced healthcare technology and evidence-based medicine should always be carefully balanced with clinical experience or findings. In contrast, in acute care deliveries, the goal of the health care team and patients

align, and both are happy when patients walk back home.

Nevertheless, this is not the story for chronic care. Chronic patients require training in self-care. Doctors should become advisers rather than relying on prescriptions because there are not many drugs available to treat every chronic disease. Ayurveda advocates the concept of 'gruhopachara', a Sanskrit word meaning "caring for patients at home" or "giving treatment at home". It aims to achieve significant symptomatic control at a low cost, and it cannot be translated as palliative care in a literal sense. 'Gruhopachara' is a tradition in India and many developing nations of respecting patients' wishes to provide home care to the sick and elderly, nursing them until death. Many dying patients wish to breathe their last in their homes. Families sometimes try palliative care utilising the locally available indigenous medicines. Integrative medicine treatment of lymphoedema is home-based, and family members assist with self-care, providing a continuum of care at low cost. This is the best treatment option available for filarial leg swelling at the moment and goes beyond palliative care 5. It incorporates all recommendations of the International Society of Lymphology. Many patients who did not regularly turn up for follow-up treatments were on WhatsApp video consultations facilitated by nurse counsellors. This raises the question of how often patients with chronic diseases should be asked to attend the review. If the health care provider is more active in intervening with illness, patients are likely to return more often; another reason is that adverse effects begin to manifest as more drugs are given. Patient reviews should balance the felt needs of doctors, patients, and family members and aim to prevent disease aggravation, reinforce health literacy about the disease, and improve HRQoL. Over time, such behaviours within the nation's health care system would influence people's health-seeking behaviour.

The patient-centric approach, as described above, requires dedicated time with the patient, at least 45-60 minutes. Additionally, answering their questions when they get back home requires a dedicated healthcare worker to support them via WhatsApp consultation until they return to their routine or adjust to the changed routine the disease forces on them. Inspired by the international skincare nursing group and the International Society of Dermatology's Task Force for Skin Care for All (Community Dermatology)¹², the IAD developed a dermatology nursing syllabus in India to train nurses to care for patients suffering from chronic skin diseases as part of the holistic dermatology care system. Cosmetology, dermatosurgery, and dermatology service clinics also require nursing support for their practices. Wound care, performing minor procedures, and patient counselling require deep engagement with patients. With a smile, not a hard, long one, nurses' involvement is essential to providing better patient care. Nursing practices align with the culture of stakeholders, particularly patients and health delivery practices; nurses should become a vital part of the chronic care delivery team.

A patient-centric approach is possible if doctors treat each disease with an open mind. Doctors should internalise the skills to construct a decision tree to structure the problem, so that

alternative courses of action are defined for each chronic patient. Review the national guidelines and explain why the national guidelines or the institute's protocols might not be followed for the patient. Analyse diagnostic uncertainty by eliciting specific physical factors for a particular patient and identifying reasons for allopathically unexplained symptoms in AYUSH/CAM or in patients' individual choices. In addition to PubMed, health care providers could consult the AYUSH research portal. Most publications listed in the AYUSH research portal write about comparable biomedical diagnoses. Ayurveda journals publish an overview of patient-centric approaches in AYUSH. Nowadays, literature search is shifting to subscription-based artificial intelligence-based tools such as SciSpace. The patient-centric regimens lead to less medicalisation of consultations, fewer investigations, prevention of polypharmacy, identifying associated comorbidities, drug-drug and drug-diet interactions and optimal treatment. It comforts the sick irrespective of the ability to provide a cure.

Once patients realise that chronic disease is a permanent condition, they begin speaking with their peers on social media platforms. Doctors should also maintain an online working relationship with the patients in this digitalised world. Their questions should prompt a deviation from the doctors' patterned thinking. Learning from their problems and experiences shows the way forward and might lead to the evolution of integrative medicine treatment regimens for various diseases. Patients need relief no matter which system of medicine they take. Such a philosophy promoted allopathy's development. However, the current compartmentalised systems for this medicine, and even the specialities within it, do not always heed this fundamental principle. As patients' health literacy improves, they remind us of the Indian proverb that an old patient is better than a new doctor. Managing such chronic patients would require a multi-disciplinary approach, and one system's knowledge may not be sufficient to explain all their symptoms. As patients bring more information from other systems of medicine, doctors can choose to ignore them or begin learning from them.

Prof Terence Ryan, emeritus professor of

dermatology in Oxford, is arguing for using the currently available knowledge to improve care, reduce the cost of medical treatments, and provide better care to the world population. He advocates for 'Do K(No)w Harm' for both allopathic and CAM systems. The communication between the medical care team and patients is central to patient-centric approaches. So, the disconnect between patients and the health care team must be avoided, as it leaves patients dissatisfied despite the advances made by technology-driven medicine, while care teams tend to respect evidence-based protocols, putting aside their experience-driven insights in patient management. The patients' chapters of Oxford Medicine point to the reality that evidence-based medicine has not yet collected data in many areas of patients' well-being. It uses the analogy of the parable 'The Emperor Has No Clothes' for highly disease-driven, protocol-adherent practices, leading doctors to think that what patients are telling cannot be accurate.

What are the responsibilities of the patients and the attendants?

Patients should be aware that prescription and lifestyle disciplines are two sides of a cure tool. They are balancing Googled/AI-derived knowledge about the disease and its severity with clarity on health hazards and healing, confidence in the doctor, medicine and their own body's response based on immunity (known as bala in Ayurveda: congenital, seasonal and acquired). Sustainable relief from the disease is possible by combining the right doctor, diagnosis and drug with adherence to treatment, self-care and lifestyle. Doctors' medication gains its life only through the patient's commitment. Holistic medicine should strive to bring mental calm to patients. Stress worsens the effects of the disease and delays the effects of the drug. During the convalescence period, patients need total rest. Rest does not mean being idle round the clock. It is the proper dosage of the preferred dimension of work, such as diversion from routine work, pleasant and customised engagements, and strain-free health-compatible occupations.

There is a role for attendants and the care environment in patients' speedy recovery. Attendants should spend more time with health seekers and appear brisk, appealing and inspiring. Often, attendants' presence and personalities bring peace and instil confidence in patients. In addition, attendants trained in patient-friendly language and communication methods serve as architects of warmth and wellness, thereby accelerating tolerance to treatment. Hospital care staff should aim to send off patients with a renewed lease of life, driven by positive energy. The healthcare team should classify and customise attention to patients according to the latter's mindsets, therapeutic compatibilities, responses, and resources. An ideal wellness centre provides a sense of homeliness and exclusivity in a healing environment, nourishing well-being through comfort and solace. Such an approach could reverse the domination of cry, sorrow, seriousness and silence often seen in drugs- and device-driven modern hospital buildings.

सत्त्वमात्माशरीरंच त्रयमेतत् त्रिदिवत् ।
लोकस्तृप्तिस्तस्योपात्तत् सर्वप्रतिष्ठितिम् ॥

(Expert from the chapter on living a longer life of the ancient textbook of Ayurveda; SatwamathmaShariram Cha TrayametathTridandavath: mind, energy, and body are an individual's tripod¹³.)

References:

1. Conlon CP, Cox TM. Oxford Textbook of Medicine 6th Edition. Firth J, editor. New York: Oxford University Press; 2020.
2. Narahari SR, Ryan TJ, Bose KS, Prasanna KS, Aggithaya GM. Integrating modern dermatology and Ayurveda in the treatment of vitiligo and lymphedema in India: Modern dermatology and Ayurveda in vitiligo. *Int J Dermatol*. 2011;50:310–34.
3. Maizes V, Rakel D, Niemiec C. Integrative medicine and patient-centred care. *Explore (NY)* 2009;5(5):277–89. Available from: <http://dx.doi.org/10.1016/j.explore.2009.06.008>
4. Narahari SR, Aggithaya MG, Ryan TJ, Muralidharan K, Franks PJ, Moffatt C, et al. Self-care treatment for lymphoedema of lymphatic filariasis using integrative medicine. *Br J Dermatol*. 2023; 190:94–104. doi: 10.1093/bjd/ljad310.
5. Narahari SR, Bose KS, Aggithaya MG, Swamy GK, Ryan TJ, Unnikrishnan B, et al. Community level morbidity control of lymphoedema using self care and integrative treatment in two lymphatic filariasis endemic districts of South India: a non randomised interventional study. *Trans R Soc Trop Med Hyg*. 2013;107:566–77.
6. Narahari SR, Aggithaya MG, Morrow SE, Ryan TJ. Developing an integrative medicine patient care protocol from the existing practice of Ayurveda dermatology. *Curr Sci*. 2016;111(2):302–317
7. Li Y, Su Z, Li P, Li Y, Johnson N, Zhang Q, et al. Association of Symptoms with Eating Habits and Food Preferences in Chronic Gastritis Patients: A Cross-Sectional Study. *Evid Based Complement Alternat Med*. 2020;5:197–201.
8. Neri L, Iovino P; Laxative Inadequate Relief Survey (LIRS) Group. Bloating is associated with worse quality of life, treatment satisfaction, and treatment responsiveness among patients with constipation-predominant irritable bowel syndrome and functional constipation. *Neurogastroenterol Motil*. 2016;28:581–91
9. Thomas C, Narahari SR, Bose KS, Vivekananda K, Nwe S, West DP, et al. Comparison of three quality of life instruments in lymphatic filariasis: DLQI, WHODAS 2.0, and LF-SQQ. *PLoS Negl Trop Dis*. 2014;8(2):e2716.
10. Aggithaya MG, Narahari SR, Vayalil S, Shefuvan M, Jacob NK, Sushma KV. Self care integrative treatment demonstrated in rural community setting improves health related quality of life of lymphatic filariasis patients in endemic villages. *Acta Trop*. 2013;126:198–204.
11. Badia G. David Spiegelhalter. The art of statistics : Learning from data. London, England: Pelican; 2021;82(6):426. doi: 10.5860/crl.82.6.923.
12. Ryan TJ. The International Society of Dermatology's Task Force for Skin Care for All: Community Dermatology. *Int J Dermatol*. 2011;50:548–51.
13. Caraka.Deerghamjeevitheeyamadhayam. In: Caraka, Dridhabala, eds. Caraka Samhita. Varanasi: Chowkhamba Sanskrit Series Office, 2002; verse 46.

