INTEGRATIVE HEALTH CARE: THE ARTISTS’ HEALTH CENTRE FINDS A HOME AT THE TORONTO WESTERN HOSPITAL

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
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Abstract

This thesis examines an integrative health care (IHC) clinic set within a tertiary hospital located in large city in Canada. The enquiry began by exploring how biomedical and CAM practitioners, artists, hospital administrators, and the Artists’ Health Centre Foundation (AHCF) members interacted, communicated, and collaborated with one another for integrative patient/client care at the Artists’ Health Centre (AHC). Individual stakeholders’ knowledge and attitudes toward IHC are explored, to understand how these affected the everyday interactions among stakeholders. The thesis also examines the organizational structures of the hospital and the AHCF.

The use of qualitative research provided useful in-depth accounts of respondents’ experiences of IHC. Semi-structured focus groups with artists, health-care practitioners, hospital administrators, and AHCF members, and ten in-depth interviews with the health-care practitioners were conducted between June, 2006, and February, 2007. Steps were taken to ensure the trustworthiness of the collected data. Qualitative research software, NVIVO™, was used to manage the data.

The findings suggest that despite a perceived lack of scientific evidence, attitudes towards IHC were positively influenced when biomedical practitioners had a personal experience with CAM therapies and when practitioners developed more confidence in their own work. There remained questions about the need for and presence of IHC at the AHC, as neither the
hospital nor the AHCF worked in consultation with the practitioners and artists to develop a shared vision of IHC.

The majority of respondents described the level of communication as “sporadic” and one-sided and thus not optimal for creating a communicative environment. Most respondents perceived communication among the stakeholders as one-sided and thus not optimal for creating a communicative environment. There was a lack of understanding regarding scope of practice and how to integrate the various practitioners, particularly CAM. This led to a lack of referrals and had a direct effect on practitioners’ level of confidence. Mechanisms of communication were informal and there were no formalized structures in place to facilitate communication or integration with one another. Additionally, there was no systematic way of charting patient information at the AHC.

Respondents all agreed that IHC was an ideal to strive for and many noted how financial limitations impeded the evolution of integrative health care at AHC, truly forming a barrier to IHC. Strategies for sustainability and management of AHC funds included using a business model or an insurance model.

Important implications of this research include enhancing the current knowledge of teamwork, collaboration, and integration among practitioners in general, and biomedical and CAM practitioners in particular. This research used existing IHC models, interdisciplinary teamwork models, and educational and organizational theories for building a theoretical and conceptual framework of IHC at the AHC. Combining these models with organizational theory shed light on relationship dynamics among CAM and biomedical practitioners while taking into consideration the several structural and process dimensions of integration.
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CHAPTER 1
INTRODUCTION

1.1 Background

According to the Government of Canada (Canadian Heritage, 2004), in the early 21st century 700,000 people earned their living in the cultural sector. In the Canadian census of May, 2001, there were 131,000 artists in Canada who spent more time at their art than at any other occupation. The artists’ profiles in the census were drawn from the following groups: actors, artisans, and craftspersons; conductors, composers, and arrangers; dancers; musicians and singers; other performers; painters, sculptors, and other visual artists; producers, directors, choreographers, and related occupations; and writers. These artists had average annual earnings of $23,500, meaning that artists were in the lowest quarter of average earnings of all occupation groups (Canada Council, 2004).

In the early 21st century, Ontario had 52,500 artists, or nearly twice as many artists as any other province in Canada, and five metropolitan areas – Victoria, Vancouver, Toronto, Montreal, and Halifax – had the highest proportion of their labour force employed in the arts (Canadian Heritage, 2004). Nearly half of Canada’s artists (48 percent) resided in Toronto, Montreal, or Vancouver (Canada Council, 2004). Toronto was now firmly established as the third largest centre for English-language theatre in the world, after New York and London.

In 1994, a grassroots group of Toronto artists from diverse disciplines met with the founder and executive director of the Dancer Transition Resource Centre (DTRC), Joysanne Sidimus, to investigate the possibility of creating a specialized health-care facility for creative and performing professional artists. The impetus for the project was a unanimous frustration with the cost and lack of appropriate health care for artists. The project grew into the Al & Malka
Green Artists’ Health Centre (AHC), created to serve the “unique and complex population” of professional artists (Toronto Western Hospital, 2002).

1.2 Purpose of the Study

There are few examples of co-existing biomedical and CAM approaches of health care, especially in a hospital setting. The Artists’ Health Centre (AHC), an occupational health-care clinic for professional working artists, is located within the Toronto Western Hospital (TWH), a large downtown hospital in Toronto, Ontario. A unique centre, it offers both biomedical and complementary and alternative medicine (CAM) approaches of health care to patients/clients in a hospital setting. There are eight different health disciplines represented at the AHC: chiropractic, massage therapy, osteopathy, naturopathy, physiotherapy, psychotherapy, medicine, and nursing. Two of the publicly funded biomedical practitioners are full-time, salaried employees of the hospital. All of the CAM practitioners and two of the non-publicly funded biomedical practitioners have private practices outside the AHC. They provide their services to the AHC on a fee-for-services basis. The Artists’ Health Centre Foundation (AHCF) relies on aggressive fundraising to pay for these services. The number of fundraising dollars is thus linked to the number of hours each practitioner is provided by the AHCF.

My purpose in conducting this study was threefold. First, I needed to hone a definition of integrative health care (IHC) by exploring some perceived challenges of defining the concept at the AHC. Second, to see how IHC was working in practice, I examined the mechanisms of communication and levels of collaboration among the health-care practitioners, artists, hospital administrators, and Artists’ Health Centre Foundation (AHCF) members. Third, to discover how integrative health care might work within a hospital setting, I explored how the organizational structures of the hospital and the AHCF influenced the development of IHC at the AHC.
1.3 The Research Question

The overall research question driving this study was: *How do biomedical and CAM practitioners, artists, hospital administrators, and the Artists Health Centre Foundation (AHCF) members interact, communicate, and collaborate with one another for integrative patient/client care at the Artists’ Health Centre (AHC)*? Subsumed in this umbrella question were several questions reflecting the multi-layered analysis required to understand communication and integration at the AHC.

The inquiry began at the micro level, to uncover individual AHC stakeholders’ knowledge and attitudes. From this vantage point I then considered the meso level, to understand how knowledge and attitudes affect the everyday interactions between and among stakeholders at the AHC. At the macro level, my goal was to explore how interaction, communication, and integration were embedded in the organizational structures of the hospital and AHCF. Therefore, while the beginning point of this study was the everyday realities of health-care practitioners, artists, hospital administrators, and AHCF members at what is referred to as an integrative occupational health clinic for artists based on the perspective of these various stakeholders, the focus took into account the day-to-day interactions at the institutional level. My aim was to show the connections that existed between the micro, meso, and macro levels of integrative health care at the AHC.

Providing guidance in operationalizing the overall research question were the following sub-questions:1

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1The questions were organized into micro, meso, and macro categories in this chapter for the purpose of clarity. These divisions are somewhat artificial and during the focus group the questions were operationalized across micro, meso, and macro levels.
1.3.1  Micro level

1. How do health-care practitioners, hospital administrators, artists, and AHCF members understand and define integrative health care at the AHC?

2. How are epistemological differences between health-care practitioners resolved when biomedical and CAM approaches to health care co-exist?

1.3.2  Meso level

1. What are the informal and formal mechanisms for communication between and among the health-care practitioners, artists, hospital administrators, and AHCF members involved with the AHC?

2. How do health-care practitioners, artists, hospital administrators, and AHCF members describe their everyday interactions with one another?

1.3.3  Macro level

1. What social, economic, and hospital policies/politics influence the level of integrative health care at the AHC?

2. How do issues of sustainability, funding, and the subsidy program affect the integration of health-care services and delivery at the AHC?

The question of how biomedical and CAM practitioners collaborate and become integrated is a timely one, for interprofessional health care (i.e., care provided by many health practitioners working collaboratively) has been identified by federal, provincial, and territorial governments as a priority for health system renewal in Canada (2003 and 2004 Health Accords).

In addition, the number and diversity of therapeutic methods available to North Americans has undergone renewed growth (Kaptchuck & Eisenberg, 2001). Most of these are now broadly classified as CAM or integrative (Jonas & Levin, 1999; Kaptchuck & Eisenberg). The resurgence of CAM therapies may in part be both a reaction to the standardized dominance
of biomedicine, and an expression of a consumer-oriented culture (see chapter 2). The ascendance of CAM, however, may also be partly due to the collective desire for a kinder, gentler medicine, one that is more caring and patient centred (Rao, Weinberger, & Kroenke, 2000; Stewart et al., 2000), empowering (Mansell, Poses, Kazis, & Duefield, 2000), and holistic (Woods, 1998).

The AHC has a team of health-care practitioners in the areas of medicine, nursing, physiotherapy, psychotherapy, naturopathy, and massage therapy; all work collaboratively to deliver the best quality of care for artists. In March, 2006, the AHC added a chiropractor and an osteopath to the health-care practitioner team. Like all other health-care practitioners, the AHC practitioners had been trained separately, yet in their clinical settings were expected to work effectively together to deliver patient care.

1.4 Organization of the Thesis

Having provided an introduction to the study in this first chapter, I turn to a detailed literature review of existing theoretical and research knowledge in chapter 2. I outline, in detail, my literature review strategy, and present a definition of concepts and how they inform the study. The research question directed me to explore a range of theoretical and empirical literatures related to medical dominance, health promotion, and the emergence of CAM within this socio-political context.

In chapter 3, I delineate the interpretive lens brought to the study, informed by a particular theoretical and methodological framework. I provide a brief overview of qualitative research methods and explain how both in-depth interviews and semi-structured focus groups were used to generate data. I present the research design and implementation, and describe the iterative process of qualitative data analysis. I also provide considerations for ensuring methodological rigour and trustworthiness of the data.
Chapters 4, 5, and 6, presenting and discussing the research findings, form the core of this study. Specifically, chapter 4 begins from an organizational perspective by locating attitudes, knowledge, and communication patterns in an organizational context. Chapter 5 situates the knowledge and attitudes in the context of the everyday interactions and collaboration among health-care practitioners, artists, hospital administrators, and AHCF members. Chapter 6 extends the analysis by examining attitudes and knowledge held by the health-care practitioners, artists, hospital administrators, and AHCF members about integrative health care and how the concept of integration applied to the AHC.

In chapter 7, I offer a theoretical synthesis of the key findings of the study, in an effort to extend our understanding of integrative health care – at the AHC in particular, and within hospital settings in general. Chapter 8 concludes the thesis with a summary of the study, a presentation of key conclusions, study limitations, and a discussion of recommendations for future research.
CHAPTER 2
LITERATURE REVIEW

This literature review is structured in four main sections. The first presents the methods employed to search and collate the literature on integrative health care (IHC). The second section offers an overview of the key concepts and issues linked to IHC. The third section presents a more focused examination of IHC in hospital settings. The final section offers conclusions, recommendations, and relevance of this thesis.

2.1 Section 1: Review Methodology

This section of the literature review will offer a brief description of the aims and objectives, definitions, and methods employed to search and identify suitable material.

2.1.1 Aim and Objectives

The aim of this literature review was to search and identify and evaluate published and unpublished documents containing descriptions, discussions, and/or evaluations of integrative health-care practices as they relate to the Artists’ Health Centre (AHC), the site of my research.

Linked to this overarching aim were the following objectives: (a) to provide an overview of key concepts, issues and principles related to integrative health care; and (b) to provide a description of the nature of integrative health care (IHC) with a specific focus on the process of interaction between complementary and alternative (CAM) and biomedical health-care practitioners working together for patient/client care.

2.1.2 Definitions

In general, terms such as integrated health systems, integrative medicine, and integrative health care are often used interchangeably. The confusion of terms becomes compounded when reviewing the literature on collaboration among interprofessional, interdisciplinary, multidisciplinary, and trans-disciplinary teams of health-care practitioners. For present purposes,
I developed a working definition (described below) of integrative health care that focuses this particular thesis. I tested the working definition to see if it could be applied to the AHC setting (where IHC is presumed to be delivered) – to assess whether integration was occurring and to formulate recommendations to encourage or facilitate the process of integration at the AHC.

2.1.2.1 Integrative Health Care: A Working Definition

Boon, Verhoef, O’Hara, Findlay, and Majid (2004b) reviewed various discussions concerning the integration of CAM and traditional biomedicine to arrive at a working definition of IHC. Their working definition, slightly modified, informed my research. According to this definition, IHC: (a) seeks to assist and promote health and wellness as well as the prevention of disease through a partnership of patient and practitioner to treat the whole person (body, mind, and spirit); (b) is an interdisciplinary, interprofessional, non-hierarchical blending of both biomedical and CAM approaches that provides a seamless continuum of patient/client-centred care; (c) employs a collaborative approach based on mutual respect, trust, and a shared vision of health care that permits each practitioner to contribute their particular knowledge, skills, and attitudes for patient/client care; and (d) combines therapies and services, resulting in more effective and cost-efficient care to the patient/client and health-care system.

Since this working definition of integrative health care has many implicit and explicit concepts embedded within it, for clarity and rigour it is important to define the following terms: *biomedicine, integrative medicine, CAM, collaboration, and teamwork.*

In addition, the literature in this field uses many terms – such as *interdisciplinary, trans-disciplinary, multi-disciplinary, and interprofessional/multi-professional* – sometimes interchangeably. The section below provides definitions for these terms and a rationale for the terms that are used in this thesis.
2.1.2.2 Defining the Terms

**Biomedicine.** Also referred to as conventional medicine, Western medicine, mainstream medicine, orthodox medicine, and allopathic medicine. In terms of control over social, scientific, political, and economic discourses, what some scholars call biomedicine has held clear ascendancy in the United States for over a century. It is biomedicine to which CAM is “complementary” or “alternative” (Silenzio, 2002).

**Integrative medicine.** The use of both conventional (Western) and alternative (complementary) medicine in the management of diseases and in the promotion of health (Ovid Technologies, Inc., n.d.). This is the definition found in the Cinahl (nursing and allied health professions) database search.

**CAM.** Diagnosis, treatment, and/or prevention which complements mainstream medicine by contributing to a common whole, by satisfying a demand not met by orthodoxy or by diversifying the conceptual framework of medicine (Ernst, Mills, Hill, Mitchell, Willoughby, & White, 1995). (This is the definition adopted by the Cochrane field in this area.)

**Collaboration.** An interprofessional process of communication and decision making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided (Way, Jones, & Busing, 2000).

**Teamwork.** The interaction or relationship of two or more health-care practitioners who work interdependently to provide care for patients (Oandasan, Baker, Barker, Bosco, D’Amour, Jones, et al., 2006). Collaboration and teamwork in the literature seem to be mutually dependent.

2.1.2.3 Reviewing the Prefixes and Suffixes of Teamwork and Collaboration

In reviewing the literature, one of my first observations was that in published papers a variety of terms was used to qualify teams and the interactions that take place in team environments. In the literature, the most frequent qualifiers for a team are: *multi-disciplinary,*
interdisciplinary, and trans-disciplinary. Below is a brief description of each suffix and prefix, as well as a rationalization for using the term practitioner and interdisciplinary/interprofessional interchangeably in this thesis.

2.1.2.3.1 The suffixes “discipline” vs. “professional.” According to Cruess (2004), a discipline is a “subject that is taught,” or a “field of study”; whereas a profession is “an occupation whose core element is work based upon the mastery of a complex body of knowledge and skills.” In thinking broadly, the suffix –professional may exclude some health-care providers (e.g., massage therapists). To avoid any such exclusion, this thesis uses the term practitioner, who is “a person engaged in the practice of a profession/occupation. It is someone who practices something specified and is authorized to practice healing” (Random House, 2006).

2.1.2.3.2 The prefixes “multi-” vs. “trans-“ and “inter-.” There are distinct differences between multi- and inter-. Multi- can refer to partners working independently towards a purpose (MacIntosh & McCormack, 2001). Thus, multi-disciplinary or multi-professional refers to team members who function in parallel, working relatively independently within a group of health-care practitioners with little communication between them. Inter- describes a partnership, where members from different professions, disciplines, modalities, or domains work collaboratively towards a common purpose (Oandasan et al., 2006). Each person’s expertise is added, discussed, and evaluated in an atmosphere of sharing and respect. There is often a common purpose in working together, which is most often patient/client care. For example, interdisciplinary or interprofessional teams function in a collaborative way; they integrate their service, communicate together, and develop common understandings (Johnson, 1992). The ever-present notion of synergy (Way et al., 2000) can often be a defining feature of such teams. To fulfill patients’/clients’ needs, individuals on interdisciplinary/interprofessional teams put aside turf boundaries and share the responsibility of patient/client care (D’Amour, Sicotte, & Levy, 1999).
Trans-disciplinary is a more recent concept (Paul & Peterson, 2001). Trans-disciplinary teams are often characterized by a deliberate exchange of information, knowledge, skills, and expertise that transcend traditional discipline boundaries (Stephans, Thompson, & Buchanan, 2002). In trans-disciplinary teams, health-care practitioners often experience role blurring; sharing tasks may be a norm, and the tasks undertaken may or may not be distinct to their typical health-care practitioner roles (Hall & Weaver, 2001). As a result, blurred boundaries may even vanish (Johnson, 1992; D’Amour et al., 1999). For this thesis, trans-disciplinary teams will be subsumed under interdisciplinary/interprofessional teams.

For purposes of ease and clarity within this thesis, the terms interdisciplinary and interprofessional are used interchangeably, as many references in the literature use both terms. Both terms denote the concept of different health-care practitioners (from more than one discipline, profession, and/or modality) working together in some form of collaboration.

The use of these definitions provides clear parameters in the search for relevant literature. In effect, these definitions act as the inclusion criteria for this review.

2.1.3 Search Strategies

To address both research objectives presented above, two separate yet overlapping search strategies were employed: a “broad” strategy and a “focused” strategy.

2.1.3.1 Broad Search Strategy

To address the first objective, a broad integrative health-care search strategy was developed (see Appendix A). This search involved a three-step process.

First, a strategy designed for searching an electronic database was developed. This strategy was aimed at ensuring that a broad spread of the integrative health-care literature (e.g., research, discussion, opinion, and policy papers) would be identified. The search strategy was
used in the following three electronic databases: MEDLINE (medicine); Cinahl (nursing and allied health professions); and EMBASE (health and social care).

These databases were selected to ensure representation of a wide range of relevant sources. MEDLINE was searched for the period 1986 to 2006; Cinahl for 1982 to 2006; and EMBASE for 1980 to 2006.

Combinations of the following search terms were used in searching these three databases: integrative medicine or health care; primary health care or general practice; multi-disciplinary care team; complementary therapies; and comprehensive health care.

Second, manual searches of health- and social-care journals that publish articles on integrative health care (such as Journal of Integrated Care, Journal of Manipulative Physiology Therapy, Alternative Health Practitioner, Journal of Ecology and Natural Living) were also undertaken, to identify any relevant papers missed by the electronic database search.

Third, a search of the Internet was undertaken, using key terms from the search strategy to locate books, health policy documents (e.g., on the Health Canada website), a blog website devoted to integrative medicine, and the grey (unpublished) literature.

As a result of these searches, over 1,000 articles, documents, and books on integrative health care were identified and deemed to be potentially relevant for the review; each met the above definition for integrative health care.

Information from thesis sources was selectively included in this review to highlight key concepts and issues linked to integrative health care.

2.1.3.2. Focused Search Strategy

To address the second objective, a more focused search strategy was structured to capture articles specifically discussing the internal dynamics of integration – namely, the process of interaction and collaboration between CAM and biomedical health-care practitioners working
together for patient/client care. Since this was an interdisciplinary thesis, drawing upon the work
of several different disciplines, it was particularly important to make clear the boundaries of the
subject areas. Due to the wide scope of subjects covered in some of the reviewed disciplines, it
was necessary to be selective in reviewing the concepts, models, and theories that would be
useful for this study. I deliberately chose to confine myself to literature that was manageable and
that had the greatest opportunity of producing original insights into the issue of integrating CAM
and biomedicine in a hospital setting. This selective review of the literature does not invalidate
other conceptual frameworks, which can be investigated by other researchers.

The focused search involved two stages.

First, the broader search strategy was modified to search for literature that described the
process of interaction between and among CAM and biomedical health-care practitioners (see
Appendix A). My search strategy combined the following search terms with the broad search
terms outlined above: interprofessional communication and relations, co-operative behaviour,
and interdisciplinary communication. The three databases outlined above (MEDLINE, Cinahl,
and EMBASE) were again employed for the focused search.

Second, the results from the manual searcher of health- and social-care journals and the
Internet searches were re-scrutinized to identify any relevant material.

As a result of these efforts, 74 articles and five reviews that focused specifically on the
integration of CAM and biomedical health-care practitioners were identified. They fell within
more restrictive parameters, meeting the definitions of integrative health care as outlined above.
From these, 54 articles and all five reviews were used for this literature review. Furthermore, 19
articles focused specifically on IHC in hospital settings (see section 3 below).

The technique of content analysis (Berg, 1995; Morse & Field, 1995) was used to review
the material and identify key themes related to the specific research question. In content analysis,
information (content) is examined in written or symbolic form. For this study, the body of material requiring analysis was identified followed by creating an inclusion/exclusion criteria system (based on the definitions above) to identify articles suitable for this literature review. As shown in Tables 1 and 2, each of the 74 articles and the five reviews was categorized (the reviews are summarized in Appendix B and C):

Table 1

*Categorizations for Systematic Review of Primary Studies (74 Articles)*

<table>
<thead>
<tr>
<th>Study</th>
<th>Key Findings/ Design Details</th>
<th>Study Included?</th>
</tr>
</thead>
</table>
| Title and Author(s) | • Purpose of study  
                  • Approach to analysis  
                  • Conclusion(s) of study | Yes/No |

Table 2

*Categorization for Existing Reviews (5 Reviews)*

| Parameters of the review | Focus (utilization rates, development of IHC, collaboration between CAM and biomedical health practitioners)  
                          | Search strategy to obtain studies  
                          | Who initiated the review  
                          | Scope (e.g., international or national) |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| Design details           | Details of included study designs; which health- and social- care practitioners participated in the proposed research  
                          | Nature of research under study |
| Key findings             | Number of studies found and included in the review  
                          | Approaches to analysis  
                          | Details of any methodological critique |
| Conclusions              | author’s narrative conclusions from each review  
                          | my comments/critique on the review  
                          | areas of possible future work |
2.1.4 Excluded Articles

A number of articles were excluded as they failed to meet one or both elements of the definition criteria. For example, several papers did not discuss interactions, collaboration, or any form of teamwork despite being identified as such in the literature review (Bono-Snell, 2003; Haag, Kalina, Tourigian, & Wassel, 2004). A small number of papers were excluded because despite having some mention of integrative health care, their actual focus was on disease management (Dieppe & Brant, 2003; Oliver, 2003). Spiritual care studies (Hunt, Cobb, Keeley, & Ahmedzai, 2003), oral health (Mazey & Mito, 1993), educational teaching strategies (Jeffries, 2005), and papers with non-human subjects (e.g., studies in veterinary medicine) were excluded. Letters to the editor, commentaries, opinion, and interviews were excluded. In addition, papers not published in the English language were excluded.

2.2 Section 2: Integrative Health Care: An Overview

This second section of the literature review presents selected findings from the broad and focused literature searches that provide context for the key issues related to integrative health care. In particular, I wished to provide a contextual understanding concerning how and why IHC developed relative to the “rise and fall” of biomedicine, and the re-emergence of the CAM professions. Studies that I deemed to be strong theoretically and/or methodologically were highlighted in boxes.

The section is divided into three parts. First, a brief overview of the socio-political emergence of integrative medicine and utilization rates of CAM in Canada is discussed. Second, the process of collaborative practices and teamwork between health-care practitioners (interactions between practitioners who are biomedical, and interactions between CAM and biomedical practitioners) are examined. Third, the current models of integrated health care are reviewed.
2.2.1 Socio-political Context

The following offers a socio-political perspective on why the practices of integrative health care may have emerged in health and social care.

2.2.1.1 The Emergence of Integrative Health Care

Various reasons have been posited for IHC’s emergence; here, I describe two reasons from the socio-political arena. The first concerns government initiatives in the area of health promotion and the focus on self-care; the second has to do with current government initiatives in developing interprofessional collaborative “teams” of health-care practitioners. Throughout, this section explores the relationships between health care practitioners and the use of CAM in conjunction with biomedical care.

2.2.1.2 Medical Dominance, Health Promotion, and Social- and Health-Care Movements

We have not lost faith, but we have transferred it from God to the medical profession.

– George Bernard Shaw, The Doctors’ Page

From the vantage point of the century that has elapsed since Shaw’s pronouncement, the dominance of the medical profession in North America in general, and Canada in particular, can be depicted in a grand chronological arc, rising to great heights by mid-century and faltering as the century drew to a close.

Modern scientific medical knowledge was founded on the work of bacteriologists and germ theorists. The germ theory of disease gained prominence in the late 19th century and had a profound impact on the practice of medicine. As Waitzkin (1976) states:

The isolation of specific bacteria as the etiologic agents in several infectious diseases created a profound change in medicine’s diagnostic and therapeutic assumptions. A unifactorial model of disease emerged. Medical scientists searched for organisms causing infections and single lesions in non-infectious disorders. (p. 265)

Medical knowledge became rooted in the paradigm of the “specific etiology” of diseases; they were assumed to have specific causes that could be analyzed from a cellular or biochemical...
perspective. In this paradigm, the body was akin to a machine in that it was comprised of a series of parts that could be treated, taken apart, and reassembled. The human body was assumed to work in the same way as a machine. As McKeown (1965) states:

Nature was perceived in mechanistic terms, which led in biology to the idea that a living organism could be regarded as a machine, which might be taken apart and reassembled if its structure and function were fully understood. In medicine, the same concept led further to the belief that an understanding of disease processes and of the body’s responses to them would make it possible to intervene therapeutically, mainly by physical, chemical, or electrical methods. (p. 394)

Disease, then, was viewed as resulting from mere technical defects, and treatments were oriented towards restoring the “normal” functioning of the human machine. As Navarro (1976) argues, disease was seen as an alteration, a pathological change in the body machinery that had to be “fixed.” It could be argued that this mechanistic conception – in Doyal and Pennell’s (1979) terminology, *localized pathology* – led to the medical fragmentation of the delivery of health care. For the premise that the human body is like a machine and as such can be broken down into different parts for repair meant that there now needed to be specializations within medicine focusing on specific parts of the body machine, such as the cardiovascular system, nervous system, gastrointestinal system, reproductive system and so forth (Navarro, 1976). This shift towards “localized pathology” had a profound impact on the division of labour in medicine.

The division of labour (specialization) in medicine focusing on specific parts of the body achieved ascendancy in the late 19th and early 20th centuries. The concept of the division of labour is rooted in economics and sociology. Adam Smith, an 18th-century economist, first used the term to refer to the extreme specialization in the process of production that results from subdividing work into limited operations performed by separate workers in order to increase productivity (Rothschild, 2001). Sociologists such as Comte (Popkewitz, Olsson, & Petersson, 2006) and Durkheim (1984) recognize that the division of labour had the potential to increase social solidarity by creating relationships of mutual dependence between individuals. They also
recognize its potential for divisiveness. Marxist sociologists hold that it produces social conflict and is the primary cause of social inequality. In his book, *Division of Labor: A Political Perspective*, Krause (1982) notes that the division of labour has three essential dimensions: ownership or control of the work setting; control of existing work arrangements (including physical equipment and power arrangements/social relationships in the setting); and influence on the values and ideologies that guide individuals in the work setting. He notes that ideologies are often created to justify existing patterns of labour, and that those with the most power defend the legitimization of these patterns.

In medicine, the division of labour centres on the concept and theory of professional dominance, a theory about physicians and their control over health-care work. According to Freidson (1986):

> In the medical organization the medical profession is dominant. This means that all the work done by other occupations and related to the service of the patient is subject to the order of the physician. The profession alone is held competent to diagnose illness, treat or direct the treatment of illness, and evaluate the services. Without medical authorization little can be done for the patient by paraprofessional workers. (p. 163)

Abbott (1988) concurs with Freidson; however, in his theory of the professions, he moves the focus away from the organizational structures of professions to examine the link between a profession and its work. He states that professions are brought into conflict with each other over issues with the content and the control of work.

One of the key factors contributing to the dominant position of biomedicine and the division of labour in medicine was medical education. Abraham Flexner, the author of the *Flexner Report* (1910, as cited in Berliner, 1975, Brown, 1979, and Kunitz, 1974), best describes the condition of medical education in Canada and the United States at the beginning of the 20th century.
Flexner visited medical schools in the United States and Canada in 1904 and 1905. His report was critical of medical schools that did not have the facilities to teach laboratory-based scientific medicine. It called for the reorganization (and sometimes closure) of such institutions. His recommendations had additional philanthropic support – the Rockefeller Foundation and the Carnegie Foundation provided financial support to medical schools that implemented the report recommendations (Nielsen, 1986). As a result of the report, 92 medical schools were closed or reorganized between 1904 and 1915 (Waitzkin, 1976). Some of these institutions taught alternative forms of healing such as herbalism, homeopathy, and midwifery. Highly critical of these alternative practices, Flexner’s report helped to relegate them to a subordinate status vis-à-vis the biomedical practice of medicine (Kunitz, 1974).

The *Flexner Report* was hailed as “the document that helped change modern medicine from quackery to responsible practice” (Waitzkin, 1976, p. 261). The norm for medical education and practice very rapidly became biomedicine. Before the report’s recommendations were implemented, biomedical physicians faced competition (affecting their incomes) from practitioners trained in a variety of alternative healing traditions. The cost of delivering pre-medical education, as well as the necessity of providing expensive laboratory facilities, led to high tuition fees in medical schools, making medical education all but inaccessible to working-class students. As Waitzkin states: “The closure of many medicinal schools not based in laboratory science led to fundamental changes in the class composition of the profession, changes that went hand in hand with reduced competition and higher individual incomes for doctors” (p. 266).

Along with educational reforms, there emerged a more systematic organizational structure to evaluate and regulate educational standards. For example, the Association of Canadian Medical Colleges (ACMC), established in 1943, was now the only body that
coordinated medical education in Canada. It had official relationships with the Canadian Medical Association (CMA), the Royal College of Physicians and Surgeons of Canada (RCPSC), the Medical Council of Canada, the Association of American Colleges, and the American Medical Association (AMA) (MacDermot, 1967). As well as improving medical training, subsequent legislation enabled physicians to suppress practitioners labelled as “quacks.” As a result, the medical profession was able to restrict the activities of other health occupations, thereby gaining dominance.

The new focus on scientific education, formation of medical associations, tightening of licensing standards and marginalization of alternative forms of healing all helped to establish the monopoly of biomedicine, and raised the social profile, prestige, and income of physicians (Macionis, Benoit, & Jansson, 1999).

By the pre-World War II period, the biomedical model had eclipsed other theories of health and illness, and had discounted social, psychological, spiritual, environmental, and other ways of viewing and understanding them. At this time the principal sources of morbidity were infectious disease and great advances were being made in drugs and vaccines for such diseases as polio, diphtheria, and tetanus. In the post-World War II period, however, the primary forms of morbidity came to be diseases that were chronic, degenerative, and largely incurable. The concept of health and how it was defined began to change. During this time and up to the 1960s, many industrialized countries began to radically restructure their health-care systems, and the power of biomedicine began to decline.

During the 1940s, health-care insurance became an issue due to the large number of young recruits who were too sickly for military or industrial service (Fuller, 1998). This fact and other evidence demonstrating the poor health of the Canadian population led to health insurance being firmly established as a key component in government plans for post-war reconstruction.
(Taylor, 1978). In 1945, draft legislation was introduced, key features of which were: (a) the establishment of health regions; (b) patient registration with physicians; (c) a capitation mode of payment; (d) additional financial incentives for physicians who adopted preventive approaches to health; and (e) the administration of the system by a commission of physicians and consumers (Vayda & Derber, 1992).

There are several analytical approaches to understanding the nature and consequences of medical care insurance, medical dominance, and what these have meant for health-care delivery and service in Canada. Coburn, Torrance, and Kaufert (1983) argue that the introduction of medicare in Canada is best understood as a response to working-class agitation, and as an attempt to supply the capitalist class with adequate quantities of healthy labour. They also believe that the introduction of medicare marked the beginning of the end of medical autonomy and dominance (Coburn, 1998). Walters (1982) agrees that medicare was an attempt by the state to ensure the reproduction of a healthy and productive working class. Improved health status among the working population was assumed to be the result of access to health-care services (to hospitals and physicians in particular).

In contrast to the above approaches, Swartz (1987) draws attention to the ways in which the resistance of the medical profession to medicare resulted in modifications to the form and content of the original proposals for socialized medicine. These concessions had the effect of entrenching the interests of the medical profession (Naylor, 1986; Weller & Manga, 1983). The debate over whether medicare entrenched or undermined medical autonomy and dominance continues; however, it is clear that the organized medical profession feared losing its autonomy (Badgley & Wolfe, 1967).

National health insurance was implemented across Canada in 1971, and related efforts to directly control costs in the health-care system were made. Health promotion also became more
prominent in the early 1970s. Canada’s leadership in this area began in 1974, with the publication of “A New Perspective on the Health of Canadians,” by Marc Lalonde (1974), then Minister of Health and Welfare Canada. The report proposed that health was determined by the interplay of human biology, health-care organizations, environment, and lifestyle, and signified the first time a major Canadian government publicly acknowledged that medicine and the health-care system played only a small role in determining a population’s health status (Hancock, 1986). It was the first Canadian document to suggest health promotion as a key strategy for improving health.

In this period, critics of medical care highlighted the limitations of the professional health-care system; the contribution of modern medicine in improving the health status of people was critically appraised and questioned. For example, early feminist analyses of the health-care system raised many questions of gender inequality in medical education, science, and practice (Muller, 1990). These early feminist critiques pointed to physicians’ arrogant and dismissive attitudes, their excessive enthusiasm for surgical procedures, their tendency to define all aspects of life in medical terms, and their unwillingness to share responsibility for decision-making (Plechner, 2000). Overall, people began to voice the belief that professional health-care systems were paternalistic, and saw themselves sharing a state of powerlessness in it (Illich, 1976). Some even argued that modern, scientific medicine had a direct negative impact on health (Illich).

In response to disillusionment with the professional health-care system, efforts to exercise more control over one’s health began to gain momentum. The concept of self-care emerged as a strategy for involving and empowering people in promoting and caring for their own health. It was defined as the process whereby an individual functions at the level of primary health resource in the health-care system on his/her own behalf, in health promotion, prevention, and in disease detection and treatment (Levin, Katz, & Holst, 1977). One of the first examples of
self-care came from the women’s movement, with the publication of *Our Bodies, Ourselves* (Boston Women’s Health Book Collective, 1971), developed to promote self-care among women (Kickbusch, 1989).

Two interesting points arise. First, more women than men have embraced the concept of self-care. For example, the utilization rate for CAM – which has a strong association with self-care – is higher among women than it is among men (Millar, 1997). Second, the women’s movement, initially quite positive in relation to health promotion and concepts of self-care, out of their belief that CAM could play a useful role in challenging the scientific basis of medical orthodoxy, came to be concerned that aspects of CAM placed undue responsibility on the individual, thereby potentially contributing to victim-blaming (Hill, 2003; Lupton, 1995). And so the seeds were sown for what became a classic debate in the late 1970s and early 1980s, in which was debated the following question: To what extent is the individual responsible for health (the so-called “victim blaming” approach) and how far is health a collective responsibility, to be addressed by communities and society as a whole (Bunton, Burrows, & Nettleton, 1995)?

This questioning of the health-care system’s service and delivery ushered in a new era of health care, with a concomitant call for greater public participation and individual responsibility for health and self-care. Individuals were encouraged to take increased responsibility for their health, and to empower themselves through knowledge about their health (Anderson, 1995). Simultaneous social and health-care movements caused a paradigm shift, preparing the ground for the emergence of integrative health care.

The popularity of CAM has largely been led by consumer demand. A new “consumer movement,” in which the patient actively participated in making health-care decisions, was born in the 1960s (Scott, Ruef, Mendel, & Caronna, 2000). Intensified by the historical battles for equal rights, waged on behalf of minorities and women, patients began to demand their
individual rights to health care as consumers. The movement urged individuals to seek personal
control over health through increased knowledge of the various available therapies, and in this
movement, patients/clients/consumers might not evaluate treatments solely in terms of any
evidence-based clinical effectiveness, but in terms of a range of quite diverse criteria (Williams
& Calnan, 1996). In contrast to the alleged authoritarian and paternalistic nature of biomedicine,
many patients saw CAM as more empowering, as it was believed to offer personal autonomy and
control over health-care decisions (Siahpush, 1999). Rather than compliantly relying on
institutional legitimacy (e.g., on the medical profession, hospitals, and clinics) for making
choices, patients seeking alternative therapies tended to engage as concerned consumers, relying
on personal legitimacy, testimonials, and anecdotes from their friends and families as the basis
for selecting CAM care (Kelner & Wellman, 1997; Zollman & Vickers, 1999).

Informed consumers of health care must make decisions about what kind(s) of health-
care practitioners would best meet their needs. The idea that individuals who use CAM take an
active role in their health care (as opposed to “passive patients” who accept medical authority
without question) is reflected in such people’s use of both CAM and biomedical approaches. For
them, CAM health-care practitioners accompany, rather than substitute for, biomedical health-
care practitioners. Studies show that people who consulted with a CAM health-care practitioner
were more likely than those who did not to have a regular physician, to have seen a specialist in
the past year, to have had 10 or more physician visits in that time, and to have had their blood
pressure checked in the preceding two years (Zollman & Vickers, 1999). Notwithstanding the
finding that people who made heavy use of CAM regarded their CAM health-care practitioner as
an adjunct to their physician, a substantial percentage of those who saw a chiropractor, massage
therapist, or other CAM therapist did so instead of seeing a physician (Berger Population Health
Monitor, 2001).
In summary, by the early 1990s health promotion and CAM seemed to be at a pivotal point in their histories, ready to make way for the emergence of integrative health care. It is beyond the scope of this thesis to explore the potential connections between these movements; in fact, a brief search in the health promotion literature revealed no citable connections between the rise in health promotion strategies and CAM. Nevertheless, these concepts appear to be increasingly popular with the public and to be gaining credibility within biomedical health care as well.

I argue that the AHC can be seen as an exciting new development – a paradigm shift in health and health care. It began with consumers (artists, in this case) who had a vision for a specialized health-care facility where they could actively participate in making health-care decisions for themselves about which health-care modalities and which health-care practitioners would best help them stay healthy. The efforts of artists, health-care practitioners, and other professionals culminated in the creation of the AHC, an occupational health clinic for artists, at the Toronto Western Hospital. Currently, the AHC offers a variety of CAM and biomedical services for the over 20,000 artists who live in the Toronto area (Artists’ Health Centre Foundation, 2007).

2.2.1.3 Utilization Rates of CAM Therapies

Several studies have shown a rise in the use of CAM in Canada, Europe, and the U.S.A. (Buske, 2002; Patterson, Neuhouser, Hedderon, Schwartz, Standish, Bowen, et al., 2002; Richardson, Jones, & Pilkington, 2001). In Canada, CAM therapies are not generally integrated into established health-care delivery systems and regulatory bodies; thus, health-care institutions (such as the Ontario Ministry of Health and Long Term Care) do not generate data on the use of CAM. However, efforts have been made by Canadian federal and provincial/territorial governments to gather information to provide a more complete picture of health care in Canada.
The National Population Health Survey (NPHS) (Health Canada, 2004b), the Canadian Community Health Survey (CCHS) (Statistics Canada, 2001), and the Berger Monitor Survey (2002) have been gathering data on CAM. Box 1 is a summary of the reported data from these surveys.

Box 1

Utilization Rates of CAM in Canada

According to the National Population Health Survey (NPHS), the use of CAM health-care providers among Canadians aged 18 or older increased from an estimated 15 percent in 1994/1995 to an estimated 19 percent in 1998/1999. Massage therapists, acupuncturists, naturopaths, relaxation therapists, and others accounted for the increase over this period of time (Millar, 2001). Historically, chiropractors are used more often than other CAM health-care providers (Ramsay, Walker, & Alexander, 1999).

The use of CAM health-care providers in Canada increases as one moves from east to west. Between 3 and 9 percent of people in the Atlantic Provinces consulted with a CAM health-care provider compared to 15 percent in Québec and Ontario, and 21 to 25 percent in the Western provinces. The rate of use was highest in Alberta. The higher use in Western Canada may partly reflect their own provinces’ health-care plans, which offer some coverage for chiropractic services (Berger, 2001).

Irrespective of their education, household income, attitude towards self-care, or chronic pain, women were more likely than men to consult CAM health-care providers. In the 1998/99 NPHS survey, 19 percent of women reported that they consulted a CAM health-care provider in the previous year, compared with 14 percent of men. This pattern is found in health care in general, as more women than men seek help for health problems (Redondo-Sendino, Guallar-Castillon, Banegas, & Rodriguez-Artalejo, 2006).

The World Health Organization (WHO) has recognized that collaboration among the various health-care practitioners is an important condition for the integration of CAM and biomedicine (World Health Organization, 1978). The section below briefly describes the interest and research on collaborative teamwork in health care (mostly between biomedical health practitioners) and how this work can inform and support the concept of integrative health care.
2.2.1.4 Collaborative Practices and Teamwork

This section will discuss the evolution of health-care service and delivery towards interprofessional collaboration and teamwork. Interprofessional collaboration is when health-care practitioners work and learn for, with, and about each other for patient/client care (Freeth, 2001). Research on collaboration and teamwork between CAM and biomedical health-care practitioners will be examined as will the burgeoning research on integrating CAM with biomedical approaches to care.

2.2.1.4.1 The evolution of teamwork and collaboration in Canada. Historically, the movements away from the traditional, hierarchical approach to patient/client care towards a patient/client collaborative relationship emerged in the past decade along with the rise in health promotion (Feeley & Gottlieb, 2004). More recently, numerous forums and government reports have called for a collaborative approach among health-care practitioners as a key strategy in health-care renewal (Health Canada, 2004a; Romanow, 2002).

In Canada, there have been a number of initiatives supported by Health Canada related to collaborative care. Box 2 provides a brief description of several initiatives.

Box 2

*Canadian Initiatives in Collaborative Care*

The “Collaboration of Prevention” initiative began in the early 1990s. It has evolved into the “Coalition on Enhancing Preventive Practice.” Formed by 10 professional health organizations, the initiative developed various activities funded, in part, by the federal government. In 1994, Health Canada initiated “Supporting Self-Care,” a program focused primarily on collaboration between family medicine and nursing. It was active until 2002 and led to a number of projects that demonstrated how teams of health-care providers could work together and involve patients/clients in decision-making. In 2000, Health Canada announced a “Primary Health Care Transition Fund,” and allocated $800 million in funding for it. A substantial portion of these funds was distributed through provincial and territorial agreements with the understanding that collaborative care was to be a major priority.
Oandasan et al. (2006) conducted in-depth interviews with key informants and undertook a wide-ranging survey of peer-reviewed and grey literature on teamwork in health care. They looked at the components of teamwork, effectiveness of teams, types of interventions, health-care team dynamics, and the impact of government infrastructure, legislation, and policy on teamwork in the Canadian health-care system, and identified challenges in building and maintaining effective teamwork. These included a lack of common definitions of teams and teamwork, the relationship between teamwork and collaboration, the spectrum of collaboration in health care, organizational factors affecting teamwork, and the implication of current policy, regulation, and legislation on teams.

International experience may also guide the transition to collaborative practice in Canada. For example, studies in the United States have focused on the use of teams to improve the delivery of chronic disease care, through applying clinical guidelines on core competencies for practice in primary care settings (Institute of Medicine, 1999; O’Neil & Pew Health Professions Commission, 1998). In the United Kingdom, reforms in the National Health Service (NHS) have resulted in most primary care groups adopting the model of interprofessional team practice (University of Sheffield and Sheffield Hallam University, 2004). In Australia, to respond to rural and other populations, a number of health centres and other practice arrangements have been established as multidisciplinary teams (Marriot & Mable, 2002). Finally, in New Zealand, the government launched a “Primary Health Care Strategy,” which, like the NHS in the United Kingdom, focused on universal access to primary health-care services (Mays & Cumming, 2004).

2.2.1.4.2 Teamwork among biomedical health-care practitioners. Teamwork and collaboration include two sets of relationships: those between health-care practitioners and patients/clients, and those among health-care practitioners. With respect to the
practitioner/patient relationship, improved teamwork and collaborative care have been shown to improve quality of care and patient satisfaction (Meads, Ashcroft, Barr, Reeves, & Wild, 2005). A collaborative relationship supports the patient/client’s efforts in taking control over their own health. Both partners – health-care practitioner and patient/client – respect one another and the relationship benefits both individuals by allowing them to learn, gain, and grow from the relationship (Hill, 2003). With respect to the relationships among health-care practitioners, teamwork has been hypothesized as a solution to reducing staff shortages, stress, and burnout (Hayward, Forbes, Lau, & Wilson, 2000; Lomas, Culyer, McCutcheon, McAuley, & Law, 2005). Other research has shown that teamwork significantly reduces workloads, and increases job satisfaction and retention (Borrill, West, Shapiro, & Rees, 2000; Health Council of Canada, 2005; Zwarenstein, Reeves, & Perrier, 2005).

Moving towards interdisciplinary teamwork and collaboration requires a shift and alteration in health practitioners’ attitudes, existing values, socialization patterns, and workplace organizational structures. Due to health-care practitioners’ autonomous, specialized, and separate professional training and socialization, they tend to believe that their discipline is more rigorous than other disciplines (Holm, 1995). Few practitioners are knowledgeable about the scope of practice, expertise, responsibilities, and competencies of other disciplines (Mariano, 1989). As a result, they tend to lack knowledge of other disciplines, and display chauvinistic attitudes, distrust, and lack of confidence in other disciplines and their therapies (Muller, 1990).

Hierarchy and power imbalances exist in the relationships between health-care practitioners (Blair & Buesseler, 1998; Vrfdenburgh & Bender, 1998) and between health-care practitioners and their patients/clients (Hardy & Leiba-O’Sullivan, 1998). Willis (1989) identifies three different levels of hierarchy and power imbalance in the relationship between health-care practitioners. First, the medical profession exercises autonomy over its own work and
is not subject to direction and evaluation by other health practitioners. Second, the medical profession exercises authority over other health-care practitioners through direct supervision, limitation (restriction of groups, such as physiotherapists and dentists, to particular parts of the body or to particular procedures), or exclusion (outright denial of legitimacy to groups such as naturopaths and chiropractors). Third, the medical profession wields formidable administrative power, over health occupations in the form of referrals and over access to non-medical benefits and privileges such as sick leave. This formidable administrative power is also seen in their over-representation in senior administrative positions within the hospitals and health services organizations, and with regard to health policy formation. Most of the literature of government/group relationships in the health policy field proceeds on the assumption that the dominance of the medical profession exerts influence on government decision-making (Boase, 1994).

These power imbalances lead to a lack of sharing in decision-making about patients (Hunter, 1996) and have frequently excluded the patient from planning for and implementing their own health care (Coyle, 1999; Staniszewska & Ahmed, 1999). To facilitate change, a new culture in health systems must be created that supports trust, a willingness to share in decision-making, and meaningful inclusion of patients/clients/family members in discussions about their care. Box 3 provides a model for creating a culture for interdisciplinary collaborative professional practice (Orchard, Curran, & Kabene, 2005).
Box 3

A Client-Centred Collaborative Professional Practice Model

Orchard et al. (2005) present a client-centred collaborative professional practice model. They contend that the future of the health system is dependent on health-care practitioners re-working the way they practise together. Our current education and health systems are structured around a multi-disciplinary model of practice with physicians or nurse practitioners as decision-makers and rarely are clients included in care planning. No longer can a multi-disciplinary model support the complex health needs of many clients, nor can any one-health profession have all the knowledge needed to provide total patient-centred care. True interdisciplinary practice is defined as a partnership between a team of health-care practitioners and a client in a participatory, collaborative, and coordinated approach to shared decision-making about health issues. Such a practice requires revamping the way future health-care practitioners are educated, and new ways in which the system can accommodate shared decision-making. The authors propose a client-centred, collaborative, professional practice model as a means for fostering and facilitating the culture for this change.

There are certain knowledge gaps in the teamwork literature. To date, a study comparing health-care teams across settings (e.g., comparing hospital-based and primary care settings) has not yet been done. Therefore it is unclear whether teams working in different environments have different characteristics. Current literature presents little theory with which to evaluate the effect of health-care settings on teams and/or teamwork. Some work has been done to develop a multi-layered, theoretically informed model in the case of interprofessional initiatives in primary, maternity, and mental health care, which helped to inform the micro dimensions of this research (Mulvale & Bourgeault, 2007). These models consider teamwork only among biomedical practitioners; however, many of the macro-meso-micro factors influencing the full realization of IHC between CAM and biomedical practitioners are similar to those which either foster or impede interprofessionalism in general. In addition, there are gaps in knowledge with respect to the organizational context of teams. For example, the literature shows that remuneration affects behaviour, attitudes, and a willingness to work in new models of health care (Hollander, Anderson, Béland, Havens, Keefe, Parent, et al., 2000), but no mechanism exists to tie incentive funding to collaboration and teamwork.
The contribution of this thesis in this particular area is twofold. First, it contributes to the literature by examining the effect of a setting – an occupational health clinic for artists, located within a hospital – on the level of integration of CAM and biomedical practitioners. Second, it examines the organizational context and mechanisms of remuneration of health practitioners at the AHC to better understand the organizational contexts of health-care teams.

The literature review also reveals a wide range of literature that considers medical dominance to be a structural feature of the health division of labour (Blair et al., 1998; Hardy et al. 1998; Willis, 1998). However, despite the documented structural relationship of dominance and subordination of other health professions and modalities to the medical profession, the degree to which different groups of health-care practitioners experience this structural dominance has not yet been researched. This thesis contributes initial insights regarding the current perceptions of eight occupational groups (medicine, nursing, physiotherapy, psychotherapy, massage therapy, chiropractic, osteopathy, and naturopathy) and their interrelationships among each other, and considers issues of biomedical dominance and authority.

2.2.2 Collaboration between CAM and Biomedical Health-Care Practitioners

This section reviews studies that consider the relationship between CAM and biomedical health-care practitioners in primary care settings. Most of the studies focus on the steps towards integrating CAM (Coulter, Singh, Riley, & Der-Martirosian, 2005; Emanuel, 1999; Mootz, 2001; Paterson & Peacock, 1995; Visser, 1990), and the barriers related to integrating CAM into multi-disciplinary practice (Burk & Sikora, 1993; Christie, 1991; Jonas, 1998; Montbriand, 2000; Pietroni, 1992; Reason, Chase, & Desser, 1992; Shuval, 2002). The studies illustrate the different knowledge base CAM and biomedical health-care practitioners’ work with, and the power relations that exist in interprofessional workplaces. Detail is provided on reciprocal relationships,
education/training, and communication between CAM and biomedical health-care practitioners as they contribute to integrating CAM into multi-disciplinary practice. The section concludes with a review of IHC models.

2.2.2.1 Reciprocal Relationships

To successfully integrate CAM into a multi-disciplinary practice, practitioners must reflect on their beliefs regarding illness and healing, to find whether they believe a reciprocal relationship will benefit their patient/client. Research from the last decade suggests that some primary health-care practitioners (e.g., physicians and nurse practitioners) have expanded their therapeutic repertoire to include CAM practice, and, reciprocally, some CAM practitioners have taken primary responsibility for patients/clients; and both groups have been referring patients to each other (Cooper & Stoflet, 1996). A Canadian study of general practitioners found that 54 percent perceived some benefits from the use of alternative therapies, and were sometimes willing to recommend their patients use these therapies (Verhoef & Sutherland, 1995). Most physicians were interesting in therapies they had had personal experience with or professional training in, such as lifestyle therapies (nutrition and exercise) and mind-body therapies (Berman, Singh, Lao, Singh, Ferentz, & Hartnoll, 1995; Goldszmidt, Levitt, Duarte-Franco, & Kaczorowski, 1995). Other studies found evidence of favourable opinions towards CAM therapies on the part of practising nurses (Hayes & Alexander, 2000; King, Pettigrew, & Reed, 1999). One study of nurse practitioners found that “almost 65 percent indicated that they had recommended or referred clients for one or more alternative modality” (Richardson, Jones, & Pilkington, 2001). Box 4 illustrates health-care practitioners’ perspectives on CAM referrals.
Van Haselen, Reiber, Nickel, Jakob, and Fisher (2004) assessed primary care health practitioners’ perceptions of need and of ways to integrate CAM in primary care. Their questionnaire assessed health-care practitioners’ perspectives on complementary medicine, referrals, ways to integrate complementary medicine into primary care and interest in research on CAM. Responses were obtained from 149 GPs (40 percent response rate after one reminder), 24 nurses, and 32 other primary care team members. Of this number, 171 respondents (83 percent) had previously referred patients for CAM treatments (or influenced such a referral). Main reasons cited for this were: patient’s request (68 percent), failure of conventional treatments (58 percent), and evidence (36 percent); more than one reason could be given. Acupuncture and homeopathy were the therapies for which patients were most frequently referred, followed by manual therapies. They showed significant interest in gaining more training/information about CAM (66 percent). Only 12 respondents (6 percent) were against any integration of CAM into mainstream primary care. Most respondents felt that CAM therapies should be provided by doctors (66 percent) or other health-care practitioners trained in CAM (82 percent). This study suggests that considerable interest in CAM exists among primary care practitioners, and provides evidence that many are already referring or suggesting referrals.

The research mentioned above suggests that attitudes, beliefs, and perceptions regarding the usefulness of CAM therapies were mainly driven by patient demand and by dissatisfaction with the results of conventional medicine – that is, by perceived limitations to conventional health care. For example, the biomedical model emphasizes diagnosis, definitive treatment, and cure; yet the leading causes of mortality and morbidity in the Canadian population – heart disease, stroke, and cancer – are chronic and not curable (Spiegel, Stroud, & Fyfe, 1998). Many systemic disorders (such as fibromyalgia) frequently fail to respond to biomedical treatment approaches (Yunus, Bennett, Romano, & Russell, 1997). People also explore CAM out of dissatisfaction with the fast pace and pharmaceutical focus of conventional care as a reason, and dramatic statistics on medical errors and pharmaceutical risks have alerted practitioners to the need for concern about the safety of conventional medical practices (Lazarou, Pomeranz, & Corey, 1998). For example, in 1997, deaths from medical error exceeded those from motor vehicle accidents, breast cancer, AIDS, or workplace injuries (Institute of Medicine, 1999). The
CAM approach towards self-healing and health promotion is often believed to be especially useful for chronic care management (Oliver, 2003). Several examples of CAM therapies used in chronic care management follow, in Table 3.

Table 3

*Examples of CAM Therapies Used in Secondary Care*

<table>
<thead>
<tr>
<th>CAM Therapies</th>
<th>Conventional Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain clinics Acupuncture</td>
<td>Anaesthetists, physiotherapists, palliative care physicians, professional acupuncturists</td>
</tr>
<tr>
<td>Physiotherapy departments</td>
<td>Physiotherapists trained in manipulative medicine or acupuncture</td>
</tr>
<tr>
<td>Rheumatology departments</td>
<td>Manipulative therapy, acupuncture</td>
</tr>
<tr>
<td>Hospices</td>
<td>Aromatherapy, reflexology, massage therapy, hypnosis, relaxation, acupuncture, homeopathy</td>
</tr>
<tr>
<td>Clinical psychology departments</td>
<td>Hypnosis or relaxation training</td>
</tr>
<tr>
<td>Obstetric departments</td>
<td>Yoga, acupuncture, massage therapy</td>
</tr>
<tr>
<td></td>
<td>Notes: adapted from Zollman &amp; Vickers, 1999.</td>
</tr>
</tbody>
</table>

However, the mere coexistence of different modalities does not produce an integrative system of care, and to restore health, combining both approaches may not work synergistically. For example, the literature is silent on any systematic examination of issues involved in IHC and patient care/patient safety. To help optimize the quality and safety of patient care, such research
is needed in order to develop reasonable evidentiary criteria to determine whether specific therapies merit inclusion or exclusion in a collaborative model (Hammerly, 2002).

For many biomedical health practitioners, the chief reported impediment to a change in attitude towards IHC was a perceived lack of quality research in CAM (Bower, 1998). Research publication bias against CAM, dearth of research funding, and the challenges of research design inherent in some CAM modalities have contributed to this lack of quality and quantity in published research (Haynes, 2003; Kaptchuck & Miller, 2005; Markman, 2002; Verhoef, Vanderheyden, Dryden, Mallory, & Ware, 2006). In addition, much of the published research has failed to show any direct health effects. However, a number of studies have supported the use of CAM therapy for particular indications. For example, some studies explore the benefits of homeopathic treatment for allergies (Frenkel & Hermoni, 2002) or migraine headaches (Kleinjnen, Knipschild, & ter Riet, 1991). With an increasingly broad spectrum of conventional medical journals publishing CAM research, the basis for these criticisms seems to be diminishing (Barnes, Abbot, Harkness, & Ernst, 1999; Truant & McKenzie, 1999; Verhoef, Casebeer, & Hilsden, 2002).

2.2.2.2 Education and Training

Few medical residencies offer or even require rotations in CAM (Wetzel, Eisenberg, & Kaptchuck, 1998), and very few published curriculum guidelines and course evaluations exist (Kligler, Gordon, Stuart, & Sierpina, 2000). Although reliable and timely publications about CAM and IHC are becoming more common, they are still not widely accessible. In one such publication, a survey of all 125 U.S. medical schools found that 67 percent of the schools offered various stand-alone courses related to CAM (Wetzel et al.). Most of Canada’s 16 medical schools include CAM in their curricula, usually as part of a required course (Ruedy, Kaufman, & MacLeod, 1999). Lectures constituted the most frequent method of information; acupuncture (in
10 schools) and homeopathic medicine (in nine schools) were the interventions most often included in such course material (Ruedy et al.).

Although beyond the scope of this thesis, it is evident that with the inclusion of CAM therapies in biomedical education, health-care students and current practitioners will require ongoing professional development to learn about topics related to CAM therapies and to learn about collaboration and integration. However, this thesis does explore the health-care practitioners’ desire to learn, teach, and/or model the principles of IHC at the AHC.

2.2.2.3 Communication between CAM and Biomedical Health-Care Practitioners

Developing a dialogue between CAM and biomedical practitioners is a neglected topic in the literature, even though such dialogue is essential to the process of integration. CAM and biomedical practitioners often describe themselves as uniquely different from each other because they each “speak a different language.” Biomedical practitioners are trained to understand a medical terminology that they share with other biomedical disciplines. CAM practitioners have their own terminology, particular to their own therapy and practice. According to Eskinazi and Muehsam (2000) this can clearly act as an impediment to constructive dialogue. Communication between CAM and biomedical practitioners requires a combined effort on the part of both parties to develop a common language (Anderson, 1999; Caspi, Bell, Rychener, Gaudet, & Weil, 2000). Box 5 is an example of the lack of communication between CAM and biomedical health-care practitioners.
Box 5

*Communication between CAM and Biomedical Health-Care Practitioners*

Christie (1991) describes a “dialogue group” consisting of alternative and modern health practitioners that started in Norway in 1989. WHO has strongly advocated promotion of cooperation between traditional and modern health-care practitioners. In Norway, members of these two professions almost never meet, other than as opponents. They receive information about each other mostly through discontented patients who have been unsuccessfully treated by the other party. In this way practitioners get an insufficient and biased report of one another’s practices, as well as an unrealistic and distorted picture.

Christie’s (1991) research describes an unsuccessful attempt at creating dialogue between the different types of health practitioners. It also reveals that many patients in Norway (as in other industrialized countries) consult physicians as well as alternative practitioners. The research findings demonstrate that patients disclose fully if they know that both types of practitioners respect one another. Otherwise, they may not tell their physicians that they have sought alternative therapies. Such lack of communication – between patient and practitioner, and among CAM and biomedical health-care practitioners – has been shown to have a negative consequences on patient care and patient safety (Cohen, 2004; Crock, Jarjoura, Polen, & Rutecki, 1999; Ray, 1998). For example, some herbal remedies may have adverse interactions with conventional medicine (Giveon, Liberman, Klang, & Kahan, 2003). It is essential that communication between all health care practitioners and patients regarding care plans be clearly articulated and understood.

This thesis explores whether CAM and biomedical practitioners at the AHC believe that they communicate professionally and easily among each other and with their patients/clients, or whether communication between both schools of thought, as described by Caspi et al. (2000), is a modern form of the Tower of Babel.
2.2.2.4 Models of Integrated Health Care

Many models of IHC delivery are possible. They range from biomedical practitioners feeling comfortable talking to patients about their use of CAM modalities, to interprofessional practices that involve various levels of integrated patient management through a partnered arrangement. Three models are of particular interest to this thesis.

In the first model, in a publication by Health Canada entitled *Perspectives on Complementary and Alternative Health Care* (Health Canada, 2001), a group of 10 practitioners, educators, and researchers from across Canada – called the Advisory Group on Complementary and Alternative Health Care – were asked to identify key health systems issues related to complementary and alternative health practices and therapies, and to suggest strategic areas for future focus. One of the group’s key activities was to describe and develop a conceptual model of an integrative health system that could assist both Health Canada and others who were interested in planning an integrative health-care centre. In the second model, Mann, Gaylord, and Norton (2004) describe seven different approaches to integration. In the third model, Boon et al. (2004b) provide a congruent perspective on the second model by conceptualizing IHC and providing indicators of successful integration at various levels in a continuum of care.

Health Canada’s Advisory Group (Health Canada, 2001) report outlines expected outcomes, core values, key concepts, challenges, and strategies for implementing a national integrative health-care system for both CAM and biomedicine. The report is geared towards three groups: users of health services, practitioners, and policy-makers, and lists expected outcomes for all three groups. For users, expected outcomes are satisfaction, choice, personal responsibility, quality of life, access, resources, and non-partisan information; for practitioners, they are optimal multidisciplinary cooperation and respect, professionalism, equal legal status, and access to health-care institutions; and for policy-makers, balanced resource allocations,
accountability, universality and accessibility of essential health services, access to reliable, and quality information. The report lists 10 core values of an integrative health system: accessibility, accountability, balance, choice, comprehensive outcomes (evidence based decision-making), efficiency, mutual respect, responsibility, universality, and wellness. The report also lists six key concepts that the authors argue are vital to achieving an integrative system: (a) planned action and resources, based on a population health approach; (b) product and practice issues; (c) the public, practitioners, and policy makers access to reliable information on evidence of safety and efficacy; (d) funding; (e) redefining and re-examining the definition of essential health services and payment options; and (f) education of practitioners expanded to include greater diversity of health information, roles, skills, and structure.

Although this model is useful and is widely regarded as one of the first major contributions to IHC theory in Canada, it follows the biomedical lead in many of its expected outcomes and core values. For example, debates within biomedicine regarding issues of health care and universality, accountability, and efficiency are vast (Clarke, 2004; Hutchison, Abelson, & Lavis, 2001; Naylor, 1986). More recently, the Royal College of Physicians and Surgeons of Canada conducted research and wrote a report on the importance of multi/interprofessional teamwork amongst biomedical health-care practitioners and included topics such as scope of practice, education, and training; the need for evidence-based research on outcomes; and patient-centred care (Frank, 2005). It did not include CAM as a central component, but what was interesting and new about this model of integrative health care was that it did not advocate the inclusion of CAM services with an “add CAM and stir” mentality. Combined with some of the literature on collaboration, this model – with its focus on CAM as an integral part of the current health-care system – contributes to the conceptual framework of this thesis.
The second IHC model (in Mann et al., 2004) focuses on the different types or levels of integration in everyday clinical practice. While the model of IHC discussed above focuses on the key stakeholders (users, practitioners, and policy-makers), this second model focuses solely on the characteristics of actual practice and the practitioners working within an IHC system. According to Mann et al., there are seven different approaches\(^1\) to integration.

**Approach 1: “The Informed Clinician.”** In this simplest type of integrative practice, a biomedical practitioner becomes knowledgeable about one or more complementary and alternative therapies and is therefore better able to communicate and accurately inform patients about their use. The goal of this model is communication and information-sharing between health-care practitioner and patient. The model’s limitations include: the biomedical practitioner may not be knowledgeable about subtle distinctions that guide CAM therapy choices; there is no mechanism for feedback from CAM community health-care practitioners, only patients’ reporting of their experiences; and it may be difficult to track outcomes specifically related to integrative therapies.

**Approach 2: “The Informed Networking Clinician.”** This type of integrated practice builds upon the first model, adding informal referral networks with CAM practitioners. Building a referral base requires mutual understanding and trust that can be developed between health-care practitioners by visiting CAM practice environments and meeting with each CAM practitioner face-to-face. Autonomy of each health-care practitioner is maintained. Limitations of this model include: lack of control of documentation; lack of face-to-face time between practitioners for discussion of cases; difficulty in tracking patient follow-through and outcomes; inconvenience to patients, who must travel to different sites to follow through with treatments;

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\(^1\) Mann et al. (2004) call these “models.” To avoid confusion, in this section I am calling them “approaches.”
uneven credentialling of CAM practitioners; and lack of third-party coverage for CAM services. However, risks to patients are small when referral networks are created and maintained responsibly.

**Approach 3:** “The Informed, CAM-Trained Clinician.” The biomedical practitioner may or may not have developed referral networks, but has added specific training in CAM therapies to a basic knowledge of CAM. For example, a biomedically trained physician can become a licensed acupuncturist by taking a course with certification and becoming licensed to practice. The main advantage to this approach is that documentation of indications and outcomes is under the immediate control of the clinician. However, immersion in CAM training typically requires time and in-depth training, and a working health-care practitioner might have limited time to devote to training or continuing education.

**Approach 4:** “The Multi-disciplinary Integrative Group Practice.” In this model, health-care practitioners provide both biomedical and complementary therapies in a partnership. They work collaboratively in the same office setting, and patients see different health practitioners in the clinic, although cross-referrals also happen regularly. Although this model requires no additional training in each other’s profession/discipline/modality, additional education is required for each health-care practitioner to become adequately familiar with the others’ disciplines.

**Approach 5:** “The Interdisciplinary Integrative Group Practice.” In this model, health-care practitioners from multiple disciplines see patients together as a team. For example, the East-West Health Centers in Denver, Colorado, includes nine biomedical practitioners and six CAM health-care practitioners who come together as teams to see individual patients. The advantage of this model, even more so than the preceding one, is that it encourages daily
interactions that can stimulate continual cross-disciplinary learning and discussion. Limitations include difficulty arriving at consensus regarding the patient/client’s overall goals.

Approach 6: “Hospital-Based Integration.” This approach integrates biomedical and CAM services under the auspices of a hospital. The major goals of this approach are to expand patient care options; improve communications and patient/provider relationships; reduce dependency on pharmaceutical and technological interventions in favour of more natural treatments; prevent disease; and encourage self-care. Issues of cost, credentialling, and licensure are factors to be considered for CAM health-care practitioners working in hospital settings.

Approach 7: “Integrative Medicine in an Academic Medical Centre.” Weaving together teaching, research, and clinical care, this model facilitates an awareness and understanding of CAM in general and integrative care in particular. The model requires well-designed research projects that raise awareness of CAM therapies. The limitations of this model are similar to Model 6 regarding credentialling. Additional concerns include working under multiple administrative umbrellas with their associated political and financial pressures.

Approaches 6 and 7 are of particular interest to this thesis, as the AHC is located within the Toronto Western Hospital, whose affiliation with the University of Toronto has sustained teaching programs that involve students, resident physicians, faculty, and community practitioners. Although the AHC does not have a direct affiliation with the university, it is located in an academic teaching hospital.

Boon et al.’s (2004b) third model of IHC is congruent with the two other models presented above. There, integration occurs at a micro level (individual clinicians and groups of clinicians becoming interested in integrative health care), whereas here, the centrality of the patient/consumer is added. According to this model, integration was forced upon the health-care system by consumers who demanded more access to CAM. These demands then prompted some
practitioners to become better educated in the practice of CAM (see models 1 to 3). Integrative health practices or clinics then emerged in an effort to offer patients comprehensive care (see approaches 4 to 7).

Moving beyond the individual level and clinical practice level described by Mann et al. (2004), Boon et al. (2004b) include a macro level of analysis, the role of institutional support in the process of IHC. They recognize that integration is limited at the institutional level, as few teaching and health-care institutions have introduced courses and treatment protocols that permit CAM to become an integrated part of the health-care system. However, regulatory bodies for medicine, pharmacy, and nursing have permitted their registrants to refer to or collaborate with certain CAM professions (Cohen & Eisenberg, 2002; Sparber, 2001), and at the level of health policy, three Canadian Institutes of Health Research (CIHR) now include CAM within their funding mandates; CIHR recently funded the Canadian Interdisciplinary Network for CAM Research (Tataryn & Verhoef, 2001). Boon et al. describe their model as a starting point from which to compare and contrast the different models of integration.

In addition, Boon, Verhoef, O’Hara, and Findlay’s (2004a) model of team health-care practice complements both the broader definitions of interprofessional care (see section 2.1.2, “Definitions”) and Oandasan et al.’s (2006) model, the spectrum of collaboration. Boon et al. place seven different approaches to team-oriented health-care practice and patient care on a continuum: parallel, consultative, collaborative, coordinated, multi-disciplinary, interdisciplinary, and fully integrative. Their framework is placed around four components of integrative health-care practice: philosophy/values; structure, process, and outcomes.\(^2\) Similar to

\(^2\) Although outcomes are an important facet of health care, discussion of them is beyond the scope of the thesis.
the broader definitions of interprofessional care, Boon et al. propose that each model occupies a position along a continuum (see Figure 1).

**Figure 1.** A continuum of team health-care practice models (adapted from Boon et al., 2004a).

Analogous to Oandasan et al.’s (2006) model (see Figure 2), which described increasing interdependence among health-care practitioners as they moved from independent parallel practice to interdependent co-provision of care, Boon et al.’s models are fluid and change depending on the diversity of health-care philosophies, increasing complexity of team structure, communication between team members (including the patient) and health outcomes (including cost effectiveness).
For building a theoretical and conceptual framework of IHC at the AHC, this thesis uses the above models, but as typologies rather than continuums.

Although the CAM models described above relate to the broader definitions of interprofessional care, and conceptually define the structure and process dimensions of collaboration, absent from these models is a theoretical context that would take into account both structural and process dimensions of collaboration and their correlation. It is therefore useful to link CAM models to other collaborative models embedded in organizational theory.

Two research teams have used models to develop interprofessional collaboration in health care. The first model (West, Borril, & Unsworth, 1998) takes into account the inputs related to the task, group composition, cultural context, and organizational context (see Figure 3). The model also includes group processes, including the effect that leadership, communication, and decision-making have on teamwork. Lastly, outputs are defined and described as performance, innovation, well-being, and viability. This model has been used to study many National Health Services (NHS) organizations and to evaluate the effectiveness of cancer teams (Haward, Amir, Borril, Dawson, Scully, West, et al., 2003).
In the second model (Sicotte, D’Amour, & Moreault, 2003), inputs are the contextual variables, including characteristics of the managers and structural characteristics of the program (see Figure 4). Intra-group processes, including beliefs in collaboration, social integration, level of conflicts, and conflicting logics, are also taken into consideration. Results are analyzed in terms of the intensity of collaboration, through the degree of interdisciplinary coordination and the degree of sharing of activities. The main results show that interprofessional collaboration depends on conflicting factors, thus underlining the complexity of professional allegiances. For example, the process of professionalization (Freidson, 1986) is characterized by the achievement of dominance, autonomy, and control, whereas the development of collaborative practice depends on the mutual recognition by practitioners of their interdependence as well as the acceptance of “grey zones” where their respective contributions might overlap. Furthermore, health-care practitioners are immersed in the philosophies, values, and basic theoretical
perspectives inherent to their respective professions (D’Amour, 2001). Such differences between the various biomedical and CAM practitioners are potential sources of conflict that could hinder the development of a true collaborative practice. Also key is the importance of formalized collaboration.

Figure 4. Analytical framework of interdisciplinary collaboration (adapted from Sicotte et al., 2003).

The findings from this review of the literature demonstrate that several frameworks of collaboration and teamwork between health practitioners have been proposed. However, these frameworks address issues related to the structure of the team, such as team composition and the setting of collaborative activities, rather than addressing collaborative processes. They do not contribute to understanding what transpires in the working lives of a group of collaborating practitioners. Combining the CAM models with organizational theory models can shed light on relationship dynamics in collaborative practice between CAM and biomedical health
practitioners, while taking into consideration the several structural and process dimensions of collaboration. Although this theoretical link will be fully developed in chapter 7, the models most closely aligned with this research are a continuum of team health-care practice models (Boon et al., 2004a), the spectrum of collaboration (Oandasan et al., 2006), and the analytical framework of interdisciplinary collaboration (Sicotte et al., 2003).

2.3 Section 3: Integrative Health Care in Hospital Settings

This section describes in detail the results of the focused search strategy as it applied to IHC in hospital settings. As noted above, 19 articles regarding hospital-based IHC qualified for inclusion in this part of the review. While this section of the literature review presents material gathered from a search of international IHC practices, where useful, it will concentrate on the small subset of Canadian practices.

2.3.1 General

2.3.1.1 Geography

Most IHC practices in hospital settings were in the United States (see Table 4).

Table 4

Geographical Location

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>9</td>
</tr>
<tr>
<td>Europe</td>
<td>6</td>
</tr>
<tr>
<td>Canada</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>

Only three articles originated from Canada (Hollenberg, 2006; Mulkins, Verhoef, & Eng, 2004; Vohra, Feldman, Johnston, Waters, & Boon, 2005).
2.3.1.2 Aim

Research on IHC practices in hospital settings was focused on understanding patient usage (Boutin, Buchwald, Robinson, & Collier, 2000; Bracha, Svendsen, & Culliton, 2005; Enebo, Corbin, Gilkey, Vela-Acosta, Keefe, & Bigelow, 2005; Mercer & Reilly, 2004; Scherwitz, Steward, McHenry, Wood, Robertson, & Cantwell, 2003); health-care practitioner/institutional involvement (Ananth, 2006; Hayes & Cox, 1999; Siegenthaler & Adler, 2006; Widmer, Dongs, Wapf, Busato, & Herren, 2006); and the development of IHC (Haahr & Launso, 2006; Harris, 1999; Hewson, Copeland, Mascha, Arrigain, Topol, & Fox, 2006; Highfield, McLellan, Kemper, Risko, & Woolf, 2005; Przekop, P. R., Tulgan, Przekop, A., DeMarco, Campbell, & Kisiel, 2003; Schuster, 1996; Sendelbach, Lapensky, & Kshettry, 2003).

2.3.1.3 Theoretical Approach

There was little explicit use of theory across the 19 articles. In total, only three employed explicit theory drawn either from the theory of professions and professionalization (Abbott, 1988), adult learning theory (Kolb, 1984), or from a grounded theory approach (Glaser & Strauss, 1967).

2.3.2 Evaluation

Here, an outline is offered of the approaches to evaluation employed within the 19 articles included in the review. Specifically, the section reports on how data were gathered and analyzed, and also on the nature of methodological limitations.

2.3.2.1 Data Collection and Analysis

Most studies collected data from surveys (see Table 5). Collecting multiple forms of data (e.g., questionnaires, audit data, interviews, and observations) was used as often as using individual questionnaires and interviews. Of the studies that employed two or more methods of data collection, the most popular were the combined use of questionnaires and close-ended
survey. In general, questionnaires and surveys were popular due to the relative ease and low expense of gathering this type of data. However, the questionnaires used in these studies were, in general, pilot tools and therefore not validated. Consequently, these restricted the rigour of these studies. It was also disappointing to discover that four of the studies contained such poor descriptions of their approaches to gathering data that it was problematic to identify the specific method(s) of data collection.

Table 5

*Data Collection*

<table>
<thead>
<tr>
<th>Data Gathered</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey</td>
<td>5</td>
</tr>
<tr>
<td>Mixed</td>
<td>3</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>3</td>
</tr>
<tr>
<td>Interviews</td>
<td>3</td>
</tr>
<tr>
<td>Focus Groups</td>
<td>1</td>
</tr>
<tr>
<td>Unclear</td>
<td>4</td>
</tr>
</tbody>
</table>

In relation to the approach taken with data analysis, as displayed in Table 6, most of the studies adopted a quantitative approach.

Table 6

*Data Analysis*

<table>
<thead>
<tr>
<th>Approaches to Data Analysis</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantitative</td>
<td>11</td>
</tr>
<tr>
<td>Qualitative</td>
<td>4</td>
</tr>
<tr>
<td>Mixed (qualitative and quantitative)</td>
<td>1</td>
</tr>
<tr>
<td>Unclear</td>
<td>3</td>
</tr>
</tbody>
</table>
The lack of qualitative work meant that useful in-depth accounts of participants’ experiences of IHC were neglected. Box 6 provides an example of one of the qualitative studies.

Box 6

An Example of a Qualitative Study

Hollenberg (2006) presents findings from a research study of two newly established IHC settings in Canada. The main research question was: How are biomedical and CAM practitioners integrating or not integrating with each other at the level of professional interaction in IHC settings? Using a case study design, in-depth and in-person interviews were conducted with 13 biomedical and eight CAM practitioners during 2002 and 2003. The interviews lasted between 40 and 60 minutes. Ethnographic observations were recorded at each research site throughout the duration of the research. A document analysis was also conducted at each site. Documents such as promotional material and minutes of meetings were collected and used to supplement information obtained in interviews and observations. The findings suggest that when attempts are made to integrate biomedicine and CAM, dominant biomedical patterns of professional interaction continue to exist. Despite continued patterns of social closure, biomedical and CAM practitioners continue to provide a certain form of integrative care that may be of benefit to patients, albeit not as integrative as current models of integration would prefer.

2.3.2.2 Limitations

A disappointing 15 papers did not discuss methodological limitations. Although word restrictions in journals may partially account for lack of attention to methodological weaknesses, the failure to address this aspect of an evaluation limits the overall credibility of the studies. One good example of a research project that did offer an account of the multiple methodological limitations associated with their work discussed the limitations associated with a small sample size, the limited number of outcome and independent variables for which information was collected, the lack of collection of follow-up data, and the mostly quantitative nature of the data (Mulkins et al., 2004).

2.3.3 Understanding the Literature Related to IHC in Hospital Settings

Three main categories of research emerge in the literature related to integrative health care in hospital settings: (a) patient usage of IHC in hospital settings; (b)
physician/nurse/hospital involvement in IHC in hospital settings; and (c) general guidelines for developing successful IHC programs in hospital settings. In accordance with the definition of integrative health care (see section 2.1.2.1), to qualify for inclusion in this review I required reviewed articles to mention interaction between CAM and biomedical health practitioners. However, a very limited number of articles specifically investigated the nature of such interactions in a hospital setting (see Table 7).

Table 7

<table>
<thead>
<tr>
<th>Articles on IHC in Hospital Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
</tr>
<tr>
<td>Patient usage of IHC in hospital settings (including both patient and physician usage)</td>
</tr>
<tr>
<td>Physician/nurse/hospital interest in IHC</td>
</tr>
<tr>
<td>Developing IHC in hospital settings</td>
</tr>
<tr>
<td>Interactions between CAM and biomedical health-care practitioners at IHC centres in hospital settings</td>
</tr>
</tbody>
</table>

*Note: One article did not fit within the parameters of the inclusion criteria for this section; however, it was so closely aligned with the conceptual framework of this thesis it was included for discussion.

2.3.3.1 Patient Usage of IHC in Hospital Settings

Three main foci for the research involving recording of utilization rates of CAM in a hospital setting were cost effectiveness, patient demographic, and patient satisfaction. In Canada, CAM has traditionally existed only in the private sector; the patient, without reimbursement, pays for a major portion of these services. Thus cost is especially an issue in Canada, as only a minority of CAM therapies are covered by additional private insurance packages or are partially subsidized by government (Boon & Verhoef, 2001). The situation is different in the United States; for example, one U.S study concludes that concerns about CAM dramatically increasing
health-care costs are not substantiated by their data (Enebo et al., 2005). This might not be the case in Canada.

Data on demographics and illness help to determine some of the reasons why patients seek CAM. In general, studies in Canada, Australia, and the United Kingdom concur on the most frequently cited reasons for choosing CAM. These include preventing illness and improving the quality of life; gaining a sense of control over a chronic illness; boosting the immune system; dissatisfaction with conventional medical care; and coping with the side effects of some conventional treatments (Astin, 1998; Goldstein, 1999; Kelner & Wellman, 1997; Vincent & Furnham, 1997). In one hospital-based clinic, a total of 853 patients were seen for CAM therapies in a 23-month period (Bracha et al., 2005). Patients ranged from 14 to 89 years of age and were predominantly (75 percent) female. Thirty-two percent of patients had been referred by a hospital-based clinic, and the majority sought care for pain. Musculoskeletal diagnoses comprised the majority of cases. Cancer patients most often sought treatment in the form of acupuncture, traditional Chinese medicine, and massage therapy.

Data on utilization rates help to determine what type of therapies are most used, as well as the therapies’ impact on the health and well-being of IHC users. Box 7 provides an example of a study that examines the health benefits of IHC to patients.

Box 7

*Patient Demographic Characteristics, Symptoms, and Diagnosis, and CAM*

Scherwitz et al. (2003) report on the creation of an integrative medical clinic within the setting of a medical research and tertiary care hospital. Patients’ demographic characteristics, presenting symptoms, diagnoses, physician’s treatment recommendations, extent of understanding and adherence to treatment recommendations, changes in symptom intensity, and progress towards achieving health objectives were recorded. Patients at the clinic showed significant reductions in the severity of symptoms and made significant progress towards achieving their health objectives at the six-month follow-up. Thus far, the clinic’s experience suggests that an integrative medicine clinic can face current health-care financial challenges yet thrive in a conventional medical centre.
In response to patient demand for IHC, in 2003 approximately 25 percent of U.S. hospitals offered CAM therapies, most often to outpatients (Barrett, 2003). Among these hospitals, the outpatient services most often provided included massage (32 percent); tai chi, yoga, or chi gong (48 percent); relaxation training (43 percent); acupuncture (39 percent); guided imagery (32 percent); and therapeutic touch (30 percent) (Ananth, 2006). A Swiss study (Widmer et al., 2006) reveals a considerable interest there in CAM therapies, particularly in primary care; yet little was known about the supply of CAM in hospitals, and the total supply of CAM in Swiss hospitals was concentrated in a few hospitals only. Other studies found sporadic and inconsistent use of IHC in hospital settings. For example, a survey to determine the extent of integration of complementary therapies in critical care units in North and South Thames Regional Health Authorities in the Greater London area indicated that of the 51.1 percent of critical care units that claimed to provide complementary therapies, only 7 percent provided interventions on a routine, systematic basis. The general explanation for not providing complementary therapies was “lack of time and knowledge” (Hayes & Cox, 1999).

As discussed earlier, most physicians are interested in the CAM therapies with which they have had some personal experience or taken professional training in. Similar results were found regarding nurses and IHC in hospital settings (Sparber, 2001). In a survey of 300 nurses at a university hospital, 95 percent of the nursing staff indicated that they had recommended or applied complementary methods. Motivations for the application of complementary methods were often based on their own experiences with CAM and from reports of the experience of others.

The use of and attitudes towards CAM among hospital-based physicians and their ambulatory patients is similar to the patterns shown by the research on IHC in primary care
settings. In one study the reported frequency of use of alternative therapies was high; patients and physicians in the study reported similar interests in having alternative therapies provided, and both felt hampered by lack of information about many therapies (Ray, 1998).

2.3.5Development of IHC in Hospital Settings

The above research indicates that there is interest in developing IHC in hospital settings (although the interest is often hampered by lack of time and knowledge regarding these therapies). Several articles in this area focus on the process of developing integrative health programs in hospital settings. The research is descriptive and exploratory as researchers share their experiences with IHC in hospital settings. The experiences of IHC are most often observed through the lens of a particular health profession. For example, acupuncture (Schuster, 1996), chiropractic (Harris, 1999), and osteopathy (Przekop et al., 2003) are described as vectors for integrating CAM and biomedicine within a hospital. Similarly, other authors describe the approach and process to developing integrative therapy programs in the areas of cardiology (Sendelbach et al., 2003) and pediatrics (Highfield et al., 2005). Box 8 provides an example of an integrative therapy program in a tertiary care cardiovascular hospital.

Box 8

Developing Inpatient Integrative Therapy Program

Sendelbach et al. (2003) describe one hospital’s approach to developing an inpatient integrative therapies program and the foundation for a broader IHC vision. Several elements were described as critical to the program’s success. Review of the literature and investigation of other programs served as preparation before the actual program started. Champions (administrators, nurses, and physicians) who were able to envision the program and see the value of this approach for patients were vital. Appreciation was expressed for evidence-based outcomes research and demonstrable patient outcomes. Finally, a program manager was hired who was able to understand the culture of the hospital and the organizational change process. Each of these basic steps called for interdisciplinary collaboration, and each assisted in the goal of using integrative therapies as adjuncts to conventional medical care, thereby supporting an integrative approach. Adaptations of this experience to other populations in critical care and across other hospital setting might be possible.
The above research is an example of the importance of a team leader or champion – someone who can understand and negotiate between the culture of the hospital and the culture of professions. The literature on teamwork and collaboration agrees that champions have the ability to influence the practice of peers in health-care organizations (Wilson & Pirrie, 2000). However, little research has been conducted on the strategies used by such champions or the factors influencing their ability to impact organizational change. Overall, leadership is a subject that has not been well documented within the conceptual frameworks of collaboration. Thus, the articles cited above are of little use in providing guidance for those who wish to develop IHC in a hospital setting. This thesis explores the potential role and importance of leaders in collaborative/integrative processes as it relates to the AHC.

2.3.6 Interactions between CAM and Biomedical Health-Care Practitioners at IHC Centres in Hospital Settings

Two research articles discussed the level of professional interaction and collaboration between CAM and biomedical health-care practitioners within a hospital setting. One did not fit within the parameters of this study’s review criteria. However, it was important to include this particular article, as it discusses collaboration among CAM and biomedical health-care practitioners in one of Canada’s first integrative health-care programs (1998–2003) (Mulkins et al., 2004). Additionally, the concepts of organizational design, effective teams, and collaboration discussed in the article closely align with the conceptual framework of this thesis.

Research in the area of collaboration between CAM and biomedical health-care practitioners in hospitals often describes their relationships as fraught with power struggles (Shuval, Mizrachi, & Smetannikov, 2002) and entrenched in the medical hierarchy of the health professions (Hollenberg, 2006). Studies have found a dual process of simultaneous acceptance and marginalisation of alternative practitioners. According to Shuval et al. and Hollenberg...
small numbers of alternative practitioners were found to be practising in a wide variety of hospital departments and in a broad spectrum of specialties, but they were in no way accepted as regular staff members and their marginality was made clear by a variety of visible structural, symbolic, and geographical cues such as CAM practitioners being:

1. excluded from directly charting in the main patient file;
2. restricted from viewing patient charts;
3. excluded from group rounds and meetings, for reasons both economic (CAM practitioners not being compensated for their time to attend rounds), and cultural (the dominance of biomedical language); and
4. unable to refer patients to a physician (reflecting a physician-dominated and – directed referral system).

This arrangement created a false dichotomy between CAM and biomedicine with the biomedical practitioners focused on the diagnosis and treatment of specific disease entities, while alternative practitioners worked in the illness context, concentrating on feelings and affective states involving the alleviation of pain and suffering, and efforts to improve the quality of life. These patterns of interaction between CAM and biomedical practitioners disrupted the achievement of an integrative model of care.

Hollenberg (2006) describes the patterns of professional interaction among CAM and biomedical practitioners in two IHC centres – an independent, freestanding IHC centre and an IHC clinic in a hospital. Drawing upon professions’ closure theory, a comparative analysis of the sites revealed that biomedical practitioners enacted patterns of exclusionary and demarcationary closure (in addition to the use of “esoteric knowledge”) by such things as dominating patient charting, referrals, and diagnostic tests; relegating CAM practitioners to a specific “sphere of competence”; appropriating certain CAM techniques from less powerful CAM professions; and
using biomedical language as the primary mode of communication. CAM practitioners, in turn, performed usurpationary closure strategies – they employed their own “esoteric knowledge” in relation to biomedicine and other CAM professions; appropriated biomedical language and terminology; increased their professional status by working with biomedicine; and referred among CAM practitioners to increase patient flow. The findings suggest that when attempts were made to integrate biomedicine and CAM, dominant biomedical patterns of professional interactions continued to exist. However, despite patterns of social closure, biomedical and CAM practitioners continued to provide a certain form of integrative care that might have still been of benefit to patients, albeit not as integrative as current models of integration would posit. As Boon et al. (2004b) suggest in their IHC model (see section 2.2.2.4 above), there is an “ideal type” of what IHC settings “should look like.” However, despite this “ideal-type” model of IHC, the research to date suggests that IHC models will remain utopian in nature unless they take into account the nature of professional interactions.

At the AHC, the research site for this thesis, the foundation upon which an integrative model was imagined and developed was the practitioner team. Whether the critical elements needed to support and promote integration of a team of practitioners were present is investigated in this thesis. Of significant importance to this thesis is a research paper that closely examines the experiences of the practitioners working within such a model, in order to assess aspects they identified as supports or barriers to providing care within an IHC setting. In this study (Mulkins et al., 2004), practitioners identified four elements critical to forming and sustaining an effective IHC team:
1. effective communication tools;
2. personal attributes;
3. satisfactory compensation; and
4. a supportive organizational structure.

The study concludes that, in an integrative care program, due to the influence practitioners have on patient outcomes, attention must be focused not only on creating optimal healing environments for patients, but also towards establishing and nurturing optimal working environments for practitioners.

CAM and biomedical health-care practitioners in hospital settings need to learn how to be collaborative. However, although the ideal of effective collaboration is espoused, interprofessional interactions continue to be problematic. According to the literature on collaboration between health-care practitioners in primary care settings, interprofessional relationships are often undermined by boundary infringements such as a lack of understanding of one another’s roles, and poorly coordinated teamwork (Hughes, 1988; Pethybridge, 2004; Skjørshammer, 2001; Walby, Greenwell, Mackay, & Soothill, 1994). Box 9 is an example of a professional development program geared towards raising physician awareness of CAM in the context of integrative care in a hospital setting.
Hewson et al. (2006) developed and implemented a professional development program – an eight-hour intervention – involving experiential learning and conceptual-change educational approaches. Forty-eight cardiologists were randomly assigned to either participant or control groups. A questionnaire was administered before and after the intervention. It measured the physicians’ conceptions of and attitudes to CAM, the likelihood of changing practice patterns, and the factors most important in influencing such changes. Results were compared in pre- and post-intervention scores. Both groups, participant and control, initially shared little knowledge about and negative attitudes towards CAM. The participant group experienced significant positive changes in their conceptions about and attitudes towards CAM after the program, and significant improvements when compared with the control group. Participant physicians significantly increased their willingness to integrate CAM in their practices. Physicians in both groups rated research evidence the most important factor that would influence their willingness to integrate CAM. They requested more research evidence for CAM efficacy, and more information on non-conventional pharmacology. The study concludes that professional development in integrative medicine could successfully be offered to medical practitioners using experiential learning and conceptual-change educational approaches with the help of local CAM practitioners.

The research suggests that initiating an IHC initiative requires a motivated champion, knowledge of the hospital culture, and professional development programs. Important lessons can be learned from the few integrative programs already in existence (Zollman & Vickers, 1999); these could be codified and applied to the AHC for comparative purposes. However, the overall literature review suggest a lack of strong theoretical perspectives with which to link the current findings to an in-depth analysis that would be useful for this thesis.

2.4 Section 4: Summary and Conclusion

This final section of the review presents key conclusions and recommendations based on the findings from the general IHC literature and the literature about the 19 IHC in-hospital settings that qualified for inclusion in this thesis.
2.4.1 Summary

This chapter has provided a synopsis of the literature on IHC. The following points provide an overview of the results, and position the results in relation to the broader literature on IHC.

1. During the last 20 years, conventional views on health and health care have been subject to increasing criticism, and there has been a concomitant, growing interest in CAM. Changes occurring at the socio-political level in health care and health promotion provide a ripe environment for considering collaboration between CAM and biomedical therapies.

2. Most research examining collaboration and team effectiveness in health care concentrates on relationships between biomedical practitioners. However, a burgeoning number of projects, especially in the area of primary health care, examine collaboration between CAM and biomedical health-care practitioners. These studies have generally found that biomedicine enacts oppressive forms of occupational closure to maintain its dominance over CAM practitioners in new types of health-care settings.

3. In the literature, a number of models of integrated care delivery are discussed. These models range from biomedical practitioners feeling comfortable talking to patients about their use of CAM modalities, to interprofessional practices, which involve various levels of integrated patient management through a partnered arrangement. Indicators of successful integration at various levels in the continuum of care exist on many levels; from micro to macro, these include: patient/consumer, practitioner, clinical, institutional, regulatory, and policy/systems.

4. Currently, most IHC practices in hospital settings are found in the United States. The aim of IHC research in these hospital settings is to understand patient usage, health-care practitioner/institutional involvement, and the actual stages in the development of IHC.
5. Most studies in the review were quantitative, tended to collect survey data, and did not identify explicit uses of theory. Most studies did not discuss the methodological limitations contained in their work.

6. Literature was sparse on collaboration between CAM and biomedical health-care practitioners in hospital settings.

7. Founding an IHC centre in a conventional hospital requires considerable support from administrative leaders, health-care staff, and hospital foundations. To date, the literature reveals little insight as to how IHC can be designed and promoted.

2.4.2 Conclusion

This review provides some insight into important initial strides in the field of collaboration between CAM and biomedical health-care practitioners, but it underscores the need for more research – qualitative research in particular – to increase our understanding of the factors that either promote or hinder IHC.

One of these factors is the nature of collaboration and integration. The literature review reveals that further rigorous and comprehensive research is necessary to increase our understanding of the nature of this factor. Where possible, future research should include a qualitative component to begin to gain a deeper understanding of this relationship. The thesis uses in-depth interviews and focus groups to explore and capture the perspectives of various health-care practitioners regarding challenges of developing IHC at the AHC.

Another factor is the nature of teamwork. While the Canadian federal, provincial, and territorial governments have identified interprofessional care (i.e., care provided by multi-health-care practitioners who work collaboratively) as a priority for health system renewal in Canada, more research is needed to understand teamwork between health-care practitioners. To help gain
an understanding of the complexities of integrative teams, this thesis draws from the theoretical work of various literatures, including organizational design, teamwork, and the professions.

The AHC has many practitioners, in such areas as medicine, advanced practice nursing, physiotherapy, and psychotherapy, as well as naturopathy, chiropractic, osteopathy, and massage therapy. This thesis aims to enhance the current knowledge of interprofessional teamwork and collaboration between health-care practitioners in general, and biomedical and CAM practitioners in particular.

Finally, more medical schools, in Canada and abroad, are becoming interested in incorporating CAM into their curricula. As CAM becomes more integrated within the biomedical health-care practitioner curriculum, future research could further examine the relationships between teaching hospitals and their associated higher educational institutions.
CHAPTER 3
RESEARCH DESIGN AND METHODS

In this chapter, I provide a brief overview of qualitative research, followed by details on the overall study design, the specific methods for data collection (namely, in-depth interviews and focus groups), and the population of interest. I review some of the ethical considerations in conducting qualitative research, and explain strategies for data analysis and for ensuring the trustworthiness of the data and results.

3.1 Qualitative Research

Many attempts have been made to define qualitative research, but as it has grown out of a wide range of intellectual traditions and disciplines, there is no consensus. However, basic tenets of qualitative research that are specific to this thesis can be identified as follows.

Qualitative research is grounded in a broadly interpretivist philosophical position, in the sense that it is concerned with how the social world is interpreted, understood, experienced, and produced. According to Creswell (1998), qualitative research is:

An inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting. (p. 99)

The emphasis is on deriving an understanding of how people perceive and construct their lives as meaningful processes, how people interact with one another and interpret those interactions in the context of the social world, and the importance of observation in “natural” settings (as opposed to the laboratory).

An inductive approach to conducting qualitative research is suitable for this exploratory and descriptive research project, as it seeks to establish an understanding between the research objectives and the summary findings derived from the interview and focus group data. Grounded
theory is one of several interpretive approaches. According to Strauss and Corbin (1990) amassing and understanding of complex data is done in grounded theory studies:

... inductively, derived from the study of the phenomenon it represents. That is, discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis, and theory should stand in reciprocal relationship with each other. One does not begin with a theory, then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge. (p. 16)

To inductively gain an understanding of the phenomenon studied, it is necessary to use methods of data generation\(^1\) that are both flexible and sensitive to the social context in which data are produced (Berg, 1995). As such, the central methods of qualitative research include interviewing people, recording what they say, observing people in the course of their daily routines, and recording their behaviours. In the current study, qualitative research methods were used, particularly in-depth interviews and semi-structured focus groups, to facilitate the gathering of information about integrative health care (IHC) at the AHC. Through these methods, it was possible to gain an understanding of how the health-care practitioners at the AHC interact with each other, how they interpret those interactions, and how these meanings are informed by the wider socio-political context in which IHC takes place (e.g., the hospital setting, the AHCF).

Qualitative research often uses some form of quantification; however, statistical forms of analysis are not seen as central (Lee, 1998). In qualitative research, there is emphasis on holistic forms of analysis and explanation, rather than on charting patterns, trends, and correlations: “By qualitative research we mean any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification” (Lee, p. 67).

\(^1\) The term “generate” is used instead of “collect” because qualitative researchers do not merely collect and describe data in a neutral and detached manner. They are involved in a more creative way, actively constructing knowledge. It should be clear that this does not mean that data is “invented” or “made up.”
Qualitative interviews are not appropriate when answers are sought to factual or quantitative questions.

Although integrating and/or combining both qualitative and quantitative data might yield interesting results, the purpose and scope of this thesis is to qualitatively study IHC at the AHC.

To explore the experiences and interactions among the various respondents regarding the level of integration at the AHC requires a flexible methodology such as qualitative research, which is methodologically versatile. This type of research provides a means to fully describe and explain the various interactions, perceived level of integration, and collaboration that occur at the AHC from the respondents’ perspectives. The sections below describe in detail the process of interviewing and conducting focus groups.

3.2 In-Depth Qualitative Interview

3.2.1 Background

According to Patton (1987), a qualitative interview should be open-ended, neutral, sensitive, and clear to the interviewee. In-depth qualitative interviews are generally flexible and exploratory in nature. For example, the researcher adjusts later questions depending on how the interviewee answers earlier questions, to clarify the responses, to follow promising new lines of enquiry, or to probe for more detail. The interview style is unstructured and conversational, and the questions asked are generally open-ended and designed to elicit detailed, concrete stories about the subject’s experiences (Whyte, 1982). The purpose of such interviews is not to identify objective truth or to conclusively test hypotheses but to help the researcher understand the experiences of the respondents and the conclusions the respondents themselves have drawn from them. For this particular study, in-depth interviews were used to better understand the social and physical setting of the AHC, including internalized notions of norms, traditions, roles, and values that are held by the respondents at this occupational health clinic.
In-depth qualitative interviews are most appropriate when a rich, detailed, holistic picture of people’s experience and how they interpret that experience is needed; when the data generated are best described in explanations of thoughts or behaviours that are rooted in situational or contextual factors; or when the study is exploratory in nature (Seidman, 1998). In other words, to better understand any phenomenon about which little is yet known, or to gain more in-depth information that may be difficulty to convey using other methods (such as survey methods) the in-depth interview, when framed with open-ended questions, facilitates and supports the discovery of new information.

The primary advantages of qualitative interviews are the flexibility they offer and the rich, detailed data they can provide. However, these advantages, as is true for all social science methods, are not gained without cost. There are two main disadvantages associated with qualitative interviewing (Fontana & Frey, 1994). First, due to the large amount of time and effort they involve, qualitative interviewers cannot usually study a very large sample of people and thus cannot be generalized to other similar populations. However, the interpretivist approach in qualitative research does not make any claims of “truth” or generalizability. Making a claim that the findings of such a study can be generalized is not appropriate to – nor a desired outcome of – qualitative research. This study does not claim to be generalizable to other occupational health clinics that provide IHC. Second, since the interviewer in a qualitative interview takes a very active role in determining what data are collected, there is a higher probability that he or she may inadvertently bias the results of the study (Fontana & Frey). Following the interpretivist approach, the notion of the researcher being separate from the subject of research is neither desirable nor possible. As a qualitative researcher I understand that no matter how faithfully a researcher adheres to scientific methods (qualitative or quantitative), research outcomes are
neither totally objective nor unquestionably certain. However, see “Data Analysis” (section 3.5), below, for steps to ensure trustworthiness in qualitative research.

3.2.2 Selection of Respondents

Between June and December, 2006, I conducted 10 individual in-depth interviews with each of the health-care practitioners at the AHC. The average length of the interview was 60 minutes and each ranged from 45 minutes to 90 minutes in length. There was representation from the following eight health professions: chiropractic, massage therapy, medicine, naturopathy, nursing, osteopathy, physiotherapy, and psychotherapy. AHC health-care practitioners were contacted either by telephone, in person, or via e-mail to determine if they were interested in participating in an individual, in-depth interview as part of my dissertation research (see Appendix D, “Recruitment Script”).

3.2.3 Preparing to Interview

The in-depth interviews were purposefully semi-structured, since the intent of the interviews was to explore issues of interaction, collaboration, and the level of integration at the AHC from each of the health-care practitioners’ perspectives. A list of important questions was prepared and referred to during the actual interview as they became relevant.

Initially, it was planned that the focus group would be conducted before the in-depth interviews, as I believed that it would stimulate the respondents’ thinking by hearing one another’s opinions regarding the topic. Then there would be a follow-up with individual interviews to further explore any issues that respondents may have been reluctant to share publicly in a focus group. I had conducted research with this group a year before, for another project, and believed that their previous experience would serve as an enabler in recruiting for this project. However, during the recruitment phase, it was difficult to find a common time for the health-care practitioners to attend a focus group. After several months of failed attempts to
recruit enough health-care practitioners for the focus group, I decided to begin individual in-
depth interviews so as to complete data collection within a reasonable time.

Proceeding in this way had two key advantages. First, I was able to obtain information
including minority or “silent majority” viewpoints regarding integration and collaboration among
the health-care practitioners at the AHC – viewpoints that might not initially have been shared in
a group format. Such issues were subsequently brought forward in the focus group for
discussion. Second, by conducting the individual interviews first, rapport/trust with individual
health-care practitioners was established, which facilitated their willingness to become further
involved in my research by attending a focus group.

3.2.4 The Interview Process

Most interviewees are willing to provide the kind of information the researcher wants, but
they need to be given clear guidance about the amount of detail required. According to Patton (as
cited in Whyte, 1982), it is usually best to start with questions that the interviewee can answer
easily, and then proceed to more difficult or sensitive topics. The interview was organized into
three stages. In the first stage, the purpose was to establish an understanding of the interviewees’
background, asking questions about them, their health profession, and a brief history of how they
came to be health-care practitioners at the AHC. In the second stage, the focus shifted to the
details of their present experience at the AHC. For example, they were asked to “reconstruct a
typical day” or “talk about their relationships with the people they work with.” In the third stage,
having reflected on their background and experience, respondents were asked to reflect on the
meaning of their experience. Typical questions were: “What have you concluded from all this?”
and “In your experience, is IHC happening at the AHC?”

While this was a basic outline for the interviews, it was not always possible to keep to
this structure. For example, one of the health-care practitioners quickly started the interview with
their thoughts on integrating CAM at the AHC. Following an iterative approach, the questions would be adjusted depending on what the interviewee discussed. At the end of each interview each respondent was asked if there were any issues they deemed important that had not been discussed, or if there were anything that they would like to know more about (from the health administrators at the hospital and/or the AHCF board members).

3.3 Focus Groups

3.3.1 Background

Focus groups, composed of relatively homogenous groups of people, are a form of in-depth group interview, which provides information on topics specified by researchers (Hughes & DuMont, 1993). The groups are fairly homogenous with respect to one or more characteristics of interest to the researcher. While focus groups were originally used mainly in marketing research as a preliminary step preceding quantitative research, their use has expanded into the social sciences. They may be used as a self-contained method, serving as the principle source of data, or (as in this case) as part of a multi-method approach, in combination with other qualitative methods such as the individual interview (Fontana & Frey, 1994).

Reliance is on interaction within the group (Morgan, 1997). The main advantage of a focus group is the opportunity to observe the group interact on a particular topic (Morse & Field, 1995). Similarities and differences in respondents’ opinions and experiences are provided directly through group discussion rather than inferred from statements by individual interviewees. Focus groups may also be useful when the researcher wants to give the group control over the direction of the session, as is the case with exploratory work.

In comparison to quantitative methods (such as surveys designed by the researcher), focus groups provide researchers with direct access to the language and concepts respondents use to structure their experiences and to think and talk about a designated topic (Kitzinger, 1995).
Thus, focus groups move beyond the level of the individual and examine cultural knowledge that is shared among group members. I anticipated that the use of focus groups would allow a collective sense of community shared by group respondents to emerge from their discussions. For these reasons, focus groups were particularly well suited to study interaction, collaboration, and integration at the AHC.

### 3.3.2 Selection of Respondents

Between June, 2006, and February, 2007, I conducted four semi-structured, qualitative focus groups with artists/clients of the AHC, hospital administrators, AHCF members, and health-care practitioners working at the AHC.

This part of the study involved purposeful sampling (Patton, 1987), the rationale of which is to select information-rich cases whose study will illuminate the research questions under study (Morse, 1995). Respondents were selected based on one of two characteristics: (a) they were judged to be a key or critical representative of that category by the thesis committee, and/or (b) if they were known to one of the team members, and recruited given their interest and their ability to provide valuable information (convenience sampling).

#### 3.3.2.1 Artists (n=8)

Artists who sought care at the AHC had an opportunity to see a recruitment brochure that was handed out by reception and also posted on the message board and in the waiting room at the AHC (see Appendix G, “Recruitment Brochure”).

#### 3.3.2.2 Key Hospital Administrators (n=5)

Key hospital administrators, those who were actively involved in assisting the AHCF, were identified with the assistance of my thesis committee and with the AHCF. Each hospital administrator was contacted over the telephone to explain the purpose of the research, ask for their interest in being part of a focus group, and answer any of their questions.
3.3.2.3 *Key Advocates from the AHCF (n=8)*

A key informant list was generated in consultation with the AHCF, as well as the health-care practitioners at the AHC. I contacted these informants to explain the purpose of the research, recruit for the focus group, and answer any questions.

3.3.2.4 *AHC Health-Care Practitioners (n=5)*

Upon completion of the individual interviews, each of the health-care practitioners was contacted either by phone or secure e-mail to explain the purpose of conducting focus groups, recruit for the focus group, and/or answer any questions.

3.3.3 *Preparing for the Focus Groups*

Four different guides were constructed for each of the focus group sessions. Each guide included the background and context of the respondents, including specific, detailed information vis-à-vis their relationships and roles as client, health-care practitioner, administrator, and member of the AHCF (see Appendix E, “Focus Group Guide”). Whenever possible, I posed questions that asked respondents to share their story or experience with the group as opposed to collecting opinions (in public forums some people are reluctant to challenge others’ opinions but will usually contribute contradictory stories or experiences).

There was a seven-week gap between the last health-care practitioner individual interview and the health-care practitioners’ focus group, which may have allowed each practitioner time to reflect upon the interview. In fact, several of the practitioners contacted me after their interview to provide me with additional thoughts that emerged as a result of the interview. Logistically, the gap allowed time for transcription of the individual interviews, so that issues that had been raised in the interviews (along with any follow-up considerations sent to me) were addressed in the focus group. This process, referred to as “multiple depth conversations,” describes the continuous clarification of emergent meanings (Seale, Gobo,
Gubrium, & Silverman, 2004). The seven-week gap between interview and focus group was also a result of several failed attempts to coordinate the schedules of busy and mostly part-time health-care practitioners. In the end, five of the 10 health-care practitioners attended the focus group.

3.3.4 The Focus Group Process

My role in each of the focus groups was to moderate or facilitate the discussion as an interested respondent. This study was exploratory and I was particularly interested in finding out what respondents believed to be important or interesting. I also wanted to observe how the health-care practitioners would interact when placed in a situation that required the construction of a collective identity. Hence, my involvement was minimal in the sense that I allowed information to emerge naturally.

I introduced myself and briefly explained my role in this process. I made clear that I was there to learn from them and their experiences, and assured them that the information they shared in the focus group would be anonymous. I asked everyone in the group to refrain from discussing any particular stories that had been shared during the focus group with others – “what is said in the focus group stays in the focus group.” In so doing, I hoped to create an environment where respondents felt comfortable enough to explore the similarities and differences of the various perspectives of integrative health care at the AHC as honestly and openly as possible. Speaking with various informants emphasizes the relativist tenet that no one experience is the norm; multiple voices are sought (Charmaz, 2000). Respondents were reminded that the session would be tape-recorded and transcribed verbatim. The consent form was reviewed prior to commencing with the group.
Each focus group took place in a classroom outside the AHC with the exception of one group, which was hosted at a respondent’s home. Respondents sat around a large rectangular table to encourage interaction and allow respondents to see each other.

As in the in-depth interviews, a list of important topical questions was prepared ahead of time and referred to during the focus group. Each focus group began with one of the topical questions and then we worked through each succeeding topic. Generally there was equal participation among each of the respondents in the groups.

As with the individual interviews, at the end of each focus group respondents were asked if there was anything that they wished to add.

3.4 Ethical Considerations

As most social research involves intervention in some aspects of social life, there is always a risk that even asking a respondent a seemingly innocent question could be disturbing to that person. The University Health Network and University of Toronto’s code of ethics relating to the ethical treatment of human respondents was followed. Prior to every interview and focus group, each respondent was asked to read and sign the consent form (see Appendix F, “Consent Forms”). Interviews and focus groups were tape-recorded and transcribed verbatim. I assigned each participant a number in place of their name and removed any information that would identify individual respondents. Code names for the focus groups and individual interviews were as follows (Table 8):
Table 8

Participants’ Code Names

<table>
<thead>
<tr>
<th>Respondent Type</th>
<th>Method of Data Collection</th>
<th>Code Name</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complementary/alternative medical health-care practitioner</td>
<td>Focus group</td>
<td>FG CAM HP #</td>
<td>5</td>
</tr>
<tr>
<td>Biomedical health-care practitioner</td>
<td></td>
<td>FG BIO HP #</td>
<td></td>
</tr>
<tr>
<td>Artist</td>
<td>Focus group</td>
<td>Artists #</td>
<td>5</td>
</tr>
<tr>
<td>Artists’ Health Centre Foundation member</td>
<td>Focus group</td>
<td>AHCF #</td>
<td>8</td>
</tr>
<tr>
<td>Hospital administrator</td>
<td>Focus group</td>
<td>HA #</td>
<td>5</td>
</tr>
<tr>
<td>Complementary/alternative health-care practitioner</td>
<td>Individual interview</td>
<td>CAM_HP #</td>
<td>10</td>
</tr>
<tr>
<td>Biomedical health-care practitioner</td>
<td>Individual interview</td>
<td>BIO_HP #</td>
<td></td>
</tr>
</tbody>
</table>

All respondents were informed that they had the right to withdraw from the process at any time without penalty.

As a matter of course, each interview and focus group began by letting respondents know that they were not expected to self-disclose beyond their comfort level. The goal was to provide the respondents in the study a safe space within which to discuss their experiences of interaction, collaboration, and integration. The term *safe space* refers to my attempt to make the respondents in the study feel as comfortable with me (and with the process) as possible.

The University of Toronto granted ethics approval for this study on May 25, 2006, and the University Health Network granted ethics approval on July 25, 2006.
3.5 Data Analysis

The section below gives a brief description of how the trustworthiness of qualitative data is usually ensured, followed by how these techniques were performed for this particular thesis. In addition, I provide an overview of how data were organized, stored, and managed using a qualitative software system.

3.5.1 Trustworthiness of the Data

To engage in qualitative research, one must be willing to spend much time in the field to generate data, followed by the ambitious task of categorizing the large amount of data into themes (Mason, 2002). The aim of a qualitative researcher is to explore a problem and/or describe a setting, a process, a social group, or a pattern of interaction (Marshall, & Rossman, 1995). By producing a detailed, in-depth description of a setting, the research will reveal the complexity of the social interactions of everyday life. Even so, as a researcher who aims to produce this description and to share what I have learned, the question remains: why should anyone believe what I say or write? Or, how is validity assured?

In quantitative research the standards for good and convincing research include the concepts of validity and reliability. Validity refers to the extent to which the test used actually measures the characteristic or dimension that it was intended to measure. Reliability refers to the extent to which some attribute is being measured in a systematic and therefore repeatable way (Walsh & Betz, 1995). However, the concepts of validity and reliability do not fit within the qualitative research paradigm. According to Rubin and Rubin (1995), qualitative researchers judge the credibility of their research by how the research demonstrates transparency, consistency-coherence, and communicability. Additionally, researchers (Rubin & Rubin) often rely on the process of triangulation of the data to guard against the concern that a study’s
findings might simply be an artefact of a single method, single source, or single investigator’s biases.

With respect to transparency, the reader of a credible qualitative research report is able to see the basic processes of generating data. Transparency allows the reader to assess the intellectual strengths and weaknesses of the interviewer. The interviewer must maintain careful records of what she or he did, saw, and felt to make their research transparent to others and to themselves (Heaton, 2004). Notes (including observations, conversations, maps, plans, reflections, and memos) are in many ways the data on which a substantial part of the analysis and interpretation of the study are based (Kirby & McKenna, 1989).

To ensure that the work in this thesis was transparent, three steps were taken:

1. Literature review. A detailed literature review was provided on the topic of integrative health care and specifically how that relates to an occupational health clinic in a hospital setting (AHC). This was meant to assist interested individuals to judge the extent to which the study was applicable to other situations.

2. Field notes. During and after each interview and focus group, detailed field notes were taken of any non-verbal communication that had occurred.

3. Memo writing. All interpretations were recorded in content memos attached directly to the sections of the text that I was interpreting. That way the context was not lost during data analysis.

With respect to consistency, a credible research report should show that the researcher investigated ideas and responses that appear to be inconsistent. In fact, one of the goals of qualitative research is not to eliminate inconsistencies, but to understand why they occur (Ritchie & Lewis, 2003). In demonstrating consistency, the researcher need not show that people’s beliefs are fully coherent or that the interviewees told some idealized version of the truth. The researcher
must show that inconsistencies were examined and explored carefully. This is accomplished through the process of inductive coding (see Table 9). According to Strauss and Corbin (1990), coding “represents the operations by which data are broken down, conceptualized, and put back together in new ways. It is the central process by which theories are built from data” (p. 16). Once codes are developed, they are grouped at a higher, more abstract level termed categorization. Categories are generated through the same analytical process of making comparisons to highlight similarities and differences that is used for coding. Categories provide the means by which theory can be integrated (Strauss & Corbin).

Table 9

*The Coding Process in Inductive Analysis*

<table>
<thead>
<tr>
<th>Initial read through text data</th>
<th>Identify specific segments of information</th>
<th>Label the segments of information to create categories</th>
<th>Reduce overlap and redundancy among the categories</th>
<th>Create a model incorporating most important categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many pages of text</td>
<td>Many segments of text</td>
<td>30 to 40 categories</td>
<td>15 to 20 categories</td>
<td>3 to 8 categories</td>
</tr>
</tbody>
</table>

*Note:* Adapted from *Qualitative inquiry and research design: Choosing among five traditions*, by J. W. Creswell (Thousand Oaks, CA: Sage), 1998, Figure 9.4, p. 266.

The use of peer debriefing with two committee members (RL and MJK) ensured that the data analysis in this thesis was consistent. A coding process was developed and followed with two thesis committee members (RL and MJK). To begin coding, as transcripts became available they were read two or three times, with the following questions in mind: Are there similarities/differences between transcripts? Are there similar ideas that cut across each of the transcripts? When are the ideas similar/different? What were the initial impressions and how
have they been substantiated and unsubstantiated? Is there a central idea (i.e., on integrated health care) with a series of subplots or is it more like a series of ideas and thoughts described by the respondents? Answers to these questions (which eventually led to more detailed questions) were highlighted in the margins of the transcripts.

A sub sample of transcripts (n=2) was read by RL and MJK. Each individually developed a preliminary coding frame for the sub-sample of transcripts and then came together to share interpretation of those transcripts. This strategy of ensuring trustworthiness of the data is also referred to as “investigator triangulation” (Schwandt, 1997), in which findings from different evaluators are compared and contrasted to eventually arrive at the same or similar conclusions regarding the coding of data. Similarities and differences of the data were discussed, thus producing a coding frame to be applied to all the data. This coding frame was used for the transcripts, and as new codes emerged, it was modified and the transcripts were re-read according to the new structure. Thus was a more nuanced picture of the material generated, as opposed to unwittingly imposing consensus on the data by stating “this is how it is or appears” in too simplistic or univocal terms.

With respect to communicability, in credible research, the concrete detail of the context should resonate to the respondents and to the readers of the research report. To do so, in-depth interviews and focus groups were used, to allow for “prolonged engagement” (Lincoln & Guba, 2000) with respondents. By interviewing the same person more than once and/or interviewing respondents for an extended period of time, ideas, and themes of how they interpreted their context began to emerge more fully. To ensure communicability of this thesis, each focus group lasted from 90 to 120 minutes and the individual interviews lasted from 60 to 90 minutes. Health-care practitioners were repeatedly interviewed, first individually and then in a focus group
format. Additionally, I conducted as many focus groups and individual interviews as I could, with the number of people willing and able to participate.

The final process of ensuring trustworthiness of the data was the triangulation of qualitative data sources (Schwandt, 1997). This meant comparing and cross-checking the consistency of information derived at different times and by different means within qualitative methods. It entailed one or more of the following: (a) comparing observational data with interview data; (b) comparing what people said in public with what they said in private; (c) checking for the consistency of what people said about the same thing over time; and (d) comparing the perspectives of people from different points of view. At the AHC, this meant triangulating health-care practitioner views, artist/client views, hospital administrator views, and views expressed by AHCF board members. The use of triangulation is consistent with the grounded theory approach, which advocates the use of multiple data sources converging on the same phenomenon.

Triangulation of data sources within qualitative methods will seldom lead to a single, totally consistent picture (Pope, Ziebland, & Mays, 2000). According to Glaser and Strauss (1967), “no one kind of data on a category nor technique for data collection is necessarily appropriate. Different kinds of data give the analyst different views of vantage points from which to understand a category and to develop its properties” (p. 5). The point is to study and understand when and why there are differences. The fact that focus group data produce different results than those of the individual in-depth interview data does not mean that either or both kinds of data are untrue (although that may be the case). More likely, it means that different kinds of data have captured different things. In this thesis, every attempt was made to understand the reasons for the differences. At the same time, consistency in overall patterns of data from different sources, and reasonable explanations for differences in data from divergent sources,
contribute significantly to the overall credibility of findings (LeCompte, 2000). As described throughout this section, various methods of triangulation were incorporated to ensure the trustworthiness of the data collected and analyzed.

### 3.5.2 Storing and Organizing Qualitative Data

A qualitative computer software package, NVIVO™ (Nvivo, 2002), was used to store and organize the various themes derived from the data. The software proved very useful, as each theme or topic was stored and then organized into larger categories as the research proceeded. (NVIVO™ can also be used for searches and re-coding to help test various relationships in the data.) At a more specific level, using NVIVO™ helped in the analysis and report writing in its capacity to store useful words, phrases, and dialogues that allow the researcher to visualize the data and move (or combine) information from one category to another category (as constructed by the researcher).

As the interviews progressed and more transcripts become available, I used NVIVO™ as a tool in the interpretation and management of complex data, emerging ideas, patterns, and meanings. That said, the thinking judging, deciding, and interpreting were still performed by the researcher. As Tesch (1991) explains: “The computer does not make conceptual decisions, such as which words or themes are important to focus on, or which analytical step to take next. These analytical tasks are still left entirely to the researcher” (p. 77).

### 3.6 Conceptual Framework and Organization of Results Chapters

Figure 5 presents the conceptual framework that emerged from the literature review and the results of this research. It describes the interrelationship among the three different levels: macro, meso, and micro.
Theme 1: Organizational Structure

Theme 2: Intergroup Process

Theme 3: Individual Perceptions

Figure 5. Factors that affect integrative health care at the AHC.

The framework is portrayed as a group of overlapping circles that operate at three levels. Theme 1 focuses on the effect of the organizational setting of the hospital and the AHCF; Theme 2 explores communication among the various stakeholders at the AHC; Theme 3 describes the knowledge of and attitudes towards IHC at the AHC. Together, the themes influence how the concept of IHC is practiced at the AHC. This conceptual framework is further theorized in chapter 7.

Each theme is discussed more fully in chapters 4, 5, and 6. Chapter 4 provides a background to the organization of the AHC and a description of the structure, organization, and players involved in IHC at the AHC. Chapter 5 explores communication among the various stakeholders at the AHC. In chapter 6, respondents were asked for their understanding of how personal theories, belief systems, and leadership characteristics affected perceptions and actions related to working together for artists’ health.
3.7 Summary

Overall, this chapter provided an overview of the qualitative research methods – specifically, in-depth interviews and focus groups – that were used to inform this thesis. To analyze qualitative data, several steps were taken to ensure the trustworthiness of the data. Qualitative research software, NVIVO™, was used to manage, store, and organize the data.
CHAPTER 4
ORGANIZATIONAL STRUCTURE

The following chapters describe the results of the focus groups with the artists, health-care practitioners at the AHC, hospital administrators, and AHCF members; and also the face-to-face interviews with each of the nine health-care practitioners at the AHC. From the data, three themes emerged: (a) the organizational structure and effects of the hospital setting on IHC (macro level) (b) communication and day-to-day interactions between health-care practitioners, hospital administrators, AHCF members, and artists (meso level); and (c) personal/professional attitudes and knowledge of integrative health care (IHC) (micro level). This chapter will focus on the macro-level and sub-theme findings: the intake/referral process, the expense of integration, the respondents’ vision and hopes for the sustainable future of the AHC.

Among the many forces influencing the present health-care environment is the rapid increase in the use of complementary and alternative medicine (CAM) therapies. From the literature review, we know that approximately 62 percent of American adults aged 18 and over used some form of CAM therapy within the last year (Barnes, Powell-Griner, McFann, & Nahin, 2004). In Canada, approximately 3.8 million people reported having used the services of an alternative practitioner (Millar, 2001). Reasons cited for the trend towards the use of CAM therapies include dissatisfaction with biomedical care which is perceived as ineffectual, too expensive, or too focused on curing disease rather than on maintaining good health. CAM therapies are often seen as less authoritarian and more congruent with patients’/clients’ values and beliefs about the meaning of health and illness. Those involved in the health-care system increasingly realize that they need to pay close attention to such issues; the question is not whether to respond to the issue of growing interest in CAM therapies within their organization, but rather how. Thus, on an institutional level, the context of a growing consumer demand has
encouraged biomedical institutions, such as the Toronto Western Hospital (TWH), to incorporate alternative practitioners. According to a recent report, more than 25 percent of Canadian hospitals offer CAM therapies, most often to outpatients (Health Canada, 2004b). In hospitals where they are available, complementary services most often provided on an outpatient basis include massage (71 percent); tai chi, yoga, or chi gong (48 percent); relaxation training (43 percent); acupuncture (39 percent); and therapeutic touch (30 percent) (Ananth, 2006). That said, although hospitals are including some CAM therapies, they do not allocate formal posts or salaried positions to CAM practitioners (Shuval, Mizrachi, & Smetannikov, 2002). This is also true for the CAM practitioners working for the Artists’ Health Centre (AHC) at the TWH.

The purpose of an integrative occupational health clinic for artists is to deliver health-care services to meet the needs of artists, through full and effective application of the knowledge and skills of the health-care practitioners. Given the competing interests from this particular population (and their demand for CAM therapies), the health-care practitioners at the AHC, and the hospital administrators at the TWH and the AHC Foundation (AHCF), several diverse forces must be taken into consideration when examining integrative health care (IHC) at the AHC. Friedland and Alford (1991) make mention of how “institutional contradictions” exist in many institutions where diverse forces work simultaneously. In the context of health care in Canada, at one end of the spectrum is the institutional logic of efficiency, driven by norms of rationality and economics. Scott (1995) refers to this form of institutional logic as “managerial or corporate logic.” At the other end of the spectrum, logics of empathy and benevolence suggest that empathy, equity, and quality of care may comprise a more appropriate institutional logic.

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1 In 2002, Al and Malka Green provided a gift of $1 million for the AHC. They continue their interest and support of the AHC.
The empathy/benevolence logic somewhat mirrors the process of integrating many CAM therapies and biomedical care. On the one hand, in the biomedical world, evidence-based medicine is accepted as the goal for which all medicine should strive (Ernst, 2000), based on a form of logic that is rational, positivist, and authoritarian. On the other, the CAM world suggests that gathering evidence using randomized control trials is inappropriate in proving the efficacy of CAM therapies. Most CAM therapies follow healing traditions that emphasize factors such as trust, relationship, and healing energy – factors that may never be quantifiable. Interestingly, biomedical institutions such as hospitals have sided with patient/consumer demand as the prime motivator for going against their own epistemological belief in supporting CAM therapies – therapies that have not necessarily demonstrated their efficacy or safety from a biomedical perspective.

This chapter focuses on the effect of the organizational setting of the hospital and the AHCF, exploring how these two settings influence the concept of integrative health care at the AHC. This chapter is divided into four sections. The first section explores the intake/referral process. Barriers and facilitators in the intake process are examined, in addition to some strategies for improving the process. The second section examines the expense of integration. The patients/clients, practitioners, hospital, and AHCF members experience how the expense of implementing IHC directly affects the subsidy program, fundraising, and overall sustainability of the AHC. The third section describes the respondents’ vision and hopes for the sustainable future of the AHC. The fourth section provides a summary and analysis of the previous sections.

4.1 Intake and Referrals

The process of patient intake and referral was a considerable issue for the respondents. The respondents, particularly the AHC health-care practitioners, described three main concerns: First, they expressed concern about the fluid, unstructured nature of the patient intake process.
Several felt that patient intake was not given serious attention and therefore lacked the detail necessary for appropriate care planning. This was compounded by the desire of some AHC clients to access whatever health services they wanted, bypassing the intake process altogether. Second, they had reservations about whether it was appropriate for one biomedical practitioner, the nurse practitioner, to be solely responsible for the intake and referral process. Although the knowledge base of this practitioner was considered by most respondents to be vast and comprehensive, respondents still had questions about how referrals to the various practitioners were decided. Third, there were questions concerning the role of the reception staff at the AHC. Several health-care practitioners questioned whether the reception staff felt like they were part of the team, and whether their role could be expanded to include aspects of the intake process.

4.1.1 A Fluid Intake Process

The intake process at the AHC was to follow the typical biomedical model of assessing patients. The nurse practitioner would assess an incoming client at the AHC; the assessment would include a comprehensive health history, some lifestyle questions, and a care plan (including goals of treatment) collaboratively agreed upon between the nurse practitioner and client. What the client perceived to be the “problem” would open a dialogue on the most appropriate modality. Two things changed as the AHC evolved. First, the intake process, originally to be 30 to 40 minutes in length, shortened to 10 to 15 minutes. Some of the health-care practitioners expressed concern regarding both the burden carried by the nurse practitioner as the sole intake person, and the length of the intake process. One CAM practitioner said:

CAM_HP 3: Every patient funnels through one person, and that is just a small part of that person’s very busy job, so she does the absolute best she can do and she probably does a great job at it, however, medical or non-medical, . . . I don’t believe that anyone can assess a person in 10 or 15 minutes and whatever. So I don’t know about that assessment process. Again, if you lengthen that and make it more of an intense assessment you have higher upfront cost. I don’t know if you have payoff on the back end of a shorter treatment or more effective treatment. I am sure hospitals study those things . . . I don’t know.
According to most of the health-care practitioners, clients were accustomed to seeing whichever CAM modality they preferred in the community and did not necessarily want to take the “extra step” at the AHC of being funnelled by a gatekeeper. In some cases, they were permitted to bypass the intake process with the nurse practitioner altogether. However, according to the hospital administrators, since the AHC was situated in the hospital it had to follow a biomedical model of care to some degree. The majority of health-care practitioners said that they understood the differences between community and hospital models of care, and had mixed reactions to having a gatekeeper, or allowing patients to self-refer. According to this biomedical practitioner there were benefits to both gate-keeping and self-referrals:

BIO_HP 1: I still think that the ideal is to have somebody who is a primary care provider with maybe some of the experience or some of the kinds of attitudes towards integrative health to do the initial assessments and then do some work around . . . but again my philosophy is that people should be able to access who they want, but we [the hospital] are a different model from the community.

Currently, a patient can call the AHC reception and ask for an appointment with another health-care practitioner without being assessed by the nurse practitioner. However, as the same biomedical practitioner continued with her thoughts, she believed this was not always in the best interest of the client in terms of providing care with the appropriate health-care practitioner:

BIO_HP 1: I also think people often ended up with practitioners that weren’t appropriate for them, so I think we all need to work together with client, with each other, to tease out what would be the approach.

The quote above demonstrates a couple of interesting points: First, for client-driven care, clients may not know which health-care discipline/profession/modality would be most appropriate given their actual health needs. Second, as we learned in chapters 4 and 5, the data suggests that practitioners do not always have the knowledge and understanding of what each of the health practitioners does at the AHC; this too may constitute a barrier to accessing appropriate practitioners for artists. As one biomedical practitioner agreed in the focus group:
FG HP BIO 2: It is quite challenging because we have so many physical modality practitioners; we have RMT, we have two physios, we have four, so who knows where they should go between all four of them?

4.1.2 Role of the Nurse Practitioner

At the time of this research, the nurse practitioner’s role was to perform the intake of new clients at the AHC. According to the majority of health-care practitioners at the AHC, the nurse practitioner was capable and bright with a wide range of knowledge on integrative health-care. However, the majority of health-care practitioners had questions regarding how she decided to make referrals during the intake process. As one biomedical practitioner wondered:

BIO_HP 4: How she might decide someone coming in to see her, how she might decide whether they have physio or go to an osteopath, because I don’t know how she makes those decisions. And I would be interested to know, because we need to understand that too.

In general, for mental health services, referrals would be made along gender or specialty in various areas of psychotherapy. This also applied to physiotherapy, the two physiotherapists specialized in different areas of artists’ health. One of them was known for her work with musicians and contemporary dancers, and the other for her work with classical dancers; and so referrals could be made along those lines. However, as this CAM practitioner and biomedical practitioner concurred there was no set referral process that they were aware of at the AHC:

CAM_HP 5: [For mental health services] How does she decide? I think male/female, I think availability, and then you would have to ask her for the match. And perhaps for example I have specialty in cancer so there is one woman I am seeing that has cancer. So there may be some particular reasons why she would send someone or someone requests male or female, and with male that automatically puts Mike. So I think she has some criteria in addition to gender and availability.

BIO_HP 4: [For physiotherapy] I know that [biomedical practitioner] has had way more experience with dancers and particularly ballet. My experience has been more contemporary dancers and musicians and that sort of thing. I think that’s the route she might go sometimes, musicians tend to get filed this way and certainly classical ballet dancers tend to go that way but not necessarily, and the other thing is I have had a fair bit of experience with doing hand patients, or upper extremity stuff. So if it looks like it is an upper extremity case sometimes she steers them my way. Those are my guesses . . .
At times, the nurse practitioner described the referral process as complicated because it involved looking at the referral with the possible subsidy in mind. She explained:

**BIO_HPo 1:** It becomes tricky when you’ve got some practitioners that charge $70 an hour and some practitioners that charge $130 an hour, so you can get four of these [treatments] subsidized, or eight of those [treatments] subsidized. That puts me in the position of being asked: is my money better used seeing a physio or a naturopath . . . so it becomes economics a bit, and that’s a hard one to answer. Then some people can get free psychotherapy and then some people have to pay for it, but they get subsidized, so it is tricky.

Several of the health-care practitioners said that they did not feel comfortable with having patients funnelled through one gatekeeper. To the question, “how do you feel about [biomedical practitioner] being solely responsible for intake?” this CAM practitioner stated:

**CAM_HPo 3:** I’ve never liked it. For a number of reasons, I’ve learned to live with it and accept it . . . . And I have to assume that she makes the right judgment on that [referral].

As a solution, a few of the respondents discussed the potential of having a CAM practitioner alongside the biomedical one for the process of intakes. The AHCF members approached this idea with cautious optimism:

**AHCF 5:** [in reference to having a biomedical and CAM practitioner doing intake] I was thinking that it would be great to have sort of two gatekeepers, but I suspect that it is not something that we should try to push for right away because it has . . . we have to get the hospital to trust the clinic as not some “wacko” thing, I think they are close to it, but just one little thing like that could really muck things up, and five years down the road that might well, in the whole thinking in complementary medicine they will have changed and maybe filter down into the teaching hospitals a bit more by that time. But it is a neat idea as a long-term goal. Whereas working on greater integration now among the practitioners is something that should be a priority and something that you can really get your hands on.

### 4.1.3 Summary

Overall, in providing the most effective, specialized care for artists, the skills of many disciplines and modalities are often needed. The research data reveals that at the time of intake and referral, it is not always clear which of the various available approaches to health care at the AHC will best serve the needs of any particular patient/client.
For the majority of AHC patients/clients, the nurse practitioner acted as a “funnel” or “hourglass” – first contact point – for health-care services at the clinic. The AHC nurse practitioner saw herself as responsible for continuity, comprehensiveness, coordination of referrals, and understanding of the artist in the context of health. At times she described this role, though necessary, as exhausting.

Several of the health-care practitioners at the AHC said their artist patients/clients expressed dissatisfaction with not having direct access to the various disciplines/modalities without the “extra step” of going through the nurse practitioner gatekeeper. According to the biomedical model, allowing patients/clients direct access to other disciplines without an intake process might undermine the health of the clients, as well as the role of the nurse practitioner as the coordinator of health-care services. If patients/clients self-referred to a less appropriate health-care discipline/modality, then their diagnosis and treatment might become delayed, to their detriment. Several health-care practitioners and AHCF members suggested improvements to the process, for example through using universal intake and referral forms, creating both a biomedical and a CAM practitioner coordinator role, and considering a more knowledgeable front desk reception staff as part of the team.

Improving the intake and referral process would require financial backing. One biomedical practitioner pointed out logistical and cost barriers:

BIO_HP 1: Oh yeah, that is something we have talked about. Logistically again, they [CAM practitioners] are not here. I am, so for them to spend their time doing intakes when they are here, and their fee is $150 an hour, that doesn’t make sense, right.

She suggested a more cost-effective strategy for improving the intake and referral process might be to have a standardized intake form to be used across all health disciplines and modalities at the AHC:

BIO_HP 1: I think one of the things that we could do is develop a better intake form that every care provider uses. Because right now every care provider uses their own forms the
only universal one is the one that I use, but they are not using it. So I would like to develop a form, the trick is that some of them would like everything from their discipline on the form, I would like a little one-page generic that gives you a jumping off point and I would like to be able to implement that. Right now if somebody is paying $130/hr they don’t want to “waste their time” and that is in quotation marks but I think ultimately there is value in doing that. And I think that some of the other practitioners agree on some level. We have to talk about that.

The next section explores the associated costs of IHC for AHC patients/clients, health-care practitioners, and the hospital/AHCF.

4.2 Financing Integrative Health Care

AHC operating costs were funded from several different sources. According to the hospital administrators, the hospital covered the operational costs for the AHC, such as heating, lighting, computers, and office space. The AHCF was required to raise funds for the subsidy program offered to artists. Respondents all mentioned the clinic’s financial limitations. The majority of health-care practitioners agreed that IHC was an ideal to strive for and many noted how financial limitations impeded the evolution of integrative health care at AHC, truly forming a barrier to IHC. According to this CAM practitioner it was one of the only barriers to IHC at the AHC:

CAM_HP5: I think it’s an ideal to which they strive, I think because of the limitations of finances which affect resources it is not as successful as it could be . . . I think the potential is there, the interest is there, the desire is there, but it is a practical issues on who’s time? When, where? And those kinds of things . . . I mean there is a lot of talent and energy there, and I think it is more practical, I don’t think it is anything else.

4.2.1 Integrating Contract Workers into the Hospital Environment

All of the CAM practitioners and two of the biomedical practitioners said they worked at the AHC for less money than what they made in their private practices. None of the CAM practitioners were permanent employees of the TWH; they were hired as contract, fee-for-service, part-time employees; all of them described this as a limiting factor for integrative health care. For example, attending meetings or anything outside of patient care at the AHC was
unpaid. AHC patients/clients also said that they felt limited, in that the subsidy money available to them, albeit generous, was not enough to cover treatments from multiple health-care practitioners.

Respondents of this study all agreed that AHC’s sustainability and financial well-being were always on their minds. Financial limitations were often cited as the leading factor in preventing the AHC from becoming a more IHC clinic. Strategies for sustainability included using aspects of a business model and an insurance model to inform the current management of AHC funds.

The hospital administrators indicated that a small operation budget was embedded in the hospital’s Family Health Centre budget, which supplied the operational costs for various initiatives within the hospital, including the AHC. Such costs included office space, lights, and computers. The majority of the hospital administrators believed that not having to pay any of these overheads was one of the advantages, for health-care practitioners, of working in a hospital as a contract employee. As such, some hospital administrators believed a reciprocal benefit to the hospital would be for AHC health-care practitioners to meet with each other to work towards integration. Several AHCF members felt the same way. They explained why, from an arts culture perspective:

HA 1: You [health-care practitioner] are coming in with no overhead cost, you are billing your patient and then you can go home, and we [hospital administration] take care of everything else. So I am reminding them of that now, and OK, that’s all great but that’s a really good gig, so there is some reciprocity expected there.

AHCF 1: I did try to make a little bit of an educational point about the fact that it is not that we [the AHCF] have bottomless pits of money to give to subsidy, we work really hard. We know it is really important and we appreciate that it is there and I just want them to understand that I guess it’s that around that whole culture around, part of your salary being paid by us, by a volunteer board that’s getting donors to give us money and the fact that you fit into this culture is where you do have to take that extra step . . . so Google™ to learn about osteopathy or to take a couple of people out for a beer and have a discussion around what they do.
That said, most of the hospital administrators agreed that asking health-care practitioners to take time away from their private practices to attend unpaid meetings at the AHC was not ideal nor always realistic:

HA 4: So for us to ask them to come in when they don’t see a patient per se they don’t get paid. So that is one of the issues that came up in our retreat, and the foundation was looking at raising money specifically to create a fund so that we can foster some of that interprofessional collaboration and professional development and different things and how we might do that, and what ways to address that . . . but that is a core challenge, particularly because a lot of the practitioners do have their own private practice. So they work here a day or two days the rest of the time they work in there own private practice elsewhere, so to leave that practice for half a day and come here for one hour case conference and not be compensated, you know you have to be realistic about that.

As will be discussed in chapter 5, the majority of health-care practitioners felt that team meetings were essential to the creation of IHC. One CAM practitioner pointed out that if everyone was an employee of the hospital then scheduled meetings and a more integrative environment could flourish because it would be a part of everyone’s job, and thus be included in their pay to attend meetings:

CAM_HP 3: I think that is the biggest challenge in our integration is that we are paid for service. So compared to a normal hospital, because in a normal hospital you can have meetings like this, it is just a part of your day, while for us [contract employees] it is not and we are not paid for this.

The contract CAM and biomedical practitioners said taking time away from their private practices for team meetings was very time consuming and difficult. As a biomedical and a CAM practitioner explained:

BIO_HP 3: I have a very busy [private] practice when I have to take time off then I can’t see patients. So it is hard if you come here [to the AHC for an unpaid team meeting] and then you have to think of the time it takes to get here and the time to get back to your other practice and so for a one-hour meeting, it could be a three-hour treatment.

CAM_HP_3: I have only been able to make a couple of the monthly team meeting and, because I work, I also work . . . And if I do come to a team meeting it’s at my own expense.
Suggestions for improving integration amongst health-care practitioners at the AHC were offered. One CAM practitioner suggested increasing the number of work hours available to health-care practitioners:

CAM_HP 5: If there was more money then we could be there more often. And maybe if I were there a day a week as opposed to half a day, or over two half days, maybe we [health-care practitioners at the AHC] would overlap a little?

And another biomedical practitioner agreed to longer hours only if there was a patient demand for their services:

BIO_HP 4: I’m paid on fee for service, so if I don’t have patients I have no reason to be here, and if I had more patients I would be here more. There has to be enough inflow of patient clients to justify my being here longer or coming in on another day, which I am happy, to do if that were to happen. Part of that happening has to be those potential client patients that are out there have to be able to get in. Sometimes there are some stumbling blocks with them getting in and that is administrative and other reasons and that sort of thing.

4.2.2 Scheduling Contract Workers

The majority of hospital administrators described trying to determine how many hours to schedule practitioners according to patient demand as a constant challenge. They referred to it as a “delicate balance” in knowing how many practitioners to hire or when to increase practitioner hours to meet the demand of patients:

HA 3: There is still that seasonal ebb and flow in the artists health centre, there is also, there is kind of a bit of a Catch 22: do you increase the time commitment for the practitioners in the centre while the volume is there to keep them busy because they don’t want to sit there not doing anything and not be compensated? Yet at the same time you create such a demand but don’t have anyone meeting it that patients get frustrated? So it is always kind of a delicate balance.

One hospital administrator reflected upon the early years of the AHC, particularly on the difficulty in determining the practitioner-to-patient ratio. She explained:

HA 2: We made a few mistakes in the beginning. We brought in way too many massage therapists for a large period of time and then the volumes expired so we had to do our best guess. Of course the volume was only enough for one massage therapist so the other two kind of fell by the way side, and then we sort of left those [massage therapists] with
some flexibility to move those hours up as the [patient] volumes increased and then the
volume increases were dependant on so many other factors that were working.

A CAM practitioner suggested that patient volumes might be tied to the current hours of
operation at the AHC. He proposed that hospital administrators examine whether there might be
a demand for after-hours services as a means of increasing practitioner hours and patient
demand. He asked:

CAM_HP 2: I would like to find out . . . if my hours are inaccessible? My hours are kept
the way they are right now because that is the demand. I have been back in the spring
when we were getting busier – I was here for six hours a day, because there was a
demand for it . . . maybe some artists that work as graphic artists or from the TSO, I don’t
know, and they want to see us after 5:00 p.m. we should explore that. I have no
objections to that, but if I had more time then definitely I want to make sure I am busy. I
don’t want to sit here and twiddle my thumbs.

4.2.3 Subsidizing AHC Treatments

To help professional artists gain access to health-care services otherwise not covered by
the current provincial health insurance (OHIP), the AHCF offered a subsidy program for CAM
services at the AHC; raising funds for the program was their responsibility. A hospital
administrator explained how the subsidy worked:

HA 1: For the subsidy it is $500 per year; a calendar year and really the patient can
decide how they want to allocate those funds. Now there is some coaching by the staff,
and they try and take a look at how they can maximize the use of that subsidy for this
year, so you (the patient) get the best return on your treatment. So there is some of that
kind of work done as well, but really it is the patient that chooses how they want to use
that. The subsidy covers 75 percent of their fee, and then they pay 25 percent.

However, according to these two CAM practitioners, patients were often unable to afford
integrative health-care services at the AHC:

CAM_HP 6: The other thing I should mention is finances. I have referred people [clients
of the AHC] to [CAM_HP 2] and [CAM_HP 4]. I have referred people to [BIO_HP 3]
and to some of the stress reduction seminars. The problem is that a lot of them just don’t
have the money. With only $500 subsidy it is used up pretty quickly, so that is a
challenge too, that makes integrating difficult. Because even though you want to be able
to refer them they can’t go.
CAM HP 2: I think as it stands now it’s going to be very difficult to make this a multi-disciplinary clinic where the patient goes from person to person to person unless they try to appeal to a higher socio-economic patient base.

The artists in the focus group said that they appreciated the subsidy and recognized the importance of this much-needed program. Three of them discussed the benefits of the subsidy program:

ARTIST 3: There is also the cost benefit as well; you get a subsidy to come here, which helps a lot.

ARTIST 2: Because most people in the arts don’t have any money . . .

ARTIST 5: Yeah, it is $20 [for a treatment] as opposed to $60 or $80. This is a serious point for some people.

The majority of respondents described the subsidy as an important part of providing health-care services to artists that were not covered by universal health care. However, the hospital administrators, AHCF members, and AHC health-care practitioners described the challenges of sustaining and maintaining the subsidy program. All AHCF members described the task of raising funds for the subsidy program as daunting. One AHCF member elaborated:

AHCF 1: The other thing is raising thousands and thousands of dollars for subsidy . . . And I just think we are busting our butts out here and we are working with one and half staff, we have a volunteer, I am not saying that I don’t think it is not appreciated, but . . . we are not reaching into our bottomless bucket of cash and pulling out this money and saying “OK, here you go.” We have worked really hard to raise this money.

At the time of this research, AHC practitioners had been notified that the subsidy program was to be temporarily stopped. Respondents described finding this out as an eye-opener, and several expressed concern about the sustainability of the clinic, given the number of practitioners and the increasing patient demand. As one CAM practitioner explained:

CAM HP 2: So I think that’s the challenge, they have to think more long term. I think right now the subsidy program is great, but because of the diversity and number of practitioners it is not really going to be integrated in terms of a patient being able to see a number of people and getting really good care, because I don’t think they can really afford it.
One CAM practitioner described her feelings of insecurity, and her inability to discuss these feelings for fear of sounding selfish: several health-care practitioners were concerned about the status of the subsidy program, as they had been notified that it was to be temporarily stopped.

Q: When the subsidies were temporarily stopped, was there any consultation with the practitioners?

CAM_HP 4: Not with me.

Q: It was just an announcement?

CAM_HP 4: Yes, stating that they would honour subsidies that already existed, but that there would no new subsidies taken or granted for a while. And so of course when I heard that I thought we had run out of money, if there is not money what is going to happen? Is this going to close down? But I didn’t feel comfortable talking about it here with anybody because I thought I just felt too, I guess embarrassed that I would be seen as being just concerned about myself’ . . . it made me feel anxious and insecure because as a practitioner I need to know that Mom and Dad are supporting the kids, Mom and Dad are paying the rent, Mom and Dad are paying the mortgage, you know, because then I can do my job. Several respondents discussed strategies for sustainability. The first strategy suggested by the majority of hospital administrators was to examine the clientele through the lens of a business model. Two hospital administrators explained how the subsidy program was invaluable to professional artists, however, from the perspective of sustainability; there might be a need to diversify the clientele that the AHC currently serves:

HA 3: Right now the AHC is competing based on cost to starving artists and no one is going to get rich on that model. Any model has to be able to attract resources. So for that model to survive it depends very much on the foundation to raise a whack of money and if the foundation is not raising a whack of money and the hospital is not going to step up or our foundation is not going to step up it will be very challenging. Those are just very basic long-term types of things. It [the AHC] was never meant to be servicing successful professional artists, but on the other hand I think the working professional artist needs to be more of the cliental. Because otherwise you are attracting students and people who are wannabe artists, who know it is cheaper to get a massage [here] and it is tough to build a business that way.

HA 2: Currently I would say that it is close to 90 percent of our patients coming to the AHC are on subsidy, which is great in a way because they are the artists in the most need, but it creates a challenge from a cash flow perspective for the foundation because the greater the need the greater the demand on the subsidy and the more money they need to raise. So we are looking at how can we diversify our patient group in the AHC so that we have more patients that are also able to pay directly so that there is more of a balance there, so that is also what we are looking at tackling now.
AHC practitioners asked the AHCF foundation about its long-term subsidy program plans. Changes regarding who was responsible for the subsidy fund followed. One hospital administrator explained:

HA 2: We got caught last year. We were able to salvage it, but what happened was too many subsidy applications were approved, not enough donor dollars were raised, so that kind of mini crisis had us step back and go “is the process we have here the best one?” And now the Foundation has taken over the responsibility for the subsidy fund to allow them to keep a better eye on what is the commitment of the subsidy fund looking forward into the year so that we know we have got enough money in the pot to cover that commitment.

A CAM practitioner mentioned a second strategy that he believed would assist in both the sustainability of the AHC and the process of integration. He suggested that the foundation consider an insurance model for health-care services at the AHC. This would involve taking the money raised by the foundation and setting up a direct billing insurance system with an insurance company that might be affiliated or have an existing relationship with the hospital, and/or was a supporter of the arts community. He explained how it might work:

CAM_HP 2: I think it would make a lot more sense to take that budget they [the foundation] have on a yearly basis and put it towards a health plan, I think as a lobby group, I don’t know there rates but maybe that would be part of a donation from an insurance company say to the artists “you have the option to buy into a health plan, instead of getting $500 in total, you can get $300 of this $300 of that.” I think that would make a bit more bang for the buck and it would really, really add, to making this an integrative clinic. Because budget-wise I would say a patient comes in here and they get maximum five visits for the whole year. So if this is really going to be an integrative medicine model it’s only really, the patients are only going to be able to see two people in all honesty. They will see one person who will do the assessment they will do a treatment, there will be at least one follow up, maybe a referral to someone else where there will also be the treatment and the follow up, then the doctor will say try this it’s there already and then they are done for the year, but a lot of these patients can’t afford more than the five treatments, so we don’t see them for the year while they wait for subsidy renewal. I don’t think it is renewable the way it is set up. I think 500 bucks is great, I think the discounts are great, I think it is great to have that money, but I don’t think it is the best way to manage it. I think the best way is to set up an insurance plan, and say to the artists, it will cost you $25.00 a month, we will match it dollar for dollar which is good too, because it is seen that the patient will take some responsibility.
Most of the AHC health-care practitioners felt there was a need to make the larger community aware of the uniqueness of the AHC, and offered a third strategy for sustainability. Also a theme in the previous chapter, the strategy involved increasing communication and integration among the health-care practitioners, the rest of the hospital, and the community. More exposure might lead to others who could carry the torch and sustain the work being done at the AHC. An AHC biomedical practitioner suggested that this could take the form of a conference or symposium. She discussed with me her experience at an international artists’ health conference. The conference attendees were impressed with a presentation that highlighted the AHC. She described this experience:

BIO_HP 3: We [health-care practitioners] are not going to be there [AHC] forever, so you have to bring other people who are interested because what if something was to happen to any of us then you don’t want it to fall apart. So you want to bring people who are interested [in artists’ health] and are ready to take over . . . I think it would be wonderful to eventually have an artist’s medical conference at Toronto Western, and then people that might have the interest but are not working with us might want to present or something. Then you get to know them and that would be good . . . so if you want to promote your thing then you have to say, “this is what it is, this is what we do, what are you guys doing, how have you been doing, how do you do that?” And when we were in Sweden at an artists’ health conference, there was nothing like this [AHC] in the world . . . and I think we tend to forget how special this centre is, and we need to just keep reminding ourselves. And sometimes it is just a little tap on the back to say, “hey, we are pretty good.” When I went to Florida this year, after being in Sweden last year, where we presented and people were coming to me from England, they were coming to me and saying “we want to be associated with you,” and people from Australia saying “your centre is just so good,” and people from Sweden were saying “we tried to do that and it didn’t work, how did you do that?” It is truly, truly special.

The majority of hospital administrators said that they believed in the vision of the AHC. One hospital administrator explained:

HA 4: I was certainly always taken by the vision of it [AHC], and what it could mean for Healthy Connections [a hospital initiative] and what it could mean for the [Toronto] Western, as well as, because we were already clear that the need was well articulated . . . we are very proud of this program and what it has achieved in a very short length of time.
The ACHF members concurred that the AHC was a unique clinic and in many ways it could be seen as the “sexy part of the hospital” which might add to the appeal of sustaining this centre within the hospital:

AHCF 1: The first thing I always tell people about the AHC is that it is unique in the world. We don’t know of any other clinic that exists in the entire world . . . I think it is important to talk about the fact that no where else in the world is there a clinic which exists that is like this and boy are we lucky. That’s the sexy part of the hospital, and it is a big communication message for me, and for donors.

4.2.4 Summary

The findings suggest that the creation of an IHC clinic was costly and that financial limitations were a barrier to its positive evolution.

Two of the biomedical practitioners and all of the CAM practitioners were hired by the hospital as contract employees, thereby receiving none of the benefits of full-time employees. They took a pay cut in their fees (relative to their private practices) and felt like they volunteered their time to attend team meetings as these were not paid for by the hospital. Although there was some reciprocity expected by the hospital administrators and AHCF members, since overhead costs were covered by the hospital, and the arts community had a culture of being underpaid and volunteering, it was recognized by both groups that it was not always feasible or fair to ask this of the health-care practitioners.

Patient/clients of the AHC said that they also felt the financial burden, as their subsidies were not large enough for them to see multiple providers at the AHC. The subsidies and sustainability of the AHC preoccupied all of those involved at the clinic. Suggested solutions for these concerns included looking at a business or insurance model, re-examining the clientele, and promoting the “sexiness” of the AHC to the larger community.

The next section describes the respondents’ hopes and vision for the AHC as a clinic within the organizational structure of the hospital.
4.3 Organizational Growth and the Evolution of the AHC

All respondents described the AHC as a unique, wonderful occupational health clinic for artists. They wanted to see the AHC become a strong, sustainable, and ever-evolving clinic. There were several ways in which respondents wished to see the AHC evolve. AHCF members hoped one day there might be several smaller “satellite” IHC clinics across Canada that focused on artists’ health needs. Artists hoped for more services to be added to the current ones offered at the AHC. Some CAM practitioners hoped that they could work to their full scope of practice at the AHC under the umbrella of the hospital. All respondents said that an evaluation process was essential to the further growth and evolution of the AHC. They expressed an interest in understanding how useful the AHC was to the artists, health-care practitioners, hospital, and AHCF.

4.3.1 Hopes and Aspirations

As described in the section above, the issue of sustainability was first and foremost on the minds of the majority of respondents. All respondents wished to see the AHC as a sustainable, integrative health care centre. As one hospital administrator illustrated:

HA 5: I would say based on all that has happened up until this point I would like to see that it is sustained, and I would really like to support it as an opportunity for a really innovative co-op placement or inter professional stuff so I know there are many areas that need work done.

It was important to the respondents that the AHC become an integrative site, not only within the clinic, but also as part of the hospital. One AHCF member pointedly explained:

AHCF 4: [In the next 10 years, I want the AHC to become] a well-established entity that is completely a part of the hospital, as much a part of the hospital as the X-Ray department.

Respondents wanted to see the AHC expand and evolve in various different ways. Several AHCF members discussed the possibility of expanding it. One AHCF member imagined:
AHCF 5: I think the other thing would be to from the artists point of view is to expand it. I mean right now it is focused primarily in Toronto and Ontario, but have it expanded such that there is greater outreach to other areas of the provinces and maybe have almost mini clinics out in Vancouver or Winnipeg or Halifax. I mean that is pie in the sky but . . . You know the AHC is here but it has got little satellites here there and everywhere, that’s way, way off in the future, but to me that would be great.

Another way some saw of expanding on the current AHC was to make it into a centre of excellence. This is what one CAM practitioner said:

CAM_HP 6: A: You know it would be really nice to have this place evolve into a centre of excellence. A place where it is the place to come, not a place for struggling artists to come because there is a subsidy, so it would be really great to see that evolution. I know that’s huge and that’s a big thing but I think that would be amazing to have that kind of centre.

4.3.2 Limitations

Artist respondents said that there was a tremendous need for more mental health services. As one artist suggested:

ARTISTS 2: I think there would need to be a very flexible range of counselling. Everything from short-term dealing with a crisis to long-term dealing with long-established conditions and artists, as the population goes, can be a little bit more emotionally fragile, than the statistical norm, a little bit over the bell curve.

According to the hospital administrators and some of the health-care practitioners at the AHC, the demand for mental health services was largely unanticipated and often too complex for the type of clinical care that is currently offered at the AHC. As one biomedical practitioner explained:

BIO_HP 1: We can’t really be a mental health centre for artists- that’s not our mandate. And we were getting some people with some very complicated medical psych histories that were really not appropriate for the type of occupational clinic we have . . . I mean it is not all mental health, but for the last two weeks every new patient I had was all mental health, every new patient.

To accommodate such a demand, one of the hospital administrators described how referrals were often made back into the community. More recently, one of the health-care practitioners at the AHC held group therapy sessions. He explained:
HA 3: We still have a higher volume or greater demand around mental health issues and higher acuity than we had ever expected initially and so that’s why often sometimes they really are lucky to have been referred off to community mental health, because they are more appropriately treated there. Something we have done in this last year, one of the therapists at AHC is actually doing group therapy now and so we . . . the patients pay a certain percentage, what we have designed in substitute is basically a wash financially so the subsidy that the foundation is doing the patients are getting a certain amount to cover the cost, the patients who participate pay a certain amount and it becomes apparent that we break even. So it has allowed us to offer some group therapy as well. So we are on our second or third group.

Other services mentioned by the artists and hospital administrators were art therapy and dentistry. In each of the focus groups with artists and hospital administrators, art therapy was believed to be beneficial. Here are two examples, from these two different perspectives, on the well-researched benefits of how art contributes to a healing environment:

ARTISTS 5: Can I propose an art therapist? Because it is my field because again you are right there, I use real art as a form of therapy it can be extremely beneficial, not just for artists but also for any population. For visual artists I needed training as a visual artist to become an art therapist it was very difficult because I had all these ideas of how to paint and the motive and everything it was all pre-determined, but then I started to use different materials for expression of feeling and it was just incredible what happened. In our conscience it just shifted immediately then and it can be a great short cut to normal therapy.

HA 2: I think there is an opportunity for the artists that actually get service here [AHC] to be more a part of the hospital. I am very persuaded by the importance of art for health and that there are probably all kinds of things that art in all its forms could do in this hospital . . . we know a lot about art therapy, there are multiple dimension to it and how you might reflect that in hospital setting. I think there is the potential for the artists to create, help us create more of a healing environment here and open up the traditional ways we think about the kinds of work that we do. I think that is untapped, they have certainly contributed through benefits and things like that, but I think that there is probably a lot that could be done.

The CAM practitioners at the AHC said that they would like to see the centre evolve and grow to meet their needs in helping them provide treatment at the hospital, which they would otherwise provide to their patients out in the community. The CAM practitioners perceived certain barriers to performing certain procedures and ordering certain laboratory tests; they
hoped one day to offer these to their patients/clients at the AHC. One CAM practitioner

described what he identified as limitations to his practice:

    CAM_HP 2: One thing would be to find out when we will be able to get an authorization
to order X-rays and blood tests directly. If we could just find out where we are on that,
because that would definitely be the first, a big precedent and I have spoken to the
medical legal people and there doesn’t seem to be any objections, they just want to wait
for the right climate. So I would just be curious about that, because that would be neat if I
could order blood tests and that . . . and also I wouldn’t mind doing some IV treatments
here, just for patients with chronic fatigue and so on. That would be a big step in terms of
increasing practice.

However, the majority of hospital administrators believed that these requests were
politically charged. Thus, working in a hospital environment was a limiting factor. As one
hospital administrator explained, there needed to be a perfect moment in the evolution of these
requests in order for the hospital to accept the requests. He explained that, at this time, the
hospital was not quite ready:

    HA 1: I think people are OK with supporting the client in what they are using out in the
community and trying to help that happen in the hospital, actually bringing in
practitioners in the hospital is more than just conversation and then to have clinics that
actually contract practitioners . . . involved and our [CAM practitioner] wanted to do an
IV drop and it was very commonly done by lots of [CAM practitioners] . . . vitamin
therapy, and we . . . we deferred it slightly but we did kind of put it out there and put
some question marks out and kind of tested the waters a bit. I mean there was a pretty, I
wouldn’t say there was a significant push back, but there was a kind of “UGH!” kind of
response so we said maybe now is not the right time . . . this is completely within his
scope of practice so at some level you could say “too bad, we are going to do it anyway”
but you know just the politics of it all.

The above quote illustrates how consumer and practitioner enthusiasm for CAM in
general, and for specific types of CAM interventions in particular, can present complex
challenges for the hospital administrators of biomedically dominated health care systems and for
those who practise within these institutions. The hospital administrators, albeit supportive of
CAM therapists’ scope of practice, concurred that they must consider the historical contexts into
which CAM had been introduced, and consider the ethical and scientific challenges which it
poses to mainstream health systems.
4.3.3 Evaluating AHC

The data suggests that some of these challenges to the growth and evolution of the AHC were due to a lack of understanding of how success and accountability were measured. The majority of respondents said that they were unclear about how the hospital evaluated or accounted for success at the AHC. Most of the health-care practitioners were unsure of whether the overall needs of the hospital were being met. For example, these health-care practitioners – one biomedical and one CAM – had a series of questions when the topic of evaluating success at the AHC emerged during the individual interviews:

**BIO_HH 2:*** Well . . . ”is the hospital happy? Is the hospital concerned? Is it a good use of their resources? Are we still in the good books as far as space and support go? Does it help meet the mandate of the TWH?**

**CAM_HH 3:*** You see I am not privy to what are the hospital’s interests. What do they want? What does it [AHC] do for the hospital itself and are they at all interested in seeing this grow?

More specifically, for the health-care practitioners, particularly the CAM practitioners, success and what that meant to the hospital was important because they felt it was tied to their future career at the AHC. As one CAM practitioner explained:

**CAM_HH 1:*** How do they [hospital] measure success? I mean in the summer I was really busy, right now I am medium busy. What is the accountability to having it busy and how do they measure success? Let’s say if the [health-care practitioner] is only seen once so are we going to cut [them]? How do they measure success? Because I have insecurity I have to say that if it slows . . .

The majority of AHCF members revealed that they too were concerned with evaluating the success of the AHC through the eyes of the hospital. One board member explained:

**AHCF 5:*** The hospital has to get something out of this too in order for this to be successful. So I would be interested in exploring how the hospital sees us [AHCF] and whether there was a role we could play in constantly nurturing that.

All respondents in the study were concerned about whether they were meeting the needs of artists. The majority of respondents asked the question “are we meeting the needs of the
artists?” during both the individual interviews and focus groups. The majority of artists in the focus group expressed a strong interest in having their views of the services and service deliverers evaluated. These two artists in the focus group discussed evaluating AHC:

ARTIST 4: Is there evaluation here?

Q: Not that I am aware of.

ARTIST 4: But that would be also a very good thing to do, evaluate outcomes.

ARTIST 1: And following up with the clients, it just occurred to me now that I should tell all the people here about the hell they put me through, and the surgeon downstairs . . .

ARTIST 4: I think that is a part of evaluation, and evaluation of the program, they should call you and say, “did you like it [and] what were the things you liked or what can we do . . .”

The artists in the focus group attributed the lack of evaluation and patient feedback at the AHC to the influence of the biomedical hospital culture. According to one of the artists:

ARTIST 3: [The hospital] does tend to treat the ailment rather then the patient. And the Artist’s Health Centre seems to be trying very hard to treat the patient rather then the ailment. . . . Even if there were an opportunity for a suggestion box . . . probably would be helpful.

The hospital administrators in the study saw evaluation as an important aspect of measuring success. When the questions above were posed to them in the focus group, they explained that evaluations were limited due to financial constraints. Conducting evaluative research at the AHC would depend on the generosity of donors and personal contacts.

Maintaining a level of scholarship in research for the AHC was also described as challenging. As one hospital administrator explained:

HA 3: The goal initially was to establish a centre recognizing that artists were spending a lot of money on complementary and alternative therapies and they had not been studied in terms of there benefit. So it was not a matter of simply providing the services, it was meant to be evaluated and looked at critically to see to what degree they [artists] benefit and what types of models they [hospital] could be incorporated with traditional medical models and so on . . . but the [AHC] foundation is struggling [financially], which is understandable, it really always has. A study that [HA] referred to was donated by a really prominent consulting group, and they did it based on personal contacts and that
was about $200,000 worth of work, so things like that people have donated, but it’s . . . artists live like that, day-to-day, but you can’t run a academic program like that.

4.3.4 Summary

Overall, each respondent of this study held the hope and vision that the AHC would remain a viable IHC clinic. Each group of respondents had different ideas on the evolution of the AHC. The hospital administrators were passionate about the sustainability of the AHC within the hospital, hoping that it would become just as important and recognized as other clinics there (for example, the X-ray clinic). The artists hoped for increased health services, such as dentistry, art therapy, and more mental health counselling services. The AHCF members mostly discussed the possibility of satellite IHC clinics for artists located in every urban city across Canada. The health-care practitioners at the AHC, especially CAM practitioners, wanted to increase their scope of practice. They wanted to offer their patients the same types of treatments in the hospital setting as they did in their private practices in the community. However, at the time of this research, there were no evaluations undertaken to confirm whether the current services met the needs of the population of artists at the AHC, or whether more were needed. Evaluations to measure success were not performed, which was recognized as a limiting factor to the growth (both personal and professional) of those involved with the AHC. The respondents of this study recognized the importance of financial and political support for the development of an IHC clinic.

4.4 Summary

The findings reveal that several diverse forces must be taken into consideration when examining IHC at the AHC. Many hospitals have entered the market to deliver CAM services, recognizing that patients are typically going outside of the established health-care system to get them. Hospitals have developed a number of different models for delivering CAM services to consumers.
My research findings suggest that the following CAM model exists at the AHC: a hospital-supported, freestanding occupational health clinic relying on philanthropy and aggressive fundraising to cover the subsidy costs of CAM therapies for artists. The AHC offered a wide range of CAM therapies, supervised by a nurse practitioner. The nurse practitioner and physician were full-time employees of the hospital, while six of the CAM practitioners and two of the biomedical practitioners worked in a contractual relationship with the hospital. Artists often did not want to be funneled through the nurse practitioner “gatekeeper,” so sometimes self-referrals were accepted at the AHC. This was the general model of IHC at the AHC. For an in-depth analysis, the research considered the issues surrounding the intake process and referrals, the cost of implementing an IHC clinic, and the anticipated future of the AHC.

Upon exploring the patient/client intake/referral process, it was discovered that the process followed the typical biomedical model of assessing patients. The nurse practitioner was a “gatekeeper,” “hour glass,” or “funnel” between the intake of patients/clients and subsequent referrals within the AHC. She was positioned between the hospital organization (as a full-time, permanent employee) and the individuals who wished to use resources within the hospital organization (the AHC). Thus, gate-keeping intertwined the roles of the advanced nurse practitioner and hospital organization. A recent editorial in the New York Times expressed a sentiment common in Western countries such as Canada and the U.S: gate-keeping by managed care organizations is a failed experiment (“A Verdict on Gatekeepers,” 2001). On the front-line delivery of health-care, the primary-care gatekeeper has become the lightning rod for consumers’ discontent with health-care delivery. This too was an issue for the AHC as an occupational health clinic located within a hospital, because artists were accustomed to directly contacting CAM practitioners in the community for their desired services, and did not necessarily want to go
through the gatekeeper intake process for referrals to a CAM practitioner when trying to access services at the AHC.

The CAM practitioners who chose to work at the AHC earned less than they did from their private practices. They raised the issue of remuneration within the hospital system. When CAM practitioners worked inside a biomedical hospital, they were often relegated to the periphery of its structure. This marginality was expressed by their remuneration patterns, their lack of official, permanent status in the employment structure, the part-time nature of their work, and the exclusion from one of the critical and central rituals of medical practice: meetings and rounds. The status of sometimes being expected to “volunteer” their time for meetings in exchange for not paying the overhead costs could be interpreted as contributing to the marginality of their status in the hospital structure. Compounding this was the similar expectation of the AHCF members who believed that the arts have a culture of being underpaid and of volunteering. In effect, they too inadvertently supported this marginalization of CAM practitioners.

Integrative health-care was also expensive and often prohibitive for the artists at the AHC. Most CAM services in Canada were not reimbursed by third-party payors. Patients/clients of the AHC typically paid for CAM therapies out of pocket. The AHCF offered a subsidy program that professional artists were eligible to apply for, to help offset some of the costs of CAM therapies. However, to ensure the long-term financial viability of the AHC, hospital administrators were closely examining the economic demographics of the services area – in other words, moving towards a client base that can pay out of pocket.

The respondents of this study were preoccupied with how to ensure the sustainability of the AHC and the subsidy program for artists. The AHCF member described how a significant time was spent on fundraising efforts. There was a constant fear expressed by the respondents of
this study that the AHC would discontinue because of a lack of funds. Suggestions for managing the funding dollars were offered during the focus groups and individual interviews. Business and insurance models were suggested as practical ways of managing the financial needs of the AHC. Increasing the AHC’s profile through a conference/symposium was also discussed as a strategy for creating interest or a “buzz” around the AHC.

Apart from the fears and tension regarding the financial well-being of the AHC, all respondents in this study had hopes and dreams for its growth and evolution. One interesting finding was the wish of several CAM practitioners to work at their full scope of practice at the hospital, as they do in their private practices in the community. For example, one wanted to give intravenous therapy to his chronic fatigue syndrome patients at the AHC. The hospital administrators were hesitant to agree to this particular health service. Although there have been numerous studies of consumer use of CAM, studies of participation by conventional medical care organizations, especially hospitals, are few.

All respondents identified the importance of measuring success through a process of evaluation. It was obvious during the research process that the various stakeholders were passionate about the AHC. Each group had a vested interest in improving and expanding upon the number of health-care services, particularly CAM services, to artists. The findings suggest that the concept of IHC was important to the stakeholders at the AHC. There seemed to be a genuine interest in sharing knowledge between the various stakeholders to better serve the artist community.

The findings suggest that creating an IHC clinic is neither an easy nor a cheap option. It needs to be adequately resourced, the rationale for its development needs to be made explicit to all stakeholders, and clear, achievable objectives need to be set for each stage (intake, referrals, subsidy, future plans). Both the hospital administrators and AHCF members face diverse
challenges in pursuing the missions and vision of their organization and delivering health-care
services to the artists’ community they serve. It requires careful planning throughout, and its
success will ultimately depend upon the support and commitment of all staff involved.
CHAPTER 5
COMMUNICATION AND COLLABORATION

5.1 Introduction

Research is lacking in the area of communication and collaboration between biomedical practitioners and CAM practitioners. Although such journals as the *British Medical Journal* report that CAM is on the rise worldwide (Thompson & Feder, 2005), the increased acceptance of CAM by the public does not indicate that communication between health-care practitioners is satisfactory.

The mission and vision of the AHC is to provide integrative health care to artists. However, communication and coordination of services between the various stakeholders at the AHC, particularly among health-care practitioners, still remains difficult to put in place. As Abbott argues, the division of work and distribution of tasks among practitioners in the workplace remains fundamental to the daily provision of health-care services (Abbott, 1988). This seems to be the case at the AHC, as a substantial portion of the communication and coordination of services within and between the hospital and the AHCF and their delivery is still in the hands of individual practitioners who are each trained differently.

This chapter explores communication among the various stakeholders at the AHC. It is divided into five sections. The first section examines communication patterns among the health-care practitioners, artists, hospital administrators, and AHCF members. The second section describes the mechanisms for communication among the stakeholders of the AHC, both formal and informal. The third section illustrates some of the consequences of a lack of communication between these groups. The fourth section offers some of the potential solutions, as described by the respondents of this study. Section five provides a summary and analysis of the above
sections, using sensitizing concepts borrowed from various organizational theories, and the theory of the professions.

5.2 Communication and Integration at the AHC

In the focus groups and interviews, AHC respondents, particularly the health-care practitioners, described three challenges to communication and hence integration at the AHC. First and foremost, the overall consensus among the health-care practitioners was that there was little everyday interaction, posing a major challenge to communication and integration. In fact, a few respondents stated that they had never met one another. Second was the current state of scheduling and staffing at the AHC; health-care practitioners who did not practice together generally did not refer to each. Third was the current state of teamwork and the direction of communication among the respondents. There was little consensus among the respondents on whether teamwork was appropriate for the AHC. Often, issues regarding how information was passed along, by whom, and when, was identified by most of the respondents as problematic.

These challenges led to the overarching question: “Is integration happening at the AHC?” The respondents had a variety of answers, depending largely on how integration was defined. Some health-care practitioners believed that the concept of IHC, and defining the AHC as an integrative occupational health clinic, depended largely on the level of interaction among the health-care practitioners at the AHC, and between the hospital and AHCF. However, most of the AHCF members described themselves as not being fully aware of the concept of IHC, while still defining the AHC as an integrative occupational health clinic for artists on the basis of the current multidisciplinary team of health-care practitioners.

5.2.1 Level of Everyday Interaction between the Silos

Most biomedical health-care practitioners at the AHC stated that they had met each other; for example, the physician, nurse practitioner, and the physiotherapists had met and on varying
occasions worked together. Several other health-care practitioners – for example biomedical practitioners-CAM, and CAM-CAM practitioners – had only occasionally met one another, if ever. This, according to both the CAM and biomedical practitioners, made integration difficult – if not impossible – to achieve. One biomedical practitioner observed that, in general, her interactions with both groups were few and far between:

BIO_HP 4: Even though we are all on board I still haven’t met everybody, so it is hard to feel like we are integrated in some way when we don’t even know one another. We have not even had a conversation with some of the individuals.

During the individual interview with a CAM practitioner, he mentioned that there was very little interaction with some biomedical practitioners, and none with two of the six CAM practitioners working at the AHC:

CAM_HP 2: But I rarely see [biomedical practitioner] and I haven’t met the osteopath yet.

Q: I don’t think anybody has.

CAM_HP 2: I don’t think I have ever seen [the chiropractor] . . . So from that aspect it is hard to integrate when you haven’t even met the person.

Another biomedical practitioner described how he had not met a couple of the CAM practitioners, had met one CAM practitioner only in passing, and had only on rare occasions worked with one of the biomedical practitioners at the AHC:

BIO_HP 2: So I don’t really know, to be honest with you, I can’t picture her, our osteopath, that’s really embarrassing. So she should probably give an in-service in one of our team meetings . . . and hasn’t. That’s nobody’s fault . . . I haven’t worked with our osteopath at all and [biomedical practitioner] a couple of times at one point . . . [CAM practitioner] again in passing, and I guess that’s it.

Q: And the chiropractor?

BIO_HP 2: Who’s the chiropractor? I haven’t met her yet . . . so there you go.

Some of the CAM health practitioners had not met all of the biomedical health-care practitioners either. One of them said:
The AHC health-care practitioners described the level of communication with the rest of the hospital as non-existent. To their knowledge, they had never been asked for their input on integrative health care, subsidies, or artists’ health. As a result, they described feeling disconnected from the hospital. Two CAM practitioners confirmed this lack of communication between themselves and the hospital and AHCF board:

Q: Has the foundation or hospital ever asked, to your knowledge, any of the health practitioners for their input on integration, the subsidies, or just how to better help the artists reach their goals?

CAM_HP 6: Not to my knowledge. I could be wrong, but I don’t recall any of that.

CAM_HP 5: I don’t even know what the hospital’s involvement is . . .

The issue of never meeting each other was also a topic of interest with the AHCF members. Several AHCF members said that they were troubled by the fact that there were some health-care practitioners whom they had yet to meet. One member stated:

AHCF 1: There [are] a couple of practitioners that I haven’t even met, and I am the [position] and I try and get out and meet people, and I have been to several functions and I never see them there.

The quote suggests that there may have been unclaimed opportunities for interaction. This theme will be further explored in chapter 6.

5.2.2 Scheduling, Staffing, and Methods of Payment

The data reveals that scheduling served as both an enabler and a barrier to communication and integration. For example, the few interactions that had occurred did so when the health-care practitioners occupied the “same space at the same time”:

BIO_HP 3: I have collaborated in certain areas with [CAM_HP 4] and [CAM_HP 3] because they are both here on the days that I am here. I also collaborate somewhat not nearly as much as I would like with [BIO_HP 4] because I think that we do share some patients we do cover one another’s patients, and I think there is a potential there for
learning from each other, which because we are never here on the same day we can’t do. It is the same with the other practitioners.

BIO_HP 4: I feel that when I am here on one day, I feel for the most part very isolated I feel very alone. The people who are constant here are [BIO_HP 1] and [FG HA 1] who are both hospital employees and their job is multi faceted, their offices are here but they are seldom in their offices. So they are not even though they are my “go to” people, they are not always available here. So the people that I have some sort of an exchange familiar exchange are either [CAM_HP 3] or [CAM_HP 4] because they are here on the same day as me.

At the time of the study, the biomedical health-care practitioners worked in or had access to the AHC more often than any of the CAM practitioners. Two of them were permanent, full-time employees of the hospital; one was contracted to work for three days a week at the AHC.

The CAM practitioners were all contract, fee for service, employees and worked at the AHC from four hours (or less) a week to one day a week. As a result, several weeks might pass where they would not have a single patient booking and therefore would not have a reason to go to the AHC. All of the CAM and two of the biomedical practitioners had their own private practices outside of the AHC.

CAM practitioners who worked four hours a week or less said it was very difficult, if not impossible, to interact with other health-care practitioners during their shift. Two of them said:

CAM_HP 4: It is hard to parachute in and parachute out. . . . It is hard to feel the community when I am there [half a day, once a week], and I think I am the only one there . . . sometimes I see someone else float in and out, but it’s not as if we chat.

CAM_HP6: There needs to be more interaction between the team, and that is a challenge because most people are here part-time . . . and for someone like [BIO_HP 3] who’s here three or four days a week it is a little bit easier because she is here so much, she would have more interaction with different people, as opposed to someone like me who is here a half day a week. I only ever am here on a day where [BIO_HP 3] is here and [CAM_HP 4] is here, in the morning we sometimes cross paths very quickly. So I think that is part of the problem so it would nice to be able to have more interactions with the team . . .

Two biomedical health practitioners who spent more hours working at the AHC than any other health-care practitioner described communication with other practitioners (both CAM and biomedical) as relatively unproblematic. They both agreed:
BIO_HO 1: I am there more often than everybody because I am there five half days a week, other people are one half-day so it happens that there is only one practitioner that I don’t share some part of a day with. So every other practitioner pretty much I am there for part of the time they are there.

BIO_HO 3: I am here much more than any other practitioner. I am here for three days a week, so I get to be there a lot of other practitioners, there is only maybe two or three practitioners that I don’t get to see. So that’s an advantage over the other ones because I can just talk.

A CAM practitioner pointed out that during a team meeting, interaction and discussion regarding a patient were interesting and useful; however the current staffing structure at the AHC was not conducive to interactions between any health-care practitioners. He explained:

CAM_HO 3: In one of those team meetings it was very good because someone brought a case that was interesting, that they just didn’t know what to do. Myself and another [health practitioner] that was there on that particular day were able to give some important information from our perspective and I would assume that would go both ways. Possibly lots of different ways, I could perceive problems with that if everyone has got an idea which one should you go with. I think we all have our unique ways of treating people. That would have to, we would have to come together over time, and quite frankly I don’t see how that would ever be done here under the current structure.

Q: And what is the current structure here?

CAM_HO 3: Well what my experience is that we have alternative practitioners who are here at certain times, like today I am the only one here in the office, OK. So who might I collaborate with? If I needed to . . . if I wanted to, if I am booked back to back the whole time. So if I had someone sitting here for example and I thought, “well, this is kind of interesting, and I am a little stumped right now, I could take a pause in the session and say excuse me,” but that’s not doable.

Issues of organizational structure and the effects of the hospital setting will be further discussed in chapter 6.

5.2.3 Teamwork and Communication

The majority of all respondents regarded two important facets of communication to be teamwork and the direction of communication. Why, where, and from whom communication originated were questions that emerged during the focus groups and individual interviews. Most of the health-care practitioners at the AHC deemed that a certain level of teamwork was
necessary for patient care. A few health-care practitioners said that teamwork was an important part of integrative health care because it meant familiarity among practitioners, which ultimately had benefits for the patient/client. As a CAM practitioner said to a biomedical practitioner in the focus group:

**FG HP CAM 4:** But also to me the team aspect does benefit the patient in the sense that there is the potentiality there so that if they needed to see a physician, if the physician they are seeing is someone who knows me, who knows my work, who knows the preparation they are getting the benefit of that even if they only see you once.

Similarly, one biomedical practitioner reflected upon her experience of teamwork and integrating CAM with biomedicine by providing an example of her work in a rehabilitation centre:

**FG HP BIO 4:** . . . but the fact that the team was all there available then it just put in place the potential for it to be quite beneficial, because within one umbrella they would get the opportunity to return to their pre-accident level of functioning. So that is one of the things that integration is for me, the other thing is the integration between what you wouldn’t necessarily see in a formal medical model of practitioners that have been standard they have been outside of the medical model but now they are included, which to me can’t help but be a positive benefit.

The complexity of the patients’ problems dictated whether integrative health care was necessary. A biomedical practitioner who stated that teamwork and constructing care plans with other practitioners depended on the complexity of the patient reinforced this idea:

**BIO_HP 3:** Yes, for sure it depends . . . if they come to me with something reasonably complex, yeah, I will work out a care plan and then I will talk to them [other HP and the patient] about it. . . . You know if they come with something reasonably simple – they have got thumb pain and they are an oboe player and they need to play next week. Then I do the assessment, I get the treatment, and get them back working, so that is a pretty simple plan which I do not articulate as such [with others] . . .

However, as most of the biomedical practitioners and several CAM practitioners characterized their patient population, (artists) as not having complex health needs, they would not necessarily communicate with each other about patient care unless another health-care practitioner specifically asked them. For example:
BIO_HP 2: When [CAM_HP 2] is seeing patients I have no idea who he is seeing, unless he calls up and says, “I think something else is going on here, I’m not comfortable, can you see him for me?”

The majority of health-care practitioners at the AHC said that there was very little communication about patient care except when there were issues of patient safety. One CAM practitioner said:

CAM_HP 3: I think I have had one patient where I have had a couple of brief chats with [BIO_HP 2] about something he had seen and referred to me. I don’t know if we talked enough to be helpful to each other, but what we did get from that was that the patient was covered, medically by the team downstairs and his emotional crisis needs were being looked after by someone specific up here. But there was not ongoing communication, other than that; there is not much communication around specific patients at all.

Communication or follow-up around specific patients was pursued by all health-care practitioners at the AHC only when they felt that they needed to “cover everything” or “close the file” on a patient. As one CAM practitioner stated:

CAM_HP 1: I have had a patient who I knew was seeing [BIO_HP 3] and I phoned her and said, “do you think that you could work on this and I think that . . .” and that was good. I think that if there is not a structure then at least there needs to be a commitment that people will take the time to intercommunicate. Because it feels like with this person I don’t feel done with her file for her initial consultation until I talk back to the [BIO_HP 3], and then it is complete.

The majority of artists stated that they usually saw practitioners of only one modality at a time. However, two of the six artists in the focus group saw practitioners of two or more modalities at the same time. These artists did not know if the health-care practitioners talked about patient care, or even if such dialogue would be deemed necessary by the practitioners. For example, in this dialogue with artists:

Q: So, is it just one person that you see, or do you see a few of the health practitioners?

ARTIST 5: Right now I see one, but I used to see two.

Q: OK, and when you saw two, did you feel like you were a part of a team with your care?
ARTIST 5: Kind of, like one didn’t really have much to do with the other. I was using massage therapy and physio. You know with Physiotherapy I was getting exercises and everything, for massage therapy I didn’t feel like it was a therapy so much it was just kind of to relax, so I didn’t really feel like they needed to work together.

Q: How about you, ARTIST 4?

ARTIST 4: Well as I said before I worked with the naturopath, chiropodist, two physios . . . I was trying to find the answer. Yeah so, I don’t think they worked as a team. I have no idea.

Q: So for example, the chiropodist didn’t necessarily talk to the naturopath about what you were trying to find out?

ARTIST 4: I don’t know if they talked to each other, if they did I don’t know about it.

During the focus group, one of the artists said that she did not view teamwork as patient-centred. In fact, this artist was quite concerned with issues of practitioner-patient confidentiality if other health-care practitioners had access to personal patient information:

ARTIST 3: Does each person who is a patient here have only one file?

Q: Yes, I think so.

ARTIST 3: So if each person who sees the person has access to the notes of the other practitioners . . .

Q: Yeah, if that is the case, how do you feel about that?

ARTIST 3: Well I think it would be dangerous . . . .

5.2.4 Direction of Communication

The second facet of communication was the direction of that communication. The majority of health-care practitioners raised concerns about the lack of two-way communication between each other, the hospital, and the AHCF. For instance, for them communication was often facilitated through the patient/client, who was described as the vehicle for information-sharing among their colleagues. As one CAM health practitioner said:

CAM_HP 3: There is another way that there is interaction and that is usually through the patient themselves. If I have a patient that is seeing another practitioner they will often tell me what the other person has said, now that’s not the same information that we would
get from the practitioner but it is something. Sometimes that gives me more of a picture as to what is going on with a particular patient.

Such a method of communication was not seen as an optimal way to obtain information regarding patient care, since patients were thought to interpret therapies and the outcome of their therapies differently than intended. For example, one CAM practitioner stated:

CAM_HP5: The patient’s perception of treatment is often very different from what happened.

On the other hand, several CAM and biomedical practitioners, for financial reasons, chose to communicate with other CAM practitioners instead of making referrals, which seemed to run contrary to the premise of the AHC as an integrated occupational health clinic. However, having to work within the subsidy allowance, one biomedical practitioner stated:

BIO_HP 3: So when we have artists that say “you know I am not into anti-inflammatories, is there something else that you can suggest?” then I can go and talk to [CAM_HP 2] and say, “what can you recommend? And in that way they don’t necessarily have to see him, because . . . the integration is there, the only thing that is harder is the price is still expensive to get these other modalities, so even if we have subsidies it is still an expense, like it costs a lot for the subsidy process . . . we try but they might not get the full treatment . . .

A few of the health-care practitioners at the AHC expressed feelings of frustration with the one-way communication between the hospital and themselves on issues such as decision-making. For example, a CAM practitioner described the unilateral decision made by the hospital to limit their treatment session to a certain number:

Q: And there was consultation with you and the others when this [number of treatment session] all came?

CAM_HP 3: No, this was decided before we came aboard and then not really told us until we were well into it.

The majority of AHCF members expressed similar sentiments about the direction of communication between themselves and the hospital. They felt they did not have the authority to
make decisions regarding the AHC itself. One AHCF member provided an example of the hiring process to illustrate their point:

Ahcf 1: We [AHCF] can’t really influence decisions made directly [by the hospital]. . . . It is not solely at our discretion if a practitioner is hired, it certainly is the hospital, they have made that clear, they make the decision as to who is hired.

The data suggests that this directly impacts how the AHCF members interact with the AHC health-care practitioners. For example, an AHCF member described how he tended to distance himself from any of the health-care practitioners’ requests:

Ahcf 1: But there have been instances where practitioners have talked to me about their needs and certainly to [AHCF 2] . . . so and admittedly we both go “hands off” because that is not our territory and we have no control over that and we have no authority. We always, always refer them back to [HA 1].

The majority of AHCF members said that they would like to be seen as approachable by the health-care practitioners, and made an effort to be helpful. As one AHCF member stated:

Ahcf 2: I would like that kind of dialogue to be encouraged to some degree. Because again I think there is potential for us to support them, financially if there that we need to get for them if we can work it out, certainly it has happened in the past where we have tried to.

Another AHCF member supposed that there might be issues of patient-practitioner confidentiality that also potentially affected the level of communication between themselves and the practitioners:

Ahcf F3: So I don’t want them to feel discouraged about coming to us but I don’t know there are issues around confidentiality or not, I don’t know if there is, or I kind of wonder about that . . .

5.2.5 “Is integration happening at the AHC?”

Given that most health practitioners and some AHCF members had not met all the health-care practitioners, and given the ambiguity surrounding the concept of teamwork, the question “Is integration happening at the AHC?” was bound to elicit a range of responses. According to one CAM practitioner, who had worked at the AHC for several years, integration was happening
because she had some referrals and contact with a couple of the biomedical practitioners working at the AHC:

Q: So then would you say that integration is actually occurring at the AHC?

CAM_HP5: I think so, but not as well as it could be. Because for example . . . [BIO_HP 1] will talk to me about a difficult case, she won’t just refer; she will sometimes talk to me if it is something in particular. I have called on [BIO_HP 2] and briefly discussed something when it is a question of medication management. I certainly look at the other health professionals and haven’t taken advantage let’s say with something that is physical and emotionally related.

However, for a biomedical health-care practitioner, referrals did not necessarily define integrative health care. This was her answer to “is integration happening at the AHC?”:

BIO_HP 4: No not necessarily, but it is not because they don’t want to but it hasn’t evolved to that, and I do think at least in part now we are already collaborating. We cooperate and collaborate to a degree . . .

A CAM health-care practitioner echoed this sentiment during the face-to-face interview:

Q: So this is an integrative health, occupational health clinic . . .

CAM_HP 3: Only in name . . . in my opinion. I don’t see it any other way. If you describe it that way, I know that’s the vision I am on side with the vision being important but I don’t know how anyone could say that that is what it is . . . .unless we say, OK but constant referrals are coming through a medical practitioner and then perhaps are going on to a non-medical practitioner, that’s integrated, but that’s pretty well stretching it right? What we have is a lot of disciplines, which are available to refer to, but I don’t see how it is integrated at all really. I don’t mean for that to be a criticism but that’s just how it is working and I don’t know if that’s doable. Don’t know if it is necessary, it’s nice, I’ve seen films and I’ve read studies about integrative care and it’s attractive . . .

He further discussed his discomfort with telling clients that the AHC was an integrated occupational health clinic:

CAM_HP 3: I mean, but the biggest question I don’t know, that I would ask really, is that is it reasonable that we think of ourselves as doing integrative medicine or not or should we forget that, I don’t know who’s going to ask that . . . and spend our energy on doing what we are doing in a more efficient way. If need be. I don’t see anything wrong with a clinic which offers various services and a consult if and when necessary, but let’s just name it that . . . then we would all feel better about living up to at least I would feel better, because when someone comes here and say, “oh, you do integrative medicine”?
However, according to the majority of AHCF members, the whole premise of the AHC was based on integrating CAM and biomedical health-care practitioners into a team for improving services and delivery of care to artists. As one AHCF member put it:

AHCF 3: I think that is one of the elements of this whole endeavour is that it has really been about people coming together and trying to make things work and obviously that kind of culture has to want to create a truly integrative care clinic.

5.2.6 Summary

Overall, each respondent had different ideas regarding the level of communication and its relationship to integrative health care. Some health care practitioners believed that referrals and brief consultations qualified as integrative health care, while others believed that there was a need for more in-depth consultation in order to achieve a more integrative approach to health-care at the AHC. This discussion is expanded below, where informal and formal communication tools that facilitate or serve as barriers to communication and integration at the AHC are examined.

5.3 Mechanisms for Interaction

Two types of communication at the AHC were described, informal and formal.

5.3.1 Informal Methods

Informal types of communication included hallway consultations, quick telephone calls, e-mails, and even sticky-notes posted by health-care practitioners to the patient charts. Formal types of communication included documenting patient visits, diagnosis, and recommendations in a patient chart, and staff meetings. The health-care practitioners described both types of communication as dependent on a shared language.

As noted above, most of the health-care practitioners agreed that they did not often talk about patients and when they did, communication between them was very informal. This kind of communication is illustrated here:
FG HP BIO 2: Occasionally we talk about patients but that is only about 10 percent of the
time. So I know, I guess I know, I have spoken to people but I think it is mostly talking to
people in the hallway.

Q: So could we look at communication first and just talk about the methods of
communication amongst yourselves.

FG HP BIO 1: Well it is pretty informal, well I mean sometimes we call or e-mail, or
hope to run into somebody in the hall. I would say for me that is the primary method is
face to face . . . look for somebody in the hall, look around outside your office.

Although most of the biomedical practitioners said that they were comfortable with this
type of informal communication, a few of the CAM practitioners were not comfortable with the
lack of structure in informal methods of communication. A CAM practitioner expressed concern
that the informal hallway consultations might jeopardize practitioner-client confidentiality:

Q: There is no formalized structure for you or [BIO_HP 1] or anybody to talk about
patient care?

CAM_HP 3: No unless there is a two-minute rush-rush, [BIO_HP 1] grabs me in the hall
rush, rush, talking with the door open so everybody can hear, which freaks me right out,
because it is what I consider very confidential and private and I am used to working in
that kind of environment. So for me that’s an issue right there. . . . Now what she does
with others and how others may relate I don’t know.

5.3.2 Formal Methods

For formal communications, AHC health-care practitioners used standard tools such as
charting. Common in most health-care settings, patient charting involves the process of entering
diagnostic, prescriptive, progress or other notes regarding the patient, which are then kept in a
main patient file. However, charting took on different meanings when CAM and biomedical
health-care practitioners used the same patient file.

The chart, in essence, was deemed by the majority of health-care practitioners at the AHC
as an ineffective communication tool. Issues emerged that were common to most practices, such
as unruly handwriting, and when CAM and biomedical health-care practitioners used one chart,
issues of language and style also created some difficulty.
It was not surprising that “messy” handwriting was a charting issue at the AHC. During the focus group a CAM practitioner described her inability to read a patient chart due to messy handwriting:

FG HP CAM 4: And also something that I was experiencing was not being able to read peoples handwriting very well on our charts. And I use the charts a lot . . .

A biomedical practitioner said he was frustrated with the lack of systematic charting, and therefore he did not read the patient charts:

FG HP BIO 2: We could do a whole other focus group just on the charts you know what I am saying . . . I don’t even read, I barely read charts that’s terrible to say but there is no systematic charting, because we have never come to conclusion or consensus how we are really going to chart, is it going to be done by professions, or are we just going to doodle along . . . and then the reality is that there is also a whole vocabulary and nomenclature and a way of charting that physiotherapists use, that I need to be educated about.

The issue of biomedical language in particular was discussed during the focus group with the health-care practitioners at the AHC. One CAM practitioner explained how difficult it was to understand some of the acronyms that the other biomedical practitioners seemed to take for granted:

FG HP CAM 4: I am going to get her [biomedical practitioner] to tell me . . . what she is doing and to learn what she means by “SOT”?

FG HP BIO 4: Yeah, but that is standardized charting formula.

FG HP CAM 4: Yeah . . . “well that is sort of a medical convention,” yes it is but if you are not part of a medical model, and this is the issue here for us is that we have to figure out a way to include every one and to make sure that we don’t get caught up in the medical model because we are trying to do something innovative here . . . And also I didn’t know what SOT was but I am really excited to learn about it because it seems like it is very good, and I have actually started to use it myself a little bit because it makes sense.

FG HP BIO 3: It is really a very simple method; it is just sorting your information.

In addition to the difficulty of understanding the acronyms, some of the biomedical practitioners seemed to take for granted that the language used in the charts could be difficult to interpret if you were a practitioner that did not use the same terminology. Here, a biomedical and
a CAM practitioner dialogue about the CAM practitioner’s difficulty in deciphering a particular biomedical practitioner’s chart notes:

   FG HP BIO 4: I interpret hers (biomedical practitioner) easily though. I can interpret [biomedical practitioner’s] writing . . .

   FG HP CAM 4: Because you talk the same language.

5.3.3 Summary

Overall, with respect to both formal and informal communication, the majority of health-care practitioners agreed that more effort needed to be made to ensure communication channels were open and clear amongst the health-care practitioners at the AHC:

   FG HP BIO 1: I think we need to look more seriously at some communication channels amongst the practitioners, I think we have to be very proactive, making sure we communicate more regularly rather this come as things may come. Because myself I am not a practitioner who does well with hallway consultations I forget stuff and I worry about that, when I don’t get a chart.

   The majority of health-care practitioners said that the mechanisms of communication were informal and that they did not often talk about patients. They described how there were no formalized structures in place to facilitate communication. This was deemed problematic from a patient-confidentiality perspective; for example, hallway consultations were not always private.

   Formalized mechanisms of communication included charting; however the majority of health-care practitioners, particularly the CAM practitioners, said that, currently, the AHC charts were neither readable nor systematic in their structure of reporting, and thus not useful.

   The following section describes the consequences of minimal interactions for IHC at the AHC.

5.4 Consequences of Minimal Interactions

   A formalized structure of communication had not been established, creating a lack of communication and integration. As a consequence, the majority of respondents felt there were disadvantages to health-care practitioners’ work environment and personal growth. First, they
believed the lack perpetuated a lack of understanding regarding the scope of practice of each health-care practitioner. In turn this led to a lack of referrals for those who were least understood (in this case, the CAM practitioners at the AHC). Second, the lack did not allow for practitioner confidence to be established and nourished. Third, the lack of communication and integration among the health-care practitioners, hospital administration, and AHCF continued to limit and keep health practitioners at the AHC disconnected from the larger hospital/community resources.

5.4.1 Practitioners’ Scope of Practice

One biomedical practitioner pointed out:

BIO_HP 4: I sort of have an idea of what a naturopath does but I am not sure how what I do integrates with that. I do know for a lot of... a lot of the way we manage patients, there is a lot of overlap and there may be a lot of overlaps in a lot of our philosophies and our approaches, but there may be places where we differ as well, I am just not that familiar yet.

Even the thought of familiarizing oneself with the different modalities was described by most of the health-care practitioners as a daunting task. A CAM health practitioner said:

CAM_HP 4: I would like to talk more with [CAM_HP 2]. We cross paths a little bit. You know all our fields are so complex and huge it is almost like “where do you start?”

Furthermore, not knowing other practitioners’ scope of practice had a direct effect on referral patterns. The majority of health-care practitioners said that they would not refer their patients to a modality that they did not understand. For example, one biomedical practitioner stated that unless a patient requested it, she would not refer to a modality that she was unfamiliar with:

Q: So then would you refer to someone when you don’t really know what they do?

BIO_HP 1: I wouldn’t, but I wouldn’t hesitate to facilitate them [artists] going if that is what they want providing that I had a sense that they knew what safe practice was.

The majority of CAM practitioners echoed this belief. For example, in a dialogue with a CAM practitioner:
Q: So do feel like you know enough about each discipline to be able refer a patient to a naturopath instead of a medical doctor or to an osteopath instead of a physiotherapist?

CAM_HP 3: No I don’t know that I would feel really comfortable with that. . . . Certainly I would have some sense of whether or not medical intervention would be necessary and some opinion of whether or not it shouldn’t be part of the equation. As far as homeopathy and osteopathy, I don’t really know enough.

The CAM practitioners who were least likely to get referrals were asked about referrals. They attributed the lack of referrals to the (mostly) biomedical practitioners’ lack of understanding of their CAM therapy/modality:

CAM_HP 6: I don’t think that most people know what osteopathy is, so how are they going to refer to an osteopath when they don’t even understand what the difference is between osteopathy and maybe physio. . . . So that’s part of the barrier too with these alternative therapies coming in.

For clarity, I asked the CAM practitioner with the least number of referrals who referred to her and why. She stated that none of the biomedical practitioners and only one CAM practitioner had referred patients to her. She believed that referrals depended heavily on knowledge of scope of practice:

Q: And in terms of referrals, who has referred patients to you?

CAM_HP 6: [CAM_HP 2] and that’s it.

Q: And can you think of perhaps why that is?

CAM_HP 6: I think it is because he is probably the only one, who understands what osteopathy is, because he is in a more alternative discipline, he has probably had more exposure and more knowledge of osteopathy. Part of it with the other physios it is a really grey line between osteopathy and physiotherapy there is a lot of overlap. There are distinct differences but there is a lot of overlap, so that is difficult especially for someone like [BIO_HP 1] who is doing the intake work and deciding who they should be sent off too, that can be challenging. So unless somebody comes in and asks for osteopathy or cranial sacral something that is distinctly not physiotherapy I am not sure that she knows what osteopathy could do as opposed to physio . . . and I am guessing that the other practitioners don’t know what osteopathy is, that is my guess I don’t know.

A CAM practitioner pointed out that it was easier to rely on models of care and health-care practices that practitioners were most familiar with:
CAM_HP 1: I just think it depends on the model you come from. If you come from the medical model the MD refers to the physio, and then the physio does their thing and there’s not so much inter relating. So I think to be integrated, there needs to be inter reliability and inter communication on an ongoing basis, and I am not negative on it I know it is young.

Several health-care practitioners said that they wanted to learn and better understand how each health-care practitioner’s scope of practice related to their own and how they could support each other in providing better patient care. In a dialogue with a biomedical practitioner:

Q: So if you don’t have any idea of what an osteopath does then would you refer [to one]?

BIO_HP 4: Well for me I have an idea of what an osteopath is, I am certainly eager to learn more because I don’t know where I would or under what circumstances I might refer to an osteopath, I don’t know where we mesh or where we connect. I think there might be potential to do that but I don’t know where that is right now. I have some idea about chiropractic because I have worked with chiropractors before. But again there can be differences in philosophy, which doesn’t mean there is a ruling out of being able to integrate those things, it is just an awareness, we co-exists so we might as well make the best of it.

With regards to supporting each other in their practice, a CAM practitioner stated:

CAM_HP 4: I need to understand what the other practitioner doing because a lot of them do refer to me or the patients themselves self refer for [health service], so I need to be able to be supportive around their Naturopathy or their psychotherapy or their osteopathy or their physiotherapy so I need to be able to understand that.

5.4.2 Practitioner Confidence

Second, and linked to providing support to one another, was the concept of practitioner confidence. The idea of practitioner confidence was not a question in the interview guide and if it did not emerge organically from the interviews or focus groups, the question was not directly asked. However, most of the CAM practitioners said that communication and integration among the different modalities could increase practitioner confidence and help them grow as practitioners. Conversely, the biomedical practitioners did not discuss the link between integration and practitioner confidence. I asked a CAM practitioner to imagine how integration might look:
CAM_HP 3: It is kind of hard to imagine what it would be like if we did meet regularly, you know someone’s actions might change if they had more of a sense of how it would work, have an idea or practical experience.

Q: Would you be able to expand a little on your idea of what it might look like?

CAM_HP 3: Well I would think there would be, I think the over all confidence level of the practitioners, all of us medical and alternative would increase if we had a format to talk openly about what we are thinking what we are struggling with what we are not sure about in a forum where there are people of different mindsets and different lens that they are looking through. I think that would be exciting and would build the confidence level that I could easily go and ask and not feel like I was in jeopardy in any way or so but that would take time and some familiarization.

Another CAM practitioner hypothesized that an element of self-consciousness occurs when one is not familiar with the scope of practice of other health-care practitioner in the clinic:

CAM_HP 2: I think the practitioners suspect that there is something I could do naturally, but they haven’t conferred with the case so they are reluctant right and they don’t want to be embarrassed. For example, if I refer someone to the chiropractor for labour pain and the chiropractor says, “I can’t treat labour pain in your pelvis and I can’t help you with that, that should have gone to the osteopath,” right. So it embarrasses them, so they feel like they don’t really know the full scope of what a person can and can not do they don’t really want to recommend them, because as a professional when you recommend you are accountable for that recommendation.

Another CAM practitioner said that increased practitioner confidence was linked to the ability of not taking ownership of patients; explaining this, she stated:

CAM_HP 1: So I think there has got to be a lot of respect and personal confidence that there is not that ownership of the patient, and it [IHC] really is for the good of the patient. And I think it really it’s that thing that really needs to be reminded [to practitioners] because, yeah, there is overlap.

5.4.3 Access to Resources in the Larger Community

The AHC health-care practitioners said that a lack of communication and integration, coupled with the clinic’s unique location (in a hospital), meant that they felt isolated. They did not know if there was a network that could be tapped into, and they described feeling like the larger hospital community was completely unaware of their presence. Both the CAM and
biomedical practitioners said that there was no outside network of specialists to consult with at the hospital. One CAM practitioner pointed out:

CAM_HP 3: Who is available if I want to consult not with a medical doctor but with a [specialist]? Someone who not only prescribes drugs, but someone who is familiar with [my field]. I mean, am I the chief person here? I mean that’s the way it operates. Now I haven’t had a strong need for that, but it would nice to know, to meet someone to know I had the backup available, as far as I know, there might be someone, but I have never been told that this is the person or person’s or office. . . . I don’t really know what other services are available here. . . . So there is some work on the hospitals side on how to integrate people into the hospital and what is it all about there is nothing that happens here as far as I know. I was told there is nothing.

One biomedical practitioner echoed this:

BIO_HP 3: I think . . . our biggest challenge is that we don’t have very many specialist practitioners – that’s my biggest concern. I would like to have an orthopaedic surgeon that I can just call the secretary and say I have this case, you know that I don’t send you anybody unless I need to, can you see them at that time? We don’t have groups that are interested in us.

During the focus group with the hospital administrators, they discussed the future prospects for building a network of health-care practitioners outside of the AHC. Two of the hospital administrators described this as an opportunity in progress:

HA 1: Opportunities are there to link to physicians who are known to provide care to the art people, to the founding school these other areas, to try and pull them into the equation.

HA 4: Yeah that’s true, I mean we are looking into that we are having a meeting in January with [HP outside of AHC] and so we are starting to some more of that kind of work. It is not like we have a list of folks who are well recognized and when the need arises we say . . . you should go and see this person. We are actually trying to establish more of a relationship with them now.

Q: So a network of specialists is starting to develop?

HA 1: Yeah.

According to the majority of AHC health-care practitioners, the sense of not knowing what was available, or even what they could ask for, had implications in their everyday practice. A few of the CAM practitioners said that were not aware of what they were entitled to ask for from the hospital administrators and/or AHCF board. One of them stated:
CAM_HP 6: Maybe, and knowing what we can ask for, is it feasible for me to say, I want these couple of posters up in the room, I would like a spine a model of a spine, I would like this anatomy book that has these pictures because when I talk to people about what there injury is I refer to these diagrams so I would like to have this anatomy atlas . . . you know things I use often in my treatment. I don’t know if it is feasible for them to provide me with this stuff or not. But you know it would be great!

5.4.4 Summary

The majority of health-care practitioners described how a lack of communication amongst them contributed to a lack of understanding regarding scope of practice and how to integrate. This had a direct effect on referral patterns between health-care practitioners at the AHC.

Some health-care practitioners said a lack of communication and integration had a direct effect on the level of their confidence. The majority of respondents described an element of self-consciousness when they were not familiar with the scope of practice of other health-care practitioners; according to the CAM practitioners, this was a limiting factor in communication and integration. Interestingly, only the CAM practitioners (during the individual interviews) discussed this issue. The importance of the issue was only realized at the time of report writing – it was not part of the focus group guide, so it had not been probed during the interviews or focus groups. It would have been interesting to explore whether the biomedical health-care practitioners at the AHC made the same link between integration and self-confidence.

Lastly, the majority of health-care practitioners believed that a lack of communication and integration kept them away from a wealth of resources. Given the unique location of the AHC in a hospital setting, both CAM and biomedical practitioners noted that it would be beneficial for themselves as practitioners and for their patients if they had a larger referral system (comprising specialists) within the hospital. They wanted to know what was available, what they could access, and what they could use for their everyday practice at the AHC.
In the section below, respondents were asked to consider strategies for improving communication and integration between the health-care practitioners, the hospital administration, and the AHCF.

5.5 Improving Communication and Integration

Respondents were asked to reflect on what they believed would assist in improving communication and integration. Three overarching themes emerged from the interview and focus group data. First, most of the health-care practitioners and some of the AHCF members suggested having face-to-face and/or virtual team meetings. In addition, the respondents said that e-mail exchanges and electronic technology could help facilitate some of the current issues in communicating and charting. Second, the majority of health-care practitioners expressed the need to review the current leadership at the AHC on two different levels: managerial (hospital administration) and practice (team leader for health-care practitioners at the AHC). Third, the majority of respondents believed they could engage in activities both within the AHC and within the hospital community to increase interaction, communication, and integration. Respondents described the need to forge networks and an awareness of the AHC in the larger community within the hospital.

5.5.1 Staff Meetings

The majority of health-care practitioners strongly believed in the benefits of staff meetings. For this CAM practitioner, meetings should be formalized and attended on a regular basis:

CAM_HP 2: I think it should be formalized, and I think the best way to do it would be a regular meeting. I think we should have weekly rounds, I think clinicians should meet once a week, I know that difficult given the number of clinicians we have, but that is something to be discussed in a logistics, to be planned around, we should definitely meet weekly. What is good about that is that everybody gets to have a voice; everybody gets to present what they have done. And it allows the other practitioners to get an idea about the types of cases you see, and the types of treatments you’ve preformed and your success, and your challenges and it allows them to make suggestions. . . . I think, as a general rule,
not everybody has an idea of what everybody else does here. This way discussing it openly and presenting your patients, you wouldn’t present every patient, but you present the ones you think are relevant then you have a better idea of what you should be referring who you should be referring them to, and what people’s scope of practice is.

Given my personal experience with scheduling a focus group with the health-care practitioners at the AHC for this thesis (see chapter 3), I questioned the CAM practitioner about the logistics of weekly meetings. He went on to say that these meetings, in addition to being held weekly, should be made mandatory:

CAM_HP 2: I think the solution is you just make it mandatory. I think it is just one of the mandatory requirements of participating in the AHC. No one likes the word mandatory, but mandatory works; if you make the meetings elective, you are going to get irregular attendance, and it is going to be frustrating.

The majority of the health-care practitioners did not agree that weekly meetings were feasible. However, almost everyone thought that monthly meetings were reasonable and essential for integration. Most of the health-care practitioners said that they had believed that meetings, especially ones without pay, were not the most convenient to attend. However, they generally stated that importance of these meetings often outweighed the barriers of convenience and money. As one CAM practitioner explained:

CAM_HP 1: Let’s just have it out – it is not convenient, but it is essential so something needs to happen. . . . But I do agree that there should be a structure and there should be. . . . I think weekly is just totally unrealistic and is going to get some negativity. Where as, “can you make a space once a month or once every two months,” because you care about it, and if there is money for it that’s even better.

According to several of the CAM practitioners, in an ideal world, those monthly meetings would be held during the hours that most of the health-care practitioners were already at the AHC and would also be funded. As one CAM practitioner stated:

CAM_HP 3: Well I think there would have to be a time, during the week a time for, a much more flexible time for meeting with people. Or time during when I am here, in my case time when I am being paid to be here for that purpose, having that scheduled in. And that’s another problem of course, trying to get people together for meetings is very, very difficult, because most of us are private practitioners up here and medical staff is very busy as well. But I think if there were time during the week or during the day, even . . .
don’t know, I would have to brain storm that a little bit but, and maybe we will doing that at this retreat thing I don’t know, but it could be with, well that everyday there is an hour that it’s sort of a drop-in, that whoever is on can take 15 to 20 minutes, can come to this room or whatever room and see who is in and do they want to talk about it or it could be by patient . . . I don’t know.

As opposed to in-person meetings, one of the biomedical practitioners suggested the AHC embrace technology and explore the possibility of holding virtual meetings:

BIO_HP 1: I think the other thing I would like to see is us being a little more proactive around complex patient care planning, and complex case conferences, and we may not be able to do it in person but maybe we need to start having some kind of chat rooms or some kind of secure interactive e-mail thing where we can start to do some of this, so I mean it is tricky in terms of technology age, in terms of patient confidentiality, but I think those are things I would like to do.

The majority of AHCF members agreed that both virtual meetings and electronic records would provide channels for communication between health-care practitioners. As one AHCF member explained:

AHCF 4: There needs to be electronics, they have to, if they can’t all meet in person, they have to somehow [meet virtually] . . .

E-mail could be useful not only between practitioners at the AHC, but also for keeping the lines of communication open between health-care practitioners and artists. Artists in the focus group discussed using e-mail and/or other features of the Internet as a method of being kept informed about their care. One artist said e-mail could be used for follow-up:

ARTIST 1: Or even for patients who have not been there for a while, to just pop out an e-mail to find out how they are doing as a forum for feedback. Western does tend to treat the ailment rather then the patient. And the Artists’ Health Centre seems to be trying very hard to treat the patient rather then the ailment, so in a way you could stream, using technological tools like the Internet and e-mail probably would be helpful.

According to the majority of health-care practitioners at the AHC, electronic health records would not address the issue of biomedical language; however, it would make reading the charts easier. A biomedical practitioner suggested colour-coding each modality as a method of making the chart more accessible to all health-care practitioners, so when practitioners opened
the chart they could identify right away who one’s patient is seeing. As one biomedical practitioner in the focus group suggested:

FG HP BIO 2: We all make decisions for the sheets that we should use – it is just that we honestly haven’t. Different colours for instance, if naturopathy would use yellow, and physiotherapy would use red or orange so you know it would be a nice easy way I could say “oh, yellow sheet there,” she’s seeing naturopathy – as I said we haven’t come to that.

5.5.2 Improving Current Team Leadership

The majority of health-care practitioners and AHCF members expressed the need to review the current leadership at the AHC on two different levels. At the managerial level, the majority of practitioners and AHCF members pointed to the presence of a hospital administrator whose portfolio included the AHC, and who was perceived to be very effective. The position had been created to establish better communication channels between AHC health-care practitioners, hospital, and AHCF. It was made very clear in the focus group with AHCF members that directing communication through this person – who would liaise with the hospital, AHC health-care practitioners, and the AHCF – was critical to effective communication. All AHCF members said that they were quite pleased with the current arrangement between the foundation and the hospital. One AHCF member explained that, through this person, their needs and concerns were being heard by the hospital:

AHCF 1: [HA 1] . . . makes me certainly feel more confident about our needs being represented there [at the hospital], and he is responsive to us and he is on board. We don’t feel anymore that we are constantly knocking our heads against a wall, we can hear the words coming out of our mouths, but we don’t feel that they are being received and I don’t feel that is true now. I feel very comfortable with [HA 1] in place, because he really does get it; he really is into the committee, and the whole foundation’s approach.

However, as discussed above, some questions remained regarding authority and decision-making power between the hospital, AHCF, and health-care practitioners.

At the practice level, the nurse practitioner took on a leadership role, but the majority of AHC health-care practitioners expressed the need for a review of that role. The majority of the
part-time health-care practitioners believed that a designated and formalized “team lead” would help to keep everyone on the same page. Having a go-between person that could provide updates to the group could also potentially improve the lines of communication among practitioners and potentially between practitioners, the hospital, and the AHCF. As two CAM practitioners explained:

FG HP CAM 4: One of the things that might facilitate better communication amongst those of us who are part-timers is somebody who is dedicated to the AHC. The is not at this particular time, nor has there ever been as I understand it, anyone who has dedicated 100 percent of their time to the AHC, most of us have, our time is split. Even [hospital administrator] admits that his time as the administrator is something like .2 percent of his entire job. So in my opinion it would help a lot of things if we could envision some time in the future somebody who is the go to person who is a constant in the AHC.

FG HP CAM_1: There may need to be a team leader if I could say at the heart of it. . . . I don’t necessarily think it could fall to [hospital administrator] or don’t know who it could fall to, but that also may be a thing where there is no leader . . . for this six months you do it and it [leadership] rotates [among the health practitioners] . . . you know that you are the hub that we would bring things to, which you know is great for communication because then the information gets disseminated properly.

The AHCF members concurred that there was a need for a formalized leadership or coordinator role to help bridge the communication gap among the health-care practitioners at the AHC. They also felt that ideally it could not be any of the current health-care practitioners at the AHC as they were already very busy with patient care:

AHCF 2: It can’t be [biomedical practitioner], she is so busy with everything else that we need to . . . we almost need another position . . . a coordinator position, which was something I had never thought about in integrative medicine but I think you are right in this case. Especially if we are trying to be integrated . . . and it is not right now and we know that.

A “team lead” would not only assist in creating a communication channel amongst the health-care practitioners at the AHC, but would also be charged with knowing each practitioner’s scope of practice. As one AHCF member said:

AHCF 1: The problem is, as we are finding out, the practitioners don’t really know much about what the other practitioners do, so you would have to have a really key person there
who really did know what all the other modalities were and someone who would be willing to spend the time doing it.

5.5.3 Networking to Increase Interaction, Communication, and Integration

Within the AHC, professional development activities, such as seminars and presentations, was believed by most health-care practitioners to be a good start to increasing interaction, communication, and integration. For example, one CAM practitioner suggested:

CAM_HP 6: We could try having seminars, have a talk on what it is, and what we do and what it can benefit. But I think it will only help to a certain extent, but it could be something. But that could be something just have a “What is osteopathy?” for an hour and I could do that, [HP 2] could do that, all the different practitioners could do that and they could even talk about all the different areas and specialties they have and just get to know who we are and what we do.

Moving “beyond introductions,” another CAM practitioner suggested that each practitioner offer a sample of one of their treatments:

CAM_HP1: Yeah, one thing I could suggest, beyond an intro meeting where we say “this is what I do” which still may not mean anything, I mean it would great to actually go to a person for a treatment, I think that would be a great suggestion.

Once there was a better sense of team, the health-care practitioners felt it important to bring the AHC to the attention to the rest of the hospital community. The majority of health-care practitioners strongly believed that they should be more involved with the hospital through presentations and awareness campaigns. A biomedical and CAM practitioner suggested the following:

BIO_HP 3: But what I think would actually help too would be for us, all the practitioners to actually go to the whole hospital and maybe do a presentation to them and maybe do a little bit that we do to introduce ourselves to each other that we do that too the whole community of the hospital.

CAM_HP 2: I think what would be good too is if our practitioners were a bit more involved in other areas of the hospital. . . . I’ve been to other parts and units in the hospital and they don’t even know there is an AHC.

To make connections and increase their network capacity outside of the hospital community, some of the health-care practitioners expressed the need to be supported financially.
by the hospital and/or the AHCF to pursue research interests, and disseminate their research findings at relevant conferences. One biomedical practitioner suggested:

BIO_HP 3: To keep our vision of integration and part of being integrated, integrated also into our own community. So you have to go out and talk to other places, and again to bring more people in, I think it is not to forget to support the practitioners who are not employees and to support them into conferences and things like that and make sure there are funds and things for them available for that. To help present and increase the profile of the place and to really show that there is a lot of expertise here that maybe other people are not aware of. So I think of that is more, yeah, I think it is more that they don’t forget that we are actually a big part of the centre . . . and sometimes it is just recognition and stuff and the foundation has been very good. I know with me personally and stuff but I think sometimes the other people they feel a part of the group by being asked to go to different things . . . and it is not just “oh, it is another volunteer thing that we have to do” and I sound like, I mean, I don’t mind doing volunteering but there is a lot of work that has to be done towards conferences and things and we have to work through it.

5.5.4 Summary

Respondents explored the possibility and potential of scheduled and formalized meetings, either in person or through some form of technology. The majority of health-care practitioners saw technology as a communication tool that might, potentially, assist with charting. The health-care practitioners and AHCF members discussed the importance of having a champion or team leader who would not only be the hub of information, but could also act as a liaison between the health-care practitioners, hospital administration, and AHCF. Although these roles currently exist, they argued that a more formalized role could assist with integration. The health-care practitioners anticipated that as the communication channels within the AHC developed, they would create opportunities to expand and reach out to the larger hospital community. Through professional development opportunities (both within the AHC and in the hospital), the health-care practitioners expressed a need for the AHC to be recognized within the hospital as part of its “map.” In addition, the majority of health-care practitioners said that they required support to attend conferences as a way of showcasing and expanding the already existing expertise they have in artists’ health.
5.6 Summary

This chapter began by drawing attention to the communication patterns between and among health-care practitioners, hospital administrators, and AHCF members. The data revealed information regarding perceived challenges to communication (and hence integration) at the AHC. Most respondents described the level of communication between the health-care practitioners at the AHC, the hospital, and the AHCF as “sporadic,” “minimal,” or “non-existent.” The literature on teamwork and collaborative practices between health-care practitioners (mostly biomedical; see chapter 2) encourages partnerships between a team of health-care practitioners and patients, to share decision-making around health issues so as to achieve improved health outcomes of patients. The majority of AHCF members believed that teamwork was an important aspect of integrative health care, while most health-care practitioners believed that the complexity of the patient’s issues, patient safety issues, and the need for follow-up (“closing the file”) dictated whether teamwork was necessary or desirable. Interestingly, only the CAM practitioners discussed patient safety and follow-up, not the biomedical practitioners. Perhaps this was due to the long history of biomedicine working to convince the general public that CAM therapies are not based on scientific enquiry and thus not the most effective approach to health-care (Baer, 2001). In order to survive, CAM practitioners at the AHC seemed to have internalized an implicit awareness that biomedicine holds most of the cards in defining roles and relationships. For this very reason, there is a fear that any potential adverse biomedical/CAM interaction could risk the legitimation of CAM in the eyes of biomedical practitioners, the hospital, and funding from the AHCF to continue their work at the AHC.

The artists had mixed reactions to collaboration/teamwork, ranging from believing it to be unnecessary, to not knowing if it even occurred, to feeling that it might breach issues of confidentiality between patient and practitioner. The respondents seemed to have a clear sense...
that there were other team members available for consultation, but this did not necessarily lead to any encounters between the groups involved at the AHC. The majority of respondents agreed that the direction of communication between health-care practitioners, the hospital administration, and the AHCF was often one-sided, and thus not optimal for creating a collaborative environment. For example, the health-care practitioners said that they had never been asked by the hospital or AHCF for their vision or interpretation of integrative health care. Incongruence between visions of IHC could limit communication and integration. Therefore, although teamwork holds the possibility to enhance the organization of the AHC as an integrative occupational health clinic for artists, very likely the health-care practitioners at the AHC will not truly benefit from teamwork unless sufficient communication, trust, and openness enables the various health-care practitioners to feel comfortable in expressing their own, unique opinions and perspectives on patient care.

A lack of communication and integration between health-care practitioners was seen as contributing to a lack of understanding regarding scope of practice and how to integrate the various health-care practitioners, particularly CAM. For example, if the physiotherapist and the chiropractor did not understand each other’s scope of practice, few, if any, referrals would be made between these two health-care practitioners. According to the majority of CAM practitioners, unfamiliarity between health-care practitioners, hence the lack of referrals to certain modalities, affected the CAM practitioners more often than the biomedical practitioners at the AHC. This parallels the current biomedically dominant Canadian health-care system, even though some CAM practitioners appear to be gaining a slow, yet significant change in status.

CAM practitioners also stated that a lack of communication and integration also had a direct effect on a practitioner’s confidence level. Some of the CAM practitioners explained how unfamiliarity with the various modalities available at the AHC led to certain level of self-
consciousness and uncertainty and that this was a limiting factor to better communication and integrative health care. The majority of respondents, particularly the health-care practitioners, believed that a lack of communication and integration kept them away from a wealth of resources. Given the unique location of the AHC, in a hospital setting, both CAM and biomedical practitioners explained that it would be beneficial to both themselves as practitioners and for patients if they had a larger referral system (comprised of specialists) within the hospital.

Interestingly, each respondent had different ideas regarding the level of communication and its relationship to integrative health care. Some health-care practitioners believed that referrals and brief consultations qualified as integrative health care. Others believed that there was a need for more in-depth consultation in order to achieve a more integrative approach to health-care at the AHC. Regardless of how health-care practitioners at the AHC defined integrative health care, they all agreed that existing mechanisms of communication were too informal, and no formalized structures existed to facilitate communication or integration with each other – no scheduled team meetings, and no agreed-upon arrangements for patient charting among the health-care practitioners at the AHC.

More specific to a lack of communication, most respondents were quite clear on the importance of “speaking the same language,” whether it was between the AHCF members and the hospital administrators or among the CAM and biomedical health-care practitioners at the AHC. For example, the CAM practitioners at the AHC discussed what they perceived as challenges that they faced with understanding the biomedical language in patient charts. It would seem that the patients/clients who demanded CAM services, and the CAM practitioners (who now outnumber the biomedical practitioners), are now in a position to exercise countervailing power as their numbers grow and they gain acceptance with patients/clients, other biomedical
health professionals, and the hospital (a biomedical institution). However, to date, there have been no corresponding changes to the charts, as proposed in the focus group.

The respondents explored the possibility and the importance of having a “team lead” who would not only be the hub of information, but could also act as a liaison between the health-care practitioners, hospital administration, and professional development opportunities as strategies for improving communication and integration (both within the AHC and in the hospital). The data reveals issues with various deficits – of communication, of formalized mechanisms for communication, of understanding the scope of practice, and of referrals – pointing to the need for more effective leadership at the AHC. Respondents, particularly the health-care practitioners at the AHC, were looking for various changes to happen, such as formalized and regular meetings, more efficient mechanisms for communication, and more presence beyond their own setting. In addition, the majority of respondents believed that a team lead would be someone who could communicate with everyone, especially those who are there on a part-time basis, to keep everyone informed and engaged.

As discussed in chapter 4, external support played a major role in ensuring that the logistical barriers of implementing integration at the AHC were overcome. For example, the impact of the administrative processes on integration requires consideration of layout, funding, and scheduling.

The following chapter will examine the attitudes of health-care practitioners, artists, hospital administrators, and AHCF members toward IHC at the AHC, and the knowledge and skills required to move IHC forward at the AHC.
CHAPTER 6
KNOWLEDGE OF AND ATTITUDE TOWARDS
INTEGRATIVE HEALTH CARE

Multi-professional “teamwork” has become the preferred model of practice promoted for many areas of health care by policy makers, professional bodies, and health-care organizations (Oandasan, Baker, Barker, Bosco, D’Amour, Jones, et al., 2006; Way, Busing, & Jones, 2000). The model is based on the assumption that when specialists working in health-care teams pool their expertise, the work will be done more efficiently and effectively, and that patients will receive better care (Kekki, 1990). There is, however, a clear indication that, while this assumption may be reasonable, it does not always work well in practice (Freeth, Reeves, Goreham, Parker, Haynes, & Pearson, 2001; Heinemann, Schmitt, Farrell, & Brallier, 1999; Schmitt, 2001). Interprofessional pitfalls including conflicting professional and organizational boundaries and loyalties, and negative mutual perceptions and prejudices are still prevalent (Ruebling, Banks, Block, Counte, Furman, Miller, et al., 2000). The lack of respect toward and understanding of roles and contributions of other practitioners as well as poor interprofessional communication are held to be the major barriers to achieving optimal patient care (McPherson, Headrick, & Moss, 2001), and I would add integrative health care at the AHC.

Respondents of my study were asked for their understanding of how personal theories, belief systems, and leadership characteristics affect perceptions and actions related to working together for artists’ health. As described by the respondents, some knowledge, skills, attitudes, and behaviours serve as barriers or enablers to IHC at the AHC.

This chapter is divided into four sections. The first section describes the respondents’ attitudes toward IHC and the factors influencing those attitudes. The second section focuses on the knowledge and skill required to move IHC forward at the AHC. The third section examines
the issues and challenges regarding defining IHC within the context of the AHC. The fourth
section provides a summary and analysis of the previous sections.

6.1 Attitude towards IHC at the AHC

The respondents, particularly the health-care practitioners at the AHC, described three
types of influences that affected their attitude towards integrative health care at the AHC: (a)
different philosophies of care, including the influence of the existing medical hierarchy/gate-
keeping; (b) the influence of personal experience with CAM; and (c) the learning and growth
potential for practitioners who can learn with, from, and about each other.

Because of the wide range of different disciplines at the AHC, there were diverse health-
care philosophies among the practitioners in my study. For example, most of the AHC health-
care practitioners recognized that the history of how biomedicine and CAM developed were so
radically different, that it was sometimes difficult to overcome that history in their everyday
practice. As one biomedical practitioner discussed:

BIO_HPT2: It [CAM] is a different world and it works on an entirely different paradigm
than [biomedicine]. I mean it’s the “fuddy-duddy” basic scientist we [biomedicine]
deepen on – level one evidence, using a randomized double-blinded, placebo-controlled
trial. That would be the best evidence as to whether or not something worked. That’s
diametrically opposed to the historical evidence that [CAM] uses.

Several biomedical practitioners reported that the differences in paradigms between
disciplines created tension. They described themselves as struggling with the discrepancy
between evidence-based research and knowledge of their own discipline’s teachings
compared

CAM_HPT1: I am here because I love the concept and I work with artists and I love what I
do, and I want to be in the team.

The majority of health-care practitioners reported that they came to the AHC with a genuine
desire to learn from, with, and about each other. One CAM practitioner described her desire to
learn more about her CAM colleague’s scope of practice:
CAM_HP 4: It has been years since I have really done any reading in the field and you know I would love to sit down with [HP] and hear about the latest and greatest, and what his philosophy is, what he practices.

A few of the CAM practitioners hypothesized that biomedical practitioners were more likely to accept CAM modalities if they had had a personal (and positive) experience with an alternative modality. For example, even with a perceived lack of scientific evidence, several CAM practitioners agreed that when biomedical practitioners had experience with or knew of people who had success with alternative modalities, they were more open to seeing those modalities as legitimate. According to one CAM practitioner:

CAM_HP 6: In my experience doctors that refer to [CAM] . . . it’s been [that] the physicians . . . themselves have had problems or someone close to them has had problems and they have been the traditional routes and they haven’t responded . . . . So I know that has happened several times, and in those cases they [physicians] will say “I don’t understand how it works but I can see that it works” and they start to see the benefits. Even though it isn’t scientifically proven and we don’t have the scientific clinical research behind us to say “yeah, it works” . . . . They [physicians] will say, “yeah, OK, I can see that it works – I don’t understand how, but it does,” so that’s great and they will be open to it.

Several CAM practitioners at the AHC also believed that the degree of openness and positive attitude toward IHC depended on the level of confidence, experience, and maturity of the health-care practitioner:

CAM_HP1: You have to have some level of confidence in yourself, to actually show your vulnerability to another therapist of any discipline – to say “I don’t really know what to do with this person,” and I think that level of honesty, I am really interested in that level of honesty.

Another CAM practitioner reflected on her earlier experiences of insecurity when establishing her private practice and how that feeling of insecurity affected her attitude towards other disciplines/modalities:

CAM_HP 4: When I was younger in practice and especially being in private practice where clients were on a fee for service basis, I felt insecure and I always felt threatened by other therapists or practitioners and so I was very, very circumspect about whether or not I would refer out, and who I would refer to, because I would be afraid if I refer to “so-and-so” that they might cultivate that client away from me. Or in certain instances that
the other therapist or another practitioner whose modality might be useful to my client, but they don’t understand what I do so they might inadvertently undermine what I am doing by some casual remark or even not inadvertently. So now that I am very much more confidant and much more established the first concern is not an issue for me.

Attitudes toward IHC seemed to change as practitioners developed more confidence in their own modalities and were able to explore the benefits of IHC for their own professional development. Most of the health-care practitioners at the AHC believed in the benefits of integration for their own professional development. A biomedical and a CAM practitioner explained:

BIO_HP 4: It was a learning potential, when you work with chiropractors, occupational therapists, social workers, everybody brings their own stuff to the table and you learn from them and I am hoping that we will be able to be in a position where we will be able to do that here.

CAM_HP 4: I guess the more information I have and also the more support I feel in my colleagues the more I can give to the patient.

In addition to professional development, some of the health-care practitioners reported that IHC could lead to better patient care. As one biomedical practitioner explained:

BIO_HP 1: So there are two things that are going to benefit . . . the person who is going for the care, and the practitioners themselves are going to be able to expand their knowledge base.

Several artists also stated that integration could be a step toward more comprehensive care:

ARTIST 1: Whenever you go to a specialist, they tend to look at your injury in terms of what they know, and they’ll treat it on their own, but it may be helpful if two people could work together, because maybe a combination of things may work, would work for me. I am here because I have issues with my back as well. When I was in physiotherapy she worked on what she knew, and when I went to massage therapy she would just massage me. But maybe if they worked together something would have helped, because I never really resolved my problem, I still have back problems.

All of the AHCF members strongly argued the benefits of integration for both health professionals and clients of the AHC:
AHCF 3: There is a place for allopathic and there is place for the complementary and holistic medicine. Because in general the artists’ community tends to gravitate towards complementary and holistic side of it, that’s why this clinic is so unique, because if it is going to break some barriers and open up some pathways between the two disciplines and help teach, you know, the allopathically trained health professionals a bit more about the holistic side. It is something where we have to get to that point, where they are all being used in a way that is being communicated between the practitioners. I mean where it is OK to send someone off to the GP and off to the massage therapist but they have to make sure it is all working together and that they are all feeling really open about what they do, and they are always teaching each other, so that people can learn what is working and what isn’t working.

However, not everyone believed that care needed to be integrated. One biomedical practitioner challenged the notion of needing an IHC model at the AHC:

Q: What needs to happen to move into a more integrative type of health clinic?

BIO_HP 2: That makes an assumption that we need to do that.

Q: If you do. I mean if it is working fine the way it is . . .

BIO_HP 2: I mean I guess we have to say, is there dissatisfaction from the patient/client perspective that we are not looking at him/her in their totality? And then looking at the provider saying I am having a tough time working with this patient . . . . I don’t think that not being integrated for the patient population is a bad thing, and it is not efficient, it’s probably not necessary for the majority of the patients that we see. The majority of our patients come in and they have a health concern that is probably being addressed by the provider that they are seeing. Whomever they selected, either by referral, by the nurse practitioner or they themselves selected, and whether we refer to one another, I don’t think that is wrong.

Overall, the findings suggests that attitudes toward IHC were influenced by the different philosophies of care held by each health-care practitioner at the AHC; the level of maturity and confidence each practitioner had with their own discipline-specific knowledge; their personal experience with CAM; and the recognition of professional development opportunities. The AHCF members and hospital administrators strongly argued for the benefits of integrative care. Although the majority of health-care practitioners and artists seemed to agree, they reported a lack of consensus regarding the knowledge and skills required to move IHC forward, which generated some questions about how necessary and important IHC was to the AHC.
6.2 Knowledge and Skills Required to Move IHC Forward

In addition to the attitudinal differences discussed in the previous section, respondents raised the need to have a certain type of health-care practitioner, one who believed in IHC on many different levels, such as: client demand, knowledge, and understanding of the unique health-care needs of artists through the lens of IHC; and understanding the needs of the artists’ community for IHC. All respondents affirmed that artists prefer a health-care practitioner who is non-judgmental, and able to understand their occupation and help them keep working and stay healthy. One biomedical practitioner explained:

BIO_HP 1: I believe that artists feel misunderstood by the conventional health model. So they decided to try and find a centre that could integrate and pull together traditional and conventional medicine, with people who understand artists and are willing to work together.

The importance of having a specific centre, and health-care practitioners who understand artists’ unique health needs, was highlighted in one artist’s story:

ARTIST 1: I had a terrible back injury, herniated disc, and could not dance for two years so this centre [AHC] helped me so much to grow psychologically and grow physically. I couldn’t even sit in a chair. And the reason why I love the centre so much is because no one made me feel like dancing wasn’t important. They all understood that I have to do this and other [HPs] I saw outside of this clinic were not encouraging. They said, “well you have to get a new career, you know it is over,” and so unaware of the emotional impact that has. I was extremely speechless . . . so I really believe in this clinic because it is so emotionally supportive of artists and it does not minimize what they do. Because society minimizes what we do – you’re an artist you’re a play toy, you’re not important, you’re lesser in a societal way. That’s why I think it’s really important.

Even when several biomedical health-care practitioners confessed to a lack of knowledge regarding some of the CAM therapies/modalities offered to artists at the AHC, the majority of them believed in client-driven care whereby the artists themselves guided the direction of the care plan. Health-care practitioners often described their clients as savvy and acutely aware of their body and health-care needs. In one face-to-face interview, a biomedical practitioner explained:
Q: And how do you know who to refer to? I wouldn’t know – the difference between an osteopath and a physiotherapist, or when would you want to refer them to a chiropractor? And where does the naturopath fit in, in to all of this?

BIO_HP 1: Well the beauty is, artists, more than anybody, know what they want in terms of health. And many of them have tried it all, so many of them know who they want. So they say, “I have this injury and I want to see an osteopath, or I have this injury and I want to see a naturopath” . . . it’s easy.

Regardless of whether health-care practitioners at the AHC had knowledge about the therapy or modality that an artist wanted to try, the majority of the biomedical practitioners described themselves as being able to keep an open mind about referring their client to an unfamiliar modality. One said:

BIO_HP 1: If someone comes to me and says, “I need to see an osteo,” I am not going to try and talk them out of it. I say, “Great, check back with me in six weeks. How do you want to do this? Do you want to do a care plan with [HP]? And then if you are making progress, great, if not come back to [HP] or do you want to come back to me?” I mean I try to keep it pretty fluid, because once again it’s very individual.

On the other hand, a few biomedical practitioners at the AHC stated that if they were uncomfortable with a client-driven treatment request they would make that known to the client and write it in the patient chart. According to this biomedical practitioner:

BIO_HP 2: I think every practitioner has to have their bottom line. . . . The truth is, and as I say to patients, “I worked hard to get this degree and I do not want to jeopardize it and I have to be very clear with you that I do not feel comfortable with us doing this and I’m going to put it into your chart that I advised this and you didn’t want to do this.” I say, “You can still see me and I can still be your care provider, but you need to know that I need to cover myself.” That’s kind of how I do it.

The majority of respondents stated that health-care practitioners who either worked at the AHC or wanted to work at the AHC had to possess certain qualities. Not only did they need to be sensitive to artists’ needs (see above), they also needed an understanding of how to navigate through the hospital’s expectations of IHC at the AHC:

AHCF 5: The health practitioners themselves are really at the forefront of representing integrative care to the hospital . . . you know how were they responding to the hospital? Because if there is any friction there, the hospital will say “oh my god, these holistic types, they are a real pain in the ass,” you know. So it is really important that when we
hire these people they are really good with their public relations and they are very
careful. . . you know none of this “airy fairy California stuff,” you know. . . because that
is one of the first things that hospital bureaucracy tends to think. So it is really important
because they are kind of carrying the torch.

Both the AHCF members and the health practitioners stated that to work at the AHC, one
had to possess an altruistic or “ego-less” personality that was not rooted in self-promotion. As
one AHCF member described:

AHCF 1: I was on the hiring committee for the [HP]. . . but one of the things that came
up was that the person we hired would have to fit in and work well not just with the other
practitioners, but somebody who would be able to integrate well in an integrated setting.
And also we were all working towards that common purpose of knowing that this is an
integrated centre and that if somebody is coming in because they want to enhance their
own reputation and their own private practice then this wasn’t going to be of benefit to
the AHC. . .

And a biomedical practitioner echoed:

BIO_HP 1: We don’t want people involved who have a very strong agenda to move their
own modality forward or their own career forward. I mean we all know that everybody
wants to make a living and make a buck but we were looking for people who were more
interested in artists’ health and in this exciting new model than they were in promoting
their own careers. I don’t think you can tease that out completely but I do think that a lot
of the people have a true passion for an AHC and helping artists.

It was believed by these two groups that the type of practitioner best suited to move
forward IHC at the AHC was someone who understood the culture of the arts and its economic
constraints. According to this AHCF member:

AHCF 1: I understand the need to be paid for your services, and nobody understands it
better than artists because they are really taken advantage of. However, that said, that is
the culture you are entering into, and that is where the question we asked earlier of “do
they fit?” and I am sorry but that is part of the fit. . . The kind of practitioner that’s
willing to do this kind of, again it is just go the extra mile the odd time. It comes back to
them in different ways. . . because if it is going to be about coming in and punching the
clock. . . I don’t want them there. . . Because if it is about money, don’t come to us.
That is not a part of our culture; they have got to know that from the beginning.

The majority of health-care practitioners generally agreed that the AHC was a unique
occupational health clinic that provided health-care services for artists over and above what was
covered by provincial health-care plans, and that artists, in general, were unable to afford
otherwise. The health-care practitioners in the study seemed quite passionate about working at the AHC. As one CAM practitioner stated:

Q: Right because the whole premise is, that it is for artists. . . .

CAM_HP 3: That’s right, and they don’t have money, most of them, 99.9 percent of them, and one of the reasons I am here working for one-quarter of my hourly rate is because I believe in that [providing health-care services for artists].

Most of the health-care practitioners said that they understood the arts culture and recognized that being paid for all their time was not part of that culture. As a CAM and a biomedical practitioner explained:

CAM_HP5: I think we are all quite dedicated to the AHC and prepared to take some of our own time and dedicate it.

BIO_HP 1: One of the concerns, of course, is: should the clinicians be paid for their time [to attend team meetings], which I think is unreasonable when you’re looking for funding sources for that. . . . I think this is a pretty one-of-a-kind sort of place and ideally people should volunteer for these things.

On the other hand, a few health-care practitioners agreed that there should be consideration for those “going the extra mile:”

CAM_HP 4: I am only paid for client hours and I’m very committed to working here and I made a personal commitment to come to team meetings, monthly team meetings which is not compulsory and nobody said anything at all or said “you have to come” but I like to do that and I want to come. I would like to come to more things if they were available, but the barrier for me is partly economic because it means that I would have to clear a time from my schedule where I would normally book a paying client . . . So I was definitely glad that [HP] brought up the idea of exploring the possibility of remuneration for coming to some of these meetings and gatherings because that certainly makes it more realistic and more realistic for me to do it more frequently.

The issues of remuneration, team meetings, and the expense of collaboration were explored in chapter 4.

Overall, most respondents believed that attitudes toward IHC were influenced by certain personal qualities in health-care practitioners, including a deep understanding of artists’ health, the demands and expectations of the artists’ community, the needs of the AHCF, and the ability
to communicate with hospital administrators. The following section describes the respondents’ attitudes and knowledge of IHC and how this affects the process of defining IHC at the AHC.

6.3 Defining IHC

Some of the health-care practitioners said that they wondered whether their definition of IHC was congruent with the vision of the AHC foundation and the hospital. One biomedical practitioner stated the following:

BIO_HP 4: The other thing that I think is a part of this process is that I have my definition of what I define integrative care as being, and I don’t know how my definition fares or exists in conjunction with everybody else; I don’t know what everybody else thinks integrative care is. And that is one of things that came, my sense, came out of retreat day, is that the different people around the table had different definitions of what integrated care was. I found that it is a relatively new thing and subjective to a degree.

Q: Now the AHC foundation in their vision/mission statement says that this is an integrated health . . .

BIO_HP 4: I know, I know, I read that and I underlined that because it says it is, but in my view at this point in time, it isn’t. It isn’t. It has the potential to be that, and there are a few steps that we have to take to get there. First define what it is, where we want to be, and how we are going to do that. I think first my hiring and getting a group of integrated practitioners on board does not make us an integrative care facility. You know it is a big coup to have things like a naturopath and chiropractor and osteopath inside a hospital, because traditionally that doesn’t happen, but that doesn’t define integrated care to me, it has to go much further than that.

In another face-to-face interview, a CAM practitioner echoed the above sentiments:

Q: Do you think the AHC has a common understanding as to what integrative or integrated health care is?

CAM_HP 6: I’m going just intuitively, I have not even met everyone, but I would say no.

Q: That has never been communicated from any of the organizational structure? I mean, has anyone articulated, “This is our common vision of integrative care . . .”

CAM_HP 6: No.

Several respondents also indicated that they did not know enough about the goals of IHC. Two AHCF members explained:

AHCF 1: I don’t feel like I know that much about integrative care. It has always been described to me, and when it has been described to me I am actually quite keen on the
idea, for the simple fact that I have always thought that is the way health care should be, is practitioners talking to each other. Not that it was a huge surprise to me that it wasn’t necessarily the case all the time, I just thought that it was certainly forward thinking and needed to be specifically the case for the Artists’ Health Centre because of the fact that we were talking about quite different modalities and the way people work.

AHCF 3: I would really like to know, because it is not clear to me, what exactly are our goals in integrative care? I mean I do hear of certain kinds of things and this is why I said this comment earlier. I really would like to look at solid strategic plans and options that are given for integrative care clinics. What exactly are the key elements that have to be in place, what are the visions?

Overall, many of the respondents described what they believed was a lack of consensus of what IHC truly represented. They attributed this lack to the newness of the AHC. The lack of consensus continued because there remained questions regarding personal definitions of IHC and organizational definitions of IHC and whether they were congruent. Given a lack of consensus regarding the definition, goals, and vision of IHC at the AHC, it was not difficult to understand why there might be questions regarding the importance or even presence of IHC at the AHC.

6.4 Summary

My research revealed diverse health-care philosophies among practitioners at the AHC because of the involvement of a wide range of different disciplines/modalities. At the AHC, each health-care practitioner brought with them a different set of values based on assumptions associated with their own profession/discipline/modality and of others. For example, the biomedical practitioners struggled with the evidence-based research and knowledge of their own discipline’s teachings compared to the perceived lack thereof with CAM research. This finding was congruent with the current debate on how best to test the efficacy and safety of CAM modalities. In the biomedical world, research is perceived to be based on the premise that credible research results are impartial and empirically verifiable. Although perceptions and openness to other research methods are slowly changing, there remains resistance by some professional groups to CAM therapies because of an assumption they are not evidence-based,
and therefore not safe and efficacious. Importantly, not all research within biomedicine is
evidence-based; within biomedicine, qualitative research such as ethnography, grounded theory,
and phenomenology are gaining acceptance as rigorous and useful methods for research in health.

This issue may be resolved in time, if adequate financial support becomes available for CAM research. Financial support for CAM research, in addition to the use of qualitative methodologies will ensure that CAM research will undergo the same degree of systematic and rigorous scrutiny, as does all good quality research.

Despite a perceived lack of scientific evidence, some of the CAM practitioners at the AHC reported that attitudes toward IHC were positively influenced when biomedical practitioners had a personal experience with CAM therapies/modalities and when health-care practitioners in general developed more confidence in their own work. Upon entering an integrative health care practice, health-care practitioners must learn to accept a blurring of practice boundaries and trust other discipline members to share patient care processes. Although the majority of health care practitioners at the AHC stated that they had positive attitudes toward the concept of IHC, the biomedical practitioners in particular reported some difficulty with the actual implementation of its principles.

As mentioned above, the findings suggest that although there appeared to be some reluctance, attitudinally, to embrace integrative health care, the majority of health-care practitioners at the AHC believed in the concept of IHC. This positive attitude seemed to be partially encouraged by the top-down approach used by AHCF members and the hospital administrators, who strongly agreed with the benefits of IHC and espoused the principles of IHC for the AHC. Thus, the vision and mission of the AHC exerted an influence on the majority of the health-care practitioners’ attitudes and buy-in toward IHC. However, the findings suggest
that neither the hospital nor the AHCF worked in consultation with the health-care practitioners at the AHC to develop this shared vision of IHC. In addition, many respondents found there was a lack of clarity amongst the AHC stakeholders of a shared definition of IHC.

In the next chapter, I pull together the discussions of chapters four, five, and six to present a synthesis of the research findings and a more theoretical discussion of key themes, including an analysis of the concept of IHC at the AHC.
CHAPTER 7
DISCUSSION

The purpose of this chapter is to draw together the interpretations of the preceding chapters into a coherent representation of how integrative health care works at the AHC. The findings provide some important insights into the nature of IHC at the AHC. For example, most respondents expressed optimism that CAM and biomedicine could eventually work more collaboratively together to better serve artists’ health care needs. However, the barriers to integration were perceived as substantial, and the benefits as unproven. Thus, implementing and sustaining this IHC clinic may prove a challenging task.

The concept of IHC as understood by the respondents of this study is embedded in particular social contexts and constructions. By analyzing these perspectives as entry points into these contexts and constructions, a clearer view develops of how IHC at the AHC is socially constructed and organized.

IHC can be summarized schematically in a conceptual framework. Here I borrow concepts from the literatures on interdisciplinary/interprofessional collaboration and teamwork, and IHC. Particularly helpful to this analysis is Boon et al.’s (2004a) model of team health-care practice and Sicotte, D’Amour, and Moreault’s (2003) analytical framework of interdisciplinary collaboration. In addition, I use sensitizing concepts from contemporary educational theories and organizational design literature to describe the intergroup process and organizational structure of integration at the AHC. These conceptual frameworks are not offered as an unchanging depiction of reality, but rather as devices for organizing the central themes of this research. Furthermore, the following explication of key themes in sequential order is not intended to suggest that the themes are layered in such an order (i.e., with each influencing the next in turn); it is simply a
pragmatic approach to presenting this information. As evidenced in the following discussion, key themes are enmeshed within one another.

This chapter is structured in five main sections. The first section revisits the conceptual framework presented in chapter 3, and presents a table of the interrelated factors – micro, meso, and macro – that emerged from this analysis. The meaning of each level and its influence on the concept of IHC at the AHC is detailed in the subsequent sections below. The second section discusses the philosophy, attitudes, and knowledge of IHC at the AHC. Key sensitizing concepts from the literature on professions and adult learning theories are used to better understand how professional socialization and personal experiences with IHC served as both barriers and facilitators to defining IHC at the AHC. Each concept and how it relates to the findings is considered in turn. The third section discusses intergroup process and communication among stakeholders at the AHC. The findings linked most closely to understanding integration at the AHC are those specific to communication, teamwork, and leadership. The fourth section discusses the organizational structure and its effect on IHC at the AHC. It discusses key organizational issues and concepts as they relate to IHC. The section initially discusses the need for organizational commitment to ensure that IHC can be developed and delivered in an effective manner. It also outlines the range of logistical issues needing attention to operationalize IHC at the AHC. The fifth section summarizes the previous sections.

7.1 A Conceptual Framework of Integrative Health Care at the AHC

This conceptual framework includes three key areas: (a) organizational factors, (b) intergroup process, and (c) individual perceptions of IHC at the AHC. This framework will help to organize the wide array of interrelated factors operating at micro, meso, and macro levels that will be useful in advancing the theorization of this area of research. Table 10 shows the factors and sub-factors. The sections following provide a more complete description.
Table 10

Factors That Affect the Concept of Integrative Health Care in Practice at the AHC

<table>
<thead>
<tr>
<th>Organizational Structure</th>
<th>Intergroup Process</th>
<th>Individual Perceptions</th>
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<tr>
<td>Organization setting (academic teaching hospital)</td>
<td>Complexity of team structure</td>
<td>Health care philosophies</td>
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<tr>
<td>Hospital policies and regulations</td>
<td>Presence of practitioners</td>
<td>Professional socialization</td>
</tr>
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<td>Credentialling/regulatory bodies</td>
<td>Leadership</td>
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<td>Multiple administrative umbrellas</td>
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<td>Communication strategies: mandatory team meetings</td>
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<td>Team composition</td>
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<tr>
<td>Clarity of vision/mission</td>
<td>Hallway consultation</td>
<td>Critical reflection</td>
</tr>
<tr>
<td>Evaluation process (how do we measure success?)</td>
<td>Technology (virtual meetings)</td>
<td>Health needs of client population</td>
</tr>
</tbody>
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7.2 Micro Level Analysis:

Individual Perceptions

The findings reveal that integration is an ongoing process that varies within the organization itself and within the philosophies and discipline-specific cultures of the various health-care practitioners. Thus, a starting point for developing a unifying concept and culture for integration would be to closely examine and understand the different philosophies/cultures of stakeholders at the AHC, and the influence these have on integrative health care. Here, the
literature on professional socialization, educational concepts of explicit and tacit knowledge, and definitions of IHC is related to the findings.

7.2.1 Professional Socialization

Professional socialization is the process by which individuals acquire the specialized knowledge, skills, attitudes, values, and norms needed to perform their professional role. Professionals are required to master substantive theory and technical skill. They also develop their own unique subcultures, demanding specific normative standards from their members. In other words, there is an acculturation process during which the values, norms, and symbols of the profession are internalized. Acculturation can be so strong that it may cause personality transformation. Referred to by the French as deformation professionelle, this transformation is usually displayed in stereotypes exemplifying a profession’s ideal by those who have internalized the profession’s culture completely (Du Toit, 1995; Hean, Clark, Adams, & Humphris, 2006). To a certain degree, working at the AHC required a deformation professionelle of the health-care practitioners. Most respondents described the “ideal” AHC health-care practitioner as one who was altruistic or “ego-less,” who was not rooted in self-promotion, and who understood the culture of the arts and its economic constraints. Although altruism is ingrained in most professions’ socialization, there also remains an emphasis on individualism, competition, and unidisciplinary thinking (Clark, 1994) which serve as a philosophical challenge to working together.

According to Clark (1997), the development of both an identity and a pattern of practice in the health professions is based on a process of socialization, during which knowledge, skill, values, roles, and attitudes associated with the particular professionals’ practice are acquired. In other words, professions are a disciplinary culture. Disciplinary cultures are founded on prevailing assumptions about epistemological, behavioural, and normative bases of action
As such, members of a health discipline bring different sets of values about integrative health care based on their professional socialization, personal experiences, and beliefs. The findings suggest that these values did affect the process of integration of the various health-care practitioners at the AHC. As discussed in chapter 4, the health-care practitioners believed that the way in which they were socialized, the influence of personal experiences with CAM, and their maturity level affected their attitudes toward IHC.

Research on the disciplinary cultures of health professions shows that individuals identify with their own professional group and that this “blocks their ability to consider the opinions and perspectives of others” (Clark & Wilcockson, 2002). Turf wars, weak leadership, and confusion regarding levels of autonomy and authority can have negative effects on the ability of team members to work together and produce positive results (Lindeke & Block, 1998). Consequently, for IHC, role socialization must be expanded to include sharing knowledge with other health-care practitioner colleagues (McCallin, 2001). The findings of this study suggest that neither the hospital nor the AHCF worked in consultation with the health-care practitioners to develop this shared vision of IHC at the AHC. Hence, a cultural shift in re-socializing health-care practitioners, hospital administrators, and AHCF members would be required to move IHC forward. Obviously, IHC does not preclude the strong socialization of disciplinary cultures, but this can be enhanced by understanding the complementary skills and expertise that all health-care practitioners bring to their care practice (Ingersoll & Schmitt, 2004).

### 7.2.2 Tacit Knowledge

Although professional socialization, acculturation, and disciplinary cultures exert a strong influence on practitioners’ knowledge and attitudes toward the concept of IHC, the findings suggest that a practitioner’s philosophy of practice is informed more by his or her own personal

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1 See section 7.2.3 below for a discussion of types of leaders and leadership.
practical knowledge than by formal knowledge. Such personal knowledge is difficult to articulate and is referred to by researchers in many different ways.

Epstein (1999) differentiates between two different types of knowledge. *Explicit knowledge* is readily taught, accessible to awareness, quantifiable, and easily translated into evidence-based guidelines. *Tacit knowledge* is usually learned during observation and practice. It includes prior experiences, theories-in-action, and deeply held values and is usually applied more inductively.

Research suggests that tacit knowledge can be brought into consciousness through *mindfulness* (Charon, 2001) – that is, non-judgmental attending to one’s own physical and mental processes during ordinary, everyday tasks. Mindful practitioners use a variety of means to enhance their ability to engage in moment-to-moment self-monitoring; to bring to consciousness their tacit knowledge and deeply held values, they use peripheral vision and subsidiary awareness to become aware of new information and perspectives, and adopt curiosity in both ordinary and novel situations. The findings of this study reveal that most of the health-care practitioners at the AHC were able to clearly articulate explicit knowledge but less able to explore areas of tacit knowledge.

Additionally, Fish and Coles (1998) believe that professional practice contains a major element of artistry, an element that does not yield simple empirical evidence. To understand professional practice, one must recognize the artistry involved in making professional judgments and being able to see individual practice within the broader context of the traditions of the practice of one’s profession. Thus, to develop more effectively, practitioners are encouraged to reflect upon, articulate, refine, and defend their practice (Fish & Coles). The findings suggest that such understanding is related to practitioner confidence. Some health-care practitioners at the AHC seemed to appreciate the art and science of their judgments and of others as they
developed more confidence in their own modalities. However, most of the health-care practitioners often had difficulty articulating this appreciation, and they described their level of confidence within a multi-disciplinary team as largely under-developed.

The views of contemporary educational theorists support the work of Fish and Coles (1998, as cited in Maudsley & Strivens, 2000), Charon (2001), and Epstein (1999). It has been recognized internationally that health professional education must value prior knowledge and experience; promote learner responsibility through facilitation rather than directed learning; encourage learners to test out and apply new knowledge, and use small-group work to foster explicitly the elusive skills of critical thinking and reflection. According to Schön (1983), professional practitioners do not pigeonhole problems in standard categories and apply fixed rules; instead, they see each problem as unique. They may frame the problem; generate questions that enable them to see likenesses and differences, and exercise selection and choice to narrow the focus. The process involves a continual back-and-forth aimed at changing the situation and arriving at a satisfactory solution-, which, in turn, can be evaluated using appropriate criteria.

The health-care practitioners at the AHC were able to express the “low-lying fruit” of tacit knowledge to some degree. The majority believed in the concept of IHC, and they stated a genuine desire to learn from, with, and about each other. The biomedical practitioners acknowledged that to reach a further understanding of artists’ health, there was a need to look at areas and levels other than the biomedical model. This suggests that despite the socialization process health-care practitioners have undergone to create stereotypes, role identifications, and professional values and beliefs, there is room for curiosity and openness toward other practitioners’ knowledge, strengths, and weaknesses. None of these practitioners were formally trained to work in collaborative practices, but their commitment to artists’ health and their passion for the arts community had brought them together. Yet the findings imply that they often
fell just short of functioning in an interdisciplinary fashion because they were unable to achieve an esprit de corps among team members that might have created a common culture.

Perhaps this was partly due to their difficulty in articulating deeper levels of tacit understandings so as to criticize, examine, and improve them. For example, when practitioners were asked to look beyond their curiosity and openness toward CAM therapies to examine concrete situations that might call for an integrated approach, the responses often proved typical, mechanical, and reactive. For example, many biomedical practitioners reported that the chief impediment to a change in attitude toward integrative health care was a perceived lack of quality research in CAM. Several biomedical practitioners stated that unlike biomedical therapies, most CAM therapies were not evidence-based and that the lack of randomized controlled trials could be problematic to those who are trained in the scientific method. A quick scan of the literature on evidence-based medicine (EBM) and the use of randomized controlled trials (RCTs) revealed that EBM has been successfully disseminated in the health care field; numerous criticisms have also been advanced (Tonelli, 2001; Straus & McAlister, 2000). Even the gold standard of the EBM research method, the randomized clinical trial, is bedevilled by low inclusion rates and potentially important recruitment biases (Celermajer, 2001). In addition, there is a bias in the hypotheses tested in large clinical trials since the costs involved are usually covered by commercially interested pharmaceutical companies. For this reason, trials of non-patentable compounds or therapies of no commercial interest may not be performed. It can be argued that scientific data cannot be expected to guide most health-related decisions directly, as not enough randomized trials or epidemiologic studies exist to do so (Kenny, 1997).

If health practitioners have presumably been taught to critically analyze data and research studies, and professional judgments are considered to be as much of an art as they are of a science, then why did some biomedical practitioners at the AHC feel so strongly about the use of
EBM and RCTs for health research? Using the lens of reflection, Schön (1983) articulates the schism between what professional schools teach and what practitioners in the real world require. According to Schön, reflection has two time frames. In reflection-on-action, it occurs before an event and after it, on considering what occurred. In reflection-in-action, it occurs during an event – a problem can be framed and solved on the spot. According to Schön, reflective practitioners reflect both “in” and “on” action. Such reflection requires a certain level of interaction between practitioners. The findings revealed that interaction among respondents at the AHC, particularly the health-care practitioners, was nominal. In their real world of mostly part-time employment, sporadic engagement with other practitioners, and lack of any formal or informal mechanisms for communication, the opportunity to reflect was virtually non-existent, resulting in a lack of critical reflection and perspective.

Some research has used the concept of reflection to link individual and organizational values (Osborne & Redfern, 2006). The following section discusses the various challenges associated with defining IHC at the AHC.

7.2.3 Defining IHC at the AHC

The majority of AHC health-care practitioners wondered how their personal definition of IHC would fit within the organizational definition at the AHC. All respondents were aware that at the very core of the AHC was the desire for an integrative health-care clinic for artists. From an organizational perspective, both the AHCF and hospital had attempted to create an organizational culture (through their vision and mission statements) that favoured the concept of IHC. Most of the hospital administrators and AHCF members agreed with the concept of IHC. However, the findings indicate that while there was a philosophical acceptance of the concept of IHC, several AHCF members and hospital administrators did not truly understand IHC, and had not developed any benchmarks or strategies to define or measure it.
At the time of this study, most respondents had multiple understandings of IHC, a finding congruent with the existing literature on integrative health care. According to Hollenberg (2007) there are many variations of IHC, including collaborative practice, interprofessional care, and “integrated” and “integrative” medicine. Not all forms necessarily combine biomedicine and CAM. Attempts to classify, define, and/or categorize IHC reveal a complex underlying puzzle over terminology, historical antecedents, diverse cultural meanings, and entrenched usage.

Very likely, the concept of IHC will continue to have multiple meanings but, as the findings clearly suggest, IHC at the AHC must have a core meaning developed in collaboration with artists, health-care practitioners, hospital administrators, and the AHCF members. However, the link between IHC theory and IHC practice has not yet been developed, either in the literature or at the AHC. As a consequence, there is no way of assessing whether the concept of IHC is relevant to the actual practice of IHC. According to the majority of health-care practitioners, neither the hospital nor the AHCF had worked in consultation with one another to develop a shared definition of IHC.

To work towards a shared definition of IHC and shared goals to achieve a desirable intensity of integrative health care, a shift is needed from the conventional, bureaucratic, organizational structures of the AHCF and the hospital. A shared vision and understanding of IHC needs to be developed with the artists and the health-care practitioners at the AHC. Drinka and Clark (2000) refer to such a shift as an equalization of organizational power, in which leadership is “unstructured, shared, informal, functional, empowering, participative . . . and consultative.”. In contrast, the current system at the AHC had inadvertently created an environment where several health-care practitioners and some artists felt that because their perspective on IHC was not asked for, it was not valued. This has resulted in a perceived lack of organizational support for IHC at the AHC. Currently, the AHC, like other centres that claim to
be integrative, has not dedicated the resources and incentives needed to develop a shared definition of IHC.

The findings of my study are somewhat congruent with Boon, Verhoef, O’Hara, Findlay, and Majid’s (2004b) paper, which was designed to clarify and define the concept of IHC as it applies to the combination of CAM and biomedical health care.

As stated in chapter 2, I prefer to use the continuum concept as a typology because, as I quickly realized, trying to achieve a precise definition of IHC at the AHC from the data gathered—one that would “fit” any one description—was akin to struggling to hit a moving target. My research showed that at the AHC overlap exists between the points of the continuum, and structure and process are not aligned. For example, the flattening of the hierarchical structure among the CAM and biomedical practitioners at the AHC did not necessarily facilitate the process of communication among individual practitioners. Nevertheless, Boon et al.’s continuum was invaluable for my research in that it assisted in theoretically grounding the data that emerged on the concept of IHC from the interviews (with the health-care practitioners) and focus groups (with the artists, health-care practitioners, hospital administrators, and AHCF members).

The following discussion uses the literature on teamwork in health care and concepts of integrative health care to describe what is happening at the AHC.

7.2.3.1 A Range of Integration

The majority of respondents believed that a goal of the AHC was to integrate CAM and biomedical practitioners in one location for artists’ health. To develop and evaluate a theoretical perspective from which to see whether this was occurring, I discuss institutional as well as practitioner integration. I draw parallels between the literatures on interdisciplinary teams and integrated team models, and I examine the concepts of interdisciplinary, multi-disciplinary,
collaborative, and consultative relationships to better understand the range of integration at the AHC.

7.2.3.2 Institutional Integration

Using the lens provided by Mann, Gaylord, and Norton’s (2004) *Approach 6 of Hospital-Based Integration*, a range of institutional integration can be seen at the AHC. In Mann et al.’s model, integration is aimed at expanding patient care options, building upon the tenets of patient-centred care, and focusing on disease/illness prevention. The model also describes institutional boundaries as often very clearly drawn within a hierarchical, hospital-based integration. Both the AHCF members and health-care practitioners described some of the limitations of having an IHC within the hospital setting. For example, all of the CAM practitioners and two of the biomedical practitioners were fee-for-service, part-time contractors and not full-time hospital employees. As such, attending hospital rounds and meetings was on their own time and often they did not do so. In addition, a few of the CAM practitioners perceived their scope of practice as being limited in the hospital environment.

In other ways, the majority of respondents described the hierarchical boundaries as much less rigid. The Toronto Western Hospital is an academic teaching hospital. As described in chapter 2, their openness to IHC is related to the socio-political context, particularly the rise of IHC, its degree of acceptance, and the links between IHC and other political agendas, such as health promotion, collaboration/teamwork, and patient-centred care. The hospital administrators worked together with the AHCF to hire CAM practitioners, as requested by the artists. Also, a burgeoning research capacity in the areas of artists’ health and IHC was currently being supervised by a senior scientist at the hospital.
7.2.3.3 Practitioner Integration

A review of the literature on interdisciplinary, multi-disciplinary, collaborative, and consultative teams and how they relate to integration reveals that the terms attempt to convey degrees of collaboration and communication within a team.

The interdisciplinary team is a structured entity with a common goal and a common decision-making process (Mariano, 1989; Wells, Johnson, & Salyer, 1998). It integrates the knowledge and expertise of each professional to propose solutions to complex problems (Paul & Peterson, 2001) in a flexible and open-minded way (Satin, 1994). There is a sharing of professional responsibilities (D’Amour, Sicotte, & Levy, 1999) and shared ownership of clients/patients (Gusdorf, 1990). The findings in my study reveal that all respondents shared a common goal of improving artists’ health, but that goal was not based on a common decision-making process. No training or education was required for the different health-care practitioners to become adequately familiar with each others’ disciplines, so as to integrate the knowledge and expertise of each one into practice. Furthermore, most artists saw only one practitioner at a time and rarely, if ever, did health-care practitioners from multiple disciplines see or share patients together as a team. At the AHC, daily interactions were sporadic, and thus the potential for cross-disciplinary learning and discussion did not exist. According to the literature on interdisciplinary teamwork, the AHC would not be considered an interdisciplinary team due to the lack of shared decision-making, shared patient care, and shared professional responsibilities.

The AHC had some characteristics of a multi-disciplinary practice, in which teams are managed by a leader who plans patient care. Individual team members continue to make their own decisions and recommendations, which may be integrated by the team leader. Although members of a multi-disciplinary team do not necessarily meet, they manage to work in a coordinated fashion (Ivey, Brown, Teste, & Silverman, 1987). At the AHC, there was a team
leader who usually directed the services. However, the team leader did not coordinate any follow-up process to ensure that information would be transferred to and from relevant practitioners and the patient. Information sharing was usually one-way, or consultative as opposed to coordinated – one practitioner would share information with another about a patient, without benefit of a back-and-forth collaborative interaction. So while the health-care practitioners at the AHC worked in the same office settings, meetings and cross-referrals did not happen regularly.

Several health-care practitioners at the AHC described their interactions as collaborative, but in reality practitioners very rarely discussed patient care or shared patient information with one another. Rather, the findings indicate that the range of integration was mainly consultative. In consultative interactions, “expert advice is given from one professional to another” (Boon et al., 2004a, p. 3). A collaborative relationship requires communication and information-sharing concerning a patient between practitioners.

Instead, what the majority of respondents described was a range of integrative care. Integrative health care at the AHC was any situation where the patient, in some way, used CAM and biomedical approaches in their health care. At the AHC, IHC was seen as some way – not one way – of combining these two approaches; thus, a referral from biomedicine to CAM or vice versa could be considered within the range of IHC at the AHC.

Integration of health-care services at the AHC was either individually initiated by patients (artists) when they sought alternative health care, or initiated by health-care practitioners when they referred patients back and forth between biomedical and CAM therapies.

This thesis highlights the importance, power, and necessity of developing shared philosophies, beliefs, decision-making, and goals when creating a nurturing environment for IHC. The importance of communicating precisely what it is that the stakeholders are trying to
achieve regarding IHC cannot be overstated. For this, health-care practitioners’ tacit knowledge needs to be represented explicitly. For example, tension and a lack of confidence were seen by some health-care practitioners as resulting from a limited knowledge of one another’s scope of practice and a consequence of minimal communication. In another example, the AHCF ran into difficulty when they attempted to communicate about issues of funding and sustainability to both the health-care practitioners and the artists. Such difficulties present sustainability problems for the organization: if the organization is to continue and survive, it needs to be able to describe, explain, and justify what it does.

The following section provides an analysis of how knowledge, skills, values, and attitudes toward the concept of IHC affect communication and integration among the health-care practitioners, artists, hospital administrators, and AHCF members.

7.3 Meso Level Analysis:

Intergroup Process

The findings show that intergroup processes, such as communication and integration among respondents; teamwork, with special consideration for biomedical and CAM terminology; and strong leadership or champions are necessary to move IHC forward at the AHC.

7.3.1 Communication and Integration at the AHC

For some health-care practitioners, a lack of basic CAM therapy knowledge may have affected their viewpoint. For example, if they did not know what osteopathy was, they probably could not express a view about its effects. Some practitioners explained how a lack of knowledge led to feelings of self-consciousness and defensiveness. The results of my research are congruent with other studies in the organizational theory literature that examine the defensive

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2 In the early 1980s, there were only 32 osteopaths in Ontario, but their numbers have since risen with the establishment of a Canadian training centre in 1992.
patterns that individuals adopt when operating in groups. For example, in a survey of 569 managers, Mulvey, Veiga, and Elsass (1996) found that 61 percent of respondents listed lack of confidence to contribute as a cause for limiting their involvement in team discussions.

The findings suggest that the threat of embarrassment or appearing incompetent weighed heavily on most of the health-care practitioners at the AHC. A lack of understanding of each others’ scopes of practice could create embarrassment or potential conflict if an inappropriate referral was made, and so as a defence mechanism, the majority of health-care practitioners at the AHC avoid the issue – they simply do not refer to practitioners they are unfamiliar with. Due to the perceived need to avoid conflict, and apart from logistical reasons, at the AHC there is thus minimal interaction, minimal understanding of scope of practice, and minimal referrals between health-care practitioners.

Mansbridge (1982) has explored the tendency in both larger and smaller communities to avoid conflict. She suggests that the organizational hierarchies have the psychological function of serving to protect individual workers from excessive contact with others on potentially adversarial matters. She likens this to an “institutional buffer zone” that protects workers from one another; workers may feel more threatened in egalitarian organizations where hierarchy is less prominent. The findings suggest that within the larger hierarchy of the hospital setting, the emphasis and acceptance of CAM therapies lack such a buffer zone. As such, fears of appearing foolish (not understanding scope of practice of the various health-care practitioners), or fear of personal attack (it may not feel “safe” to disagree with some of the alternative modalities, given their popularity at the AHC) contribute to conflict being ignored and actively avoided.

From a sociological perspective, it is also useful to incorporate Light’s (1993, 1995) concept of countervailing powers into this analysis. Light (1995) argues that the concept of countervailing powers:
. . . focuses attention on the interactions of powerful actors in a field where they are inherently interdependent yet distinct. If one party is dominant, as the . . . medical profession has long been, its dominance is contextual and eventually elicits counter-moves by other powerful actors, not to destroy it but to redress an imbalance of power. (p. 26)

Biomedicine and CAM undergo cyclical “phases of harmony and discord in which countervailing actions take place.” Dominance has ironic consequences, since “a profession’s power to shape its domain in its own image leads to excesses that prompt counter-actions” from other groups in the division of labour (Light, 1993). The cycle continues and others respond by changing their behaviour to circumvent the controls that are placed on their actions by others. The findings suggest that the AHC represents a body of various health-care practitioners that are, as Light describes above, subject to a series of countervailing pressures for change, some of which may undermine and some of which may enhance professional powers. Given that the creation of the AHC was motivated by artists’ unanimous frustration with the lack of appropriate health care services, the entire premise of this clinic can be interpreted as an expression of a countervailing power attempting to redress a frustration.

Avoidance may also be dealt with in covert ways. According to Laiken (1998), an expert in organizational learning and change, a survey of approximately 600 middle and senior managers revealed that, in describing their most frequently used style, fully two-thirds got their highest scores in “avoiding” or “accommodating” as opposed to “competing,” “consensus,” or “collaboration.” The findings of my study strongly suggest that this occurred when the health-care practitioners at the AHC were faced with the decision to refer a patient. For example, they would avoid referring to other practitioners if they did not know enough about their scope of practice but they would accommodate their patient/client if they requested to be referred to a practitioner that was unfamiliar. There was no apparent effort to either question (compete), or get to know more about that particular modality (collaborate).
The collaborative process requires that professional boundaries be transcended if each health-care practitioner is to contribute to improvements in patient care while duly considering the qualities and skills of the other practitioners. Indeed, many researchers deem collaboration as essential to ensure quality health care, and teamwork is the main context in which collaborative patient-centred care is provided. The following section discusses collaboration and the concept of teamwork as it applies at the AHC.

7.3.2 Teamwork at the AHC

In my study, the findings suggest that as a means of avoiding conflict, stakeholders, especially the health-care practitioners at the AHC, chose not to collaborate and communicate as a team (logistical barriers aside).³

Donnellon (1996) sees teamwork as essentially linguistic and conversational. Conversations may be face-to-face, over the phone, e-mail, and (I would add, for health-care practitioners at the AHC) through patient charting. Regardless of the channel, teams do their work through language. For Donnellon, words provide a window into people’s thoughts and feelings, even those they would prefer to hide; and words create thoughts and feelings in the listeners. At the AHC, the lack of everyday interactions, the lack of consensus regarding teamwork, and the inefficient formal and informal mechanisms of communication – linguistically, conversationally, or otherwise – reveal a lack of teamwork.

Teamwork is about encounters with other people, and since it partially relies on avoiding personal conflict, the question of how to encounter fellow team members (who are bound to be different from ourselves) demands attention. In this way, teamwork appears to be a double-edged sword. As the opportunity for teamwork increases, so does the likelihood that group members

³ A lack of funding could also contribute to the lack of collaboration since fee-for-service does not reward teamwork or IHC.
will be dissatisfied and fail to identify with the team. In general, all respondents concurred that communication was often minimal, informal, and one-way. Perhaps this was the easier way, since heterogeneous teams (like the health-care practitioners at the AHC) tend to experience more discomfort during an interaction (Polzer, Milton, & Swann, 2002).

Research in the teamwork literature shows that the team experiences anxiety when there is no unified perception of what values the team represents (West, 2004). Given the potential for this intra-group anxiety, the health-care practitioners, and even a few of the artists interviewed, were not convinced that teamwork was necessary or even desirable for patient care. By keeping communication and integration to a minimum, the potential for disagreements concerning patient care was also kept to a minimum.

### 7.3.2.1 Re-thinking the Concepts of Teamwork and Group Work

Currently at the AHC, opportunities do not exist for creating a shared vision of health care that permits each practitioner to contribute his or her particular knowledge and skills within the context of an interdisciplinary team approach to health care. AHC practitioners tend to work independent of one another. However, the very fact that this multi-disciplinary group of practitioners is working in a common setting is important and should not be overlooked. To a certain extent, co-location of practitioners is an example of integration by association. Even without formal arrangements, co-location can lead to familiarity and exchange between practitioners. Perhaps conceptualizing the range of IHC at the AHC should start with re-thinking the concept of teamwork.

Several practitioners questioned whether teamwork was necessary at the AHC. The practitioners referred to themselves as a team, but as this term was mostly used when referring to the fact that they were co-located, group work may better apply to what is actually happening at the AHC. A group is “a number of people or things located, gathered, or classed together”
(Barber, 2004). Implicit in this definition is the assumption that in groups, members maintain their individual roles, but are collected together. When grouped, the participants accept they are within their own professional identity and contribute from their own role and background. Therefore, it is co-location or a common identity that defines the group. However, the intragroup process as a result of this co-location is not defined.

Given the definition of group here, the health-care practitioners at the AHC can be thought of as a group. As discussed above, they have aspects that qualify them as a multi-disciplinary team, but they also have aspects of a group because they mainly function as individuals in parallel practice. For example, the outcomes of psychotherapy are not dependent on the physiotherapist completing particular tasks in a given time frame. In groups, people do not have to work together; they just have to inform each other about what they are doing when it is deemed appropriate. Although there is evidence emerging that teams are effective vehicles, little has been done to establish why a team (and which version of team structure) might be the most appropriate for the given circumstance.

Given the organizational structure of the AHC, it may be unrealistic to expect health-care practitioners to adopt a team approach. The expectations of an IHC team may be inappropriate when the tasks, for whatever reason, do not lend themselves to a collective approach. Perhaps further research on IHC at the AHC could explore how to seamlessly shift between individual and team for the best health of artists.

It seems that the capacity of practitioners to practice in a multi-disciplinary environment depends on their ability to communicate and share knowledge. The following section discusses how bridging the communication gap between CAM and biomedical practitioners is essential to move IHC at the AHC forward.
7.3.2.2 Biomedical and CAM Terminology

Individuals engage in knowledge sharing and creative problem solving only when they have already established a language in which they can combine and exchange their existing knowledge (Leonard-Barton, 1998). The findings suggest that commonality of language should be the initial focus of improving communication between biomedical and CAM practitioners. Most respondents, particularly the health-care practitioners, were quite clear on the importance of “speaking the same language,” whether it was between the AHCF members and the hospital administrators or between the health-care practitioners at the AHC. For example, CAM practitioners discussed the challenges they faced when trying to understand the biomedical language in patients’ charts. It could even be argued that the continued use of biomedical language for patient charting is a defence mechanism used to maintain biomedical control over patients (Larson, 1980).

To assist with this challenge, several articles about CAM education and training for health-care practitioners have policy recommendations to overcome the barriers of language. For example, the White House Commission on Alternative and Complementary Medicine (WHCCAMP, 2002) proposed that parallel training be provided to CAM practitioners to ensure that they receive “education and training programs that reflect the fundamental elements of biomedical science and conventional health-care relevant to and consistent with the practitioners’ scope of practice.” Such training, it is believed, will improve communication between biomedical and CAM practitioners. However, what the commission failed to understand is that making CAM practitioners responsible for attaining fluency in biomedical language would have the result of co-opting CAM, rather than increasing communication and fostering integration. As

4 Hospitals are also interested in finding more effective ways to chart patient information to enhance the quality of patient care and control costs.
one of the CAM practitioners discussed in the focus group, the AHC is trying to create something unique, whereby all practitioners become familiar with each other’s disciplines – including language – so as to improve integration of care, interdisciplinary respect, and communication in the care of patients/clients.

Several respondents believed that communication among practitioners through the patient chart could be useful if the charts were electronically based and if the information on them was organized systematically. Electronic medical records do not have many of the problems associated with paper-based records. For example, handwriting is not a problem with most electronic records. However, electronic records are not automatically more comprehensible (Rose, 1998). For electronic records to be useful at the AHC, there would need to be a systematic way of charting patient information across the various disciplines.

Overall, the majority of respondents agreed that more effort was needed to ensure communication channels were used more effectively at the AHC. Since each discipline has its own philosophy, rules, and values, many respondents discussed the need for a type of leadership that could blend the various professional perspectives together in a way that facilitates communication and integration.

Perhaps this is a consequence of having an IHC centre in a hospital setting. It would seem that to work in a hospital, a minimal fluency in biomedical language is required. To facilitate communication between biomedical and CAM practitioners there needs to be consensus between the practitioners and hospital administrators on the level of biomedical fluency necessary for patient charting.

7.3.3 Leadership at the AHC

The above literature suggests that conflict is harmful to teamwork and should be avoided. However, a study of 60 self-managing teams with 540 employees indicate that disagreeing with
each other’s ideas can be used to strengthen teamwork (Alper, Tjosvold & Law, 1998). Drinka (1994) studies developmental stages of teams (where groups are understood as transitory entities) and extends and applies the findings to the developmental stages of health care teams. Drinka’s research, based on conflict and problem resolution models, explores five stages: (a) team development (forming); (b) norms and pattern development (norming); (c) confrontation of team members (storming); (d) team performance (performing); and; (e) team dissolution (leaving). Confrontation and conflict are two important components of this model of team evolution. The findings suggest that the AHC is still in the team development stage.

However, through the process of confrontation, conflict resolution and, I would add, constructive controversy, team members could develop the confidence to deal with issues and create new solutions. The majority of respondents suggested that understanding the importance of these components would best be navigated and directed by a competent leader.

One key finding was the notion of a “team lead” or champion, who might or might not be a practitioner, and whose responsibility would be to foster and encourage collaboration among the health-care practitioners. This is in keeping with the change management literature. In their article on organizational change factors, Ginsburg and Tregunno (2005) state that champions are needed to “stimulate change, interest, and commitment across a variety of stakeholders.” Individual champions have also been heralded in the literature as crucial for change in general (Gustafson, Sainfort, Eichler, Adams, Bisognano, & Steudel, 2003), as well as change specific to integration (Vohra, Feldman, Johnston, Waters, & Boon, 2005). Respondents, particularly the health-care practitioners at the AHC, were looking for various changes to happen, such as formalized and regular meetings, more efficient mechanisms for communication, and more presence beyond their own setting. To make these changes happen, however, seemed extremely challenging.
The literature describes leaders and leadership in a variety of ways. For example, there are several references to the “leader as a role model” (Dixon, 1997; Fisher, 1993; George, 1996). This approach describes how a group leader acts in initial meetings and sets lasting precedents for group interaction. This type of leadership, despite moving toward organizational learning and partnership, assumes that all organizations are fundamentally hierarchical in nature, and that power continues to rest in management roles where good managers are seen to be teachers and coaches who help subordinates perform effectively.

This approach does not adequately describe what respondents participating in my study were looking for in a leader. Rather, the health-care practitioners and AHCF members, in particular, were looking for a leader as a catalyst – someone to create the context and conditions in which communication can be held and channelled to facilitate the work of the team.

The teamwork literature indicates that such a leadership role fosters a synergistic mode (Kasl, Marsick, & Dechant, 1997) of team learning, where members create knowledge mutually, and integrate divergent perspectives “through dialectical processes that create shared meaning schemes.” Such leaders create a “holding environment” (Heifetz & Laurie, 1997, in which diverse groups can talk to one another about the challenges facing them, frame and debate issues, and clarify assumptions behind competing perspectives and values. These leaders also see conflict as normal and positive, a prerequisite to healthy team dynamics. For the AHC, the team lead would be someone who could communicate with everyone, especially those who were there on a part-time basis, to keep him or her informed and engaged.

The AHC health-care practitioners would benefit from someone whose role was clearly articulated as a leader, not in the role-model sense, but rather in the domain of leader-as-catalyst. In its efforts to provide integrative health care, the AHC seeks to establish as non-hierarchical a model of care as possible. As such, the “leader as a catalyst” type of leadership is necessary to
move integration forward. Given the variety of health disciplines at the AHC, the leader would have to have the emotional capacity to tolerate uncertainty and frustration, and the ability to raise tough questions without getting too anxious. As Block (1993) describes, leaders must be willing to work on themselves first, to stay in intimate contact with those around them, to own their doubts and limitations, and to make them part of their dialogue with others. In this way, those who are not familiar with the different disciplines could turn to the leader for assistance.

In the section below, I use sensitizing concepts from the literatures of professions and organizational design to discuss how organizational structure affects IHC at the AHC.

7.4 Macro Level Analysis:

Organizational Structure

Creating an IHC clinic required an organizational structure that supported this type of care. In this section I discuss the intake/referral process, scheduling, and evaluating the AHC. The thread that weaves through each of these is the expense of creating an IHC centre within a publicly funded hospital setting.

The process of patient intake and referral was a considerable issue at the AHC. The respondents, particularly the health-care practitioners, expressed concern about the fluid and unstructured nature of the patient intake process. They had reservations about whether it was appropriate to have only one biomedical practitioner as the gatekeeper (intake coordinator) solely responsible for the intake process.

Health-care organizations such as hospitals believe that implementing gatekeepers saves them money. Many UK health-care analysts assert that gatekeeping is responsible for the country’s low health-care expenditures relative to other European nations (Forrest, Majeed, Weiner, Carroll, & Binderman, 2002). Although it is true that countries with gate-keeping systems spend less on health care than those without such managed referrals, it appears that gate-
keeping was not directly responsible for the lower costs. Rather, gate-keeping systems have emerged in societies with scarcer health resources (Anderson, Urst, Hussey, & Jee-Hughes, 2000). The lower costs are a function of supply side controls, rather than demand management at the primary care interface.

The relevant literature states that despite consumerist trends in most developed nations, patients will continue to need some sort of gatekeeper to guide them through an increasingly complex health-care system, and to assure an equitable distribution of resources by matching services to health-care needs. This could be applied to the services at the AHC. Cost arguments aside, primary-care gate-keeping at the AHC did provide an important filter for other health services. With the increase in different disciplines and modalities, patients/clients would continue to benefit from having a knowledgeable gatekeeper help determine which health care services would be most appropriate for their particular health-care need.

Several of the health-care practitioners said that they did not feel comfortable with having patients funnelled through one gatekeeper. As a solution, a few suggested having a CAM practitioner alongside the biomedical practitioner for the process of intakes. The AHCF members approached this suggestion with cautious optimism, stating that at the current time, the CAM practitioners were still trying to make inroads within the biomedical structure of the hospital. Once these inroads were better established, this could be a long-term goal worth pursuing. This, according to Abbott (1988), is how professions maintain their “official image of professional work”:

> The official image of professional work usually involves one among many possible settings of professional work. As long as some significant fraction of the profession works in such a setting, the official image remains in place irrespective of other changes. (p. 128)

In other words, the AHC may be considered integrative with CAM practitioners involved in patient care at the clinic within the hospital, as long as the biomedical practitioners’ presence is
front and centre. According to Abbott’s way of thinking, as long as the gatekeeping/intake process at the AHC remains in the jurisdiction of a biomedical practitioner, the image of the hospital as a biomedical institution remains in place.

It could be argued that since most IHC clinics are physician-led, the nurse-led AHC is a challenge to the biomedical model of care. However, the uniqueness of having a nurse-led IHC clinic in the AHC hospital setting did not affect the official image of the hospital as a biomedical institution. The biomedically trained nurse was a full-time salaried employee of the hospital and therefore maintained the biomedical professional image of the hospital setting. “Dominants” who are being asked to share jurisdiction with “subordinates” do not view this as a positive move forward. According to Abbott (1988), dominant professions are akin to “carnivorous competitors” that grow in strength as they engulf jurisdiction. As a result, a profession cannot occupy a jurisdiction without either finding it vacant or fighting for it – a struggle that at this time the majority of AHCF members said they were not willing to engage in.

Logistical issues – such as scheduling and the part-time status of various health-care practitioners – were described as a challenge to creating an IHC clinic for artists.

Scheduling was both an enabler and a barrier to communication and integration. The majority of respondents agreed that the current staffing structure at the AHC was not conducive to interactions between any health-care practitioners, particularly the CAM practitioners, as they were the ones with the fewest working hours at the AHC. The findings reveal that the few interactions that occurred did so during a time when the health-care practitioners occupied the “same space at the same time.”

Two of the biomedical practitioners and all of the CAM practitioners were hired by the hospital as contract employees and thus received none of the benefits of full-time employees.
They often took a pay cut in their fees relative to their private practice, and felt as though they volunteered their time to attend team meetings since these were not paid for by the hospital.

As Shuval, Mizrachi, and Smetannikov (2002) would propose, the findings suggest a dual process of simultaneous acceptance and marginalization of CAM practitioners who work in biomedical institutions. The CAM practitioners did work at the AHC, however they were not considered regular staff, and they did not have the same advantages as the nurse practitioner and physician who were full-time, salaried staff members at the hospital. In theory, the salaried practitioners had more opportunity to attend meetings, rounds, and other hospital benefits that were not extended to the part-time, non-salaried CAM biomedical practitioners at the AHC.

An additional example of the dual process of simultaneous acceptance and marginalization of CAM practitioners at the AHC is illustrated in the reaction of the hospital administrators to a request from a CAM practitioner to use an “intervention-like” therapy for clients. A CAM practitioner wanted to administer an intravenous (IV) therapy to his chronically fatigued patients. At the time of this study, the hospital administrators recognized that this type of therapy was acceptable in the community and within the scope of practice of this CAM practitioner; however, without a cost/benefits analysis of the treatment, the hospital could not comply with this treatment option for patients at the AHC.

On the one hand, the TWH could be seen as a leader in that they are offering more unconventional services (such as naturopathy) at the AHC. One study showed that acute-care hospitals, particularly academic/teaching hospitals, are becoming more involved in offering CAM services (Pagan & Pauly, 2005) which concurs with my findings; the TWH is an academic and teaching hospital. On the other hand, one of the challenges hospitals face is choosing which CAM therapy to offer and how to measure the cost/benefits and risk management involved with offering that therapy. When a hospital adopts any therapy, whether it is biomedical or CAM, it
confers a certain amount of legitimacy upon it. Congruent with my study’s findings regarding the CAM practitioner mentioned above, one small study found that hospitals are most likely to offer relaxation and stress management-related CAM services that are the least controversial and most in line with Western medicine. These services offer comfort and largely are not interventional (Ananth, 2007).

The work of Abbott (1988) may be helpful for rounding out our understanding of the professionalization of CAM and biomedicine, using the IV treatment request above to illustrate the point. According to Abbott, “the central organizing reality of professional life is control of tasks” (p. 84). These tasks themselves are defined in the professions’ cultural work and once control over them is established it is difficult for other professions to compete for jurisdiction over them. In a hospital, the task of administrating an IV drip to a patient is done by a biomedical practitioner – either a physician or a nurse. To open the “competition” to allow CAM practitioners to administer IV drips represents a loss of biomedical jurisdiction over this particular task. At the time of this study, the hospital administrators revealed that the political environment of the hospital was unreceptive to shifting the biomedical control of this particular task over to CAM therapies. As well, hospitals are constrained by medical associations and government who decide what physicians and hospitals can do, the maximum they can afford, what is scientifically justified, the cost benefits and risk management, and what is consistently publicly funded across provinces. I would suggest that stakeholders, particularly CAM practitioners, closely examine how midwives and nurse practitioners have succeeded in gaining professional autonomy in Ontario, even though they are small in number. Their leadership has astutely convinced government leaders of the compatibility of their goals with those of the government, which include promoting preventive health care and reducing the number of
hospital beds needed, and therefore costs (O’Reilly, 2000; Bourgeault, Benoit, & Davis-Floyd, 2004).

The medical profession has provided guidelines to its members to ensure that the delegation of an act does not compromise the doctor-patient relationship. It has further cautioned: “if medical acts become incorporated into the accepted scope of practice of other disciplines, the boundaries of medical practice may change” (College of Physicians and Surgeons of British Columbia, 2007). Clearly, one of the challenges of integration is to ensure clear definitions of the practitioners’ roles and expectations with regard to shared care. Defining practitioner roles and responsibilities will enhance the positive elements of integrative care and reduce misunderstandings regarding protocols, procedures, responsibility, and authority (Paquette-Warren, Vingilis, Greenslade, & Newman, 2004).

Attitudes toward IHC seemed to change as practitioners developed more confidence in their own modalities and were able to explore the benefits of collaboration and integration for their own professional development. However, although CAM is taught in some form in most Canadian medical schools, established faculty/professional development programs in Canada to teach collaboration are lacking (Steinert, 2005). In terms of education and training, few medical residencies offer or even require rotations in CAM (Wetzel, Eisenberg, & Kaptchuck, 1998), and there are very few published curriculum guidelines and course evaluations (Kligler, Gordon, Stuart, & Sierpina, 2000). Although the majority of health-care practitioners expressed a genuine desire to learn more about collaboration and integration with one another, the educational and professional development structures are currently not in place to support this type of learning.

The lack of education and training available to support collaboration and integration inevitably leads to the question of evaluating IHC settings. According to the artists, health-care practitioners, AHCF members, and hospital administrators, appropriate outcome/evaluation
measures to assess the benefits of IHC at the AHC are lacking. This finding concurs with the literature – the lack of appropriate outcome measures continues to plague IHC research. Searching the literature published within the last five years did not yield any publications describing a research-based evaluation of integrative treatment, in which an interdisciplinary team of biomedical and CAM practitioners offer treatments. In Canada and the USA, integrative treatment approaches have been assessed by patients and practitioners; however in the patient evaluations, the outcomes were not related to the treatment combinations used by patients (Mulkins, Eng, & Verhoef, 2005; Mulkins, Verhoef, Eng, Findlay, & Ramsum, 2003; Scherwitz et al., 2003). Furthermore, these teams consisted of a number of biomedical and CAM practitioners operating in parallel and referring to one another, thus characterized by a consultative or multi-disciplinary rather than an interdisciplinary approach (Oandasan et al., 2006; Boon et al., 2004b).

While evaluating the AHC was beyond the scope of this thesis, the respondents indicated that they would be interested in assessing the success of the AHC. Artists said that they were interested in participating in an evaluation that would be based on their personal and individual experiences of care at the AHC. The health-care practitioners wanted research to focus on deepening their understanding of the process of IHC and whether they were meeting the needs/expectations of the patients, hospital, and AHCF. The majority of AHCF members were also concerned with how the hospital measures success and whether the AHC was meeting the needs of the hospital’s mandate.

The literature search on research-based evaluations of IHC did not yield any publications (see chapter 2). Given the trend toward IHC that is taking place internationally (Gamst, Haahr, Kristoffersen, & Launso, 2005; Ruggie & Cohen, 2005), systematic, research-based evaluations of actual integrative treatment need to be carried out. I would suggest that any evaluation of the
AHC considers the method of participatory evaluation. Participatory evaluation provides stakeholders with the opportunity to actively engage in developing the evaluation and all phases of its implementation. Participation occurs throughout the evaluation process, including: identifying relevant research questions; planning the evaluation design; selecting appropriate measures and data collection methods; gathering and analyzing data; research consensus about findings, conclusions and recommendations; and disseminating results (Institute of Development Studies, 1998). This type of evaluation is closely aligned with the vision and mission of the AHC. In addition, it would promote collaboration among the stakeholder groups, and encourage a dialogue that currently appears to be absent. Active participation by stakeholders can result in new knowledge and a better understanding of their environment. This would enable stakeholders at the AHC to identify action steps and advocate for policy change.

Overall, several organizational factors impede the integration of CAM and biomedical practitioners at the AHC. First and foremost is the lack of funding which in turn affects the integration of CAM practitioners into the hospital setting. As a result, the CAM practitioners are relegated to the periphery of the hospital in their role as part-time, contract employees. Their lack of consistent presence at the AHC leads to a lack of understanding of scope of practice, hence a lack of referrals from other health-care practitioners, particularly those who are biomedically oriented. The current organizational structure at the AHC and the TWH does not offer funding for health-care practitioners to engage in professional development opportunities that support an increased understanding of IHC and how it could work for the AHC. Essentially, the findings suggest that all stakeholders, especially the health-care practitioners, were required to drive IHC forward without specific training on collaboration, integration, and conflict resolution.
7.5 Summary

The development of an identity and pattern of practice in the health care professions is based on a process of socialization into the roles and norms of a particular discipline; this has important implications for IHC. The implications of these patterns for the abilities of different professions to work together collaboratively were highlighted above. Little consensus exists within either biomedicine or CAM on what IHC might look like. The lack of consensus was partly due to the newness of the AHC. The lack of consensus continues because there remain questions regarding personal definitions of IHC, organizational definitions of IHC, and issues about whether they were congruent. Given a lack of consensus regarding the definition, goals, and vision of IHC at the AHC, it is not difficult to understand why there might be questions regarding the importance or even presence of IHC at the AHC.

The development of an IHC centre must be founded on core values or principles that correspond closely to the vision of stakeholders involved in the AHC. The findings suggest a need to reach consensus on the definition and range of IHC. For the AHC to grow and expand its range of integration, there is a need to develop mission statements for philosophical congruence, educate each practitioner on the capabilities and roles of the other, and foster an understanding of their own and each other’s expectations of IHC.

Communication is generally used to share ideas, philosophy, and knowledge, and establish individual and group identity. The sociology of professions and the literature on conflict management indicate that practitioners may develop different communication patterns and values that can hinder their capacity to integrate. A culture change is occurring in health care as the system grapples with ways to provide more care with fewer resources and improve safety through collaboration. For this change to be successful, health care organizations are going to
need practitioners with good conflict-management skills and the means and opportunity for integrating collaborative processes into their day-to-day operations.

Despite the descriptor *health-care team*, the findings show that there were relatively few times when health-care practitioners functioned as a team. It was found that the health-care practitioners at the AHC functioned more as a group of practitioners than as a team. Most often, they worked as individual practitioners and only in rare instances did they have the opportunity to work synergistically. Differences of knowledge and experience, together with rare opportunities for collaboration, led to an atmosphere where everyone was grouped together or co-located but not integrating. Given these results, it is unrealistic to think that simply bringing practitioners together will lead to integration. As the research shows, there a wide range of human dynamics need to be developed for integration to move forward.

The findings suggest that at the time of this study, the AHC was an integrative health care clinic neither in theory nor in practice.

If IHC at the AHC is to move forward, leadership is needed to bring together AHC stakeholders and create a shared vision of integration. This shared vision can be the path forward, and the potential role of the leader can serve to motivate and support others to follow that path. Leadership is a subject that has not been well documented in the frameworks described above. More research is needed to understand the role that leaders can play in IHC.

From an organizational perspective, hospitals face challenges in developing IHC, partly due to a lack of examples of how this complex concept translates into daily workplace experience. Several issues were raised about IHC in a hospital setting. Within the hospital, CAM and biomedical practitioners believed that one of the primary benefits of IHC was artists’ perceived quality of life as a result of CAM therapies. This finding is congruent with other studies that describe how an integrative approach to health care increases patient satisfaction.
because it is more client-centred than biomedical care (Richardson, 2001). However, the marginalization of CAM practitioners was still evident, particularly with regard to employment status, remuneration, and participation in hospital rounds. A few CAM practitioners also believed that the holistic nature of their work was constrained by hospital policy and regulations.

Several models and ranges of integration have been presented in this thesis. Despite the desire for an IHC clinic for artists, there is a paucity of evidence to demonstrate that such an approach would increase client health outcomes and quality of life. With the increasing shift toward IHC, research is urgently needed to justify the facilitation of this movement. This research further suggests that in Canada’s public health-care system, the exclusion of CAM from public funds, when the goal is integration, does not support IHC’s development. Even though the current Canadian health-care system was designed to provide universal and equitable access to health care for all Canadians, this system currently applies only to the provision of medical, hospital, and laboratory services. It could be argued that the public health care system is not financially sustainable, and therefore it is inappropriate to add therapies (both biomedical and CAM) that are perceived to be unproven to an already overburdened publicly funded system. On the other hand, it could also be argued that the current system has been designed to perpetuate the interest of key stakeholders, such as medical practitioners and pharmaceutical manufacturers. In some ways, the existing system of health care is the antithesis of collaboration and teamwork. Thus, the creation of successful IHC may necessitate a major change in the current system of health care.
CHAPTER 8
CONCLUSION

This chapter reviews the purpose and the findings of this thesis. An outline of practical implications of this study is presented as an outcome of the research findings and discussion. The contributions of this study are addressed and considered. Reflections on the limitations of the research are reported. Areas for future research and recommendations are suggested.

8.1 Purpose and Findings

The objectives of this study were to complete a thorough literature review; engage relevant stakeholders in the study; explore the perceived IHC challenges and opportunities at the AHC; and to recommend future research priorities based upon the findings of the study. The goals included an exploration of the perceptions of health-care practitioners, artists, hospital administrators, and AHCF members in relation to the concept of integrative health care at the AHC, which is housed within the organizational structure of a hospital setting.

These issues were studied from a qualitative perspective, with an underlying rationale based on the theoretical perspective of grounded theory. The research respondents participated in focus groups and the health-care practitioners also participated in face-to-face individual interviews that were open-ended and semi-structured to help the respondents reveal their experience with integrative health care at the AHC. Analysis was conducted with the assistance of a qualitative software program; it involved coding the participants’ words to discover meanings about their perceptions of IHC. The primary intention was to capture the reality of IHC at the AHC as perceived by the respondents. Based on interpretations of the findings, my conclusions are as follows:
8.1.1 Defining IHC

The majority of respondents believed that there was a lack of consensus of what IHC truly represents. The lack of consensus was partly due to the newness of the AHC. The lack of consensus continued because there remained confusion between personal definitions and institutional definitions of the concept of IHC.

8.1.2 Developing a Shared Philosophy and Culture of IHC

This was highlighted in the findings as a key step in enabling integration of health-care practitioners at the AHC. Although the hospital administrators and AHCF board members usually set the overall goals for the AHC, input from artists and health-care practitioners should be solicited and incorporated into a shared philosophy and culture of the AHC, which could then become a guide for important decisions.

8.1.3 Ensuring a “Deformation Professionelle”

The findings emphasized the importance of making hiring decisions within a framework of a shared philosophy and culture, to ensure that all potential new health-care practitioners were a fit with the AHC. New health-care practitioners should be expected to have an exceptional understanding of the arts culture and community, and be prepared to learn how to function well within this unique clinic for artists. One way of successfully ensuring a good fit would be to have multidisciplinary hiring teams in which every member had a say in the selection process.

8.1.4 Involving Stakeholders Appropriately in Decision-Making

The findings revealed that when artists and health-care practitioners were not involved or asked for their opinions, they often felt undervalued and unappreciated. Hospital administrators and the AHCF members need to ensure that all stakeholders are involved in critical decisions, in some appropriate way. This does not always imply consensus, as some decisions are givens, such as ministry health policy decisions. However, being invited to participate in decision-making, or
simply being given information about why a decision has been made, would help to keep everyone informed and engaged.

8.1.5 Allocating Time for Team Meetings

The genuine desire to learn how to better integrate with one another and understand the inner workings of a team was expressed. Team meetings were believed to be essential. However, with the limited number of hours at their disposal, and the part-time nature of the majority of AHC health-care practitioners, this was truly a dilemma. Thus, key to establishing consistency and regular attendance to team meetings at the AHC were: encouraging team meetings during work hours; providing the needed support and remuneration; booking meetings well ahead of time, to allow part-timers and others to schedule their attendance; and making meetings clinically relevant and not administrative, so that the health-care practitioners would see meetings as contributing in tangible ways to patient care.

8.1.6 Understanding Scope of Practice

To fully integrate CAM practitioners into the AHC, each health-care practitioner should have a strong knowledge base of each discipline that is available to their patients. What would seem to have the most impact would be the opportunity for people in different disciplines to interact with one another. The majority of respondents believed that providing time for meetings, full-day retreats, and seminars would contribute a great deal to better understanding the professional roles and identities of the various disciplines.

8.1.7 Financial Integration

Financial limitations were often cited as the leading factor in preventing the AHC from becoming more of an IHC clinic. Strategies for sustainability included using aspects of a business model or an insurance model to inform the current management of AHC funds.
8.1.8 Training and Education

Through this research I discovered that defining and understanding the role of each health-care practitioner was not something that came naturally. Health-care practitioners should have faculty development opportunities that are encouraged and actively supported by the hospital and the AHCF.

8.1.9 Evaluation

The establishment of organizational benchmarks, and ways to measure success are important considerations as part of the development of IHC at the AHC.

8.2 Contributions to the Literature

This study contributes to the literature in the following ways:

1. A great deal of work previously done in the area used quantitative methods. Through the use of qualitative research, this study provided useful, in-depth accounts of respondents’ experiences of integrative health care.

2. This study has enhanced the current knowledge of teamwork, collaboration, and integration among health-care practitioners in general, and biomedical and CAM practitioners in particular. It explored the current perceptions of eight occupational groups (medicine, nursing, physiotherapy, psychotherapy, massage therapy, chiropractic, osteopathy, and naturopathy) and their interrelationships, along with consideration of issues of biomedical dominance and authority.

3. This study examined the effect of physical setting – an occupational health clinic for artists in a hospital – and described how this setting influenced the level of integration of CAM and biomedical health practitioners.
4. This study examined the organizational context and mechanisms of remuneration for health-care practitioners at the AHC to better understand the organizational contexts of health-care teams.

5. This study explored health-care practitioners’ desire to learn, teach, and/or model the principles of integrative health care at the AHC.

6. This study used integrative health-care models, interdisciplinary teamwork models, and organizational theory for building a theoretical and conceptual framework of IHC at the AHC. Combining these models with organizational theory shed light on relationship dynamics among CAM and biomedical health-care practitioners while taking into consideration the several structural and process dimensions of integration.

7. This study discussed the potential role and importance of leaders in the process of integration as it relates to the AHC.

8.3 Study Limitations

This was an exploratory study and only a small number of health-care practitioners, artists, AHCF members, and hospital administrators was interviewed. The ideal in qualitative research is to continue sampling and collecting data until data saturation is reached. I acknowledge that the study themes merit further examination in a larger qualitative study with a broader sample. In addition, participants were not given a copy of the final findings. I also recognise that it might have been useful to assess the credibility of the themes and my interpretation of them, through strategies such as respondent validation. In this small-scale study, practical constraints limited the time and resources available for gathering and analyzing data.

My findings may have some transferability to IHC centres in other similar hospital settings with a professional interest in CAM. However, as all of the health-care practitioners at the AHC were under the umbrella of an academic teaching hospital, their views are unlikely to
be typical of non-academic practitioners. Ideas about scientific evidence were a prominent thread throughout their accounts, which may be a reflection of the research orientation of the particular practitioners sampled. Therefore, the findings of my study may over-emphasize the importance of scientific evidence to biomedical practitioners, as a previous study of the views of health-care practitioners in a non-academic setting found little reference to research and evidence as important factors determining the acceptance of CAM within mainstream health-care systems (Julliard, Klimento, & Jacob, 2006).

8.4 Future Research

The research and literature review for this study reveal a significant need for further research. This study opened up a number of research possibilities, as discussed below.

8.4.1 The Economics of CAM: Cost-Effectiveness and Savings

A few studies on the cost-effectiveness and cost-saving potential of CAM are promising. For instance, Canadian researchers have found that teaching transcendental meditation (TM) to heart patients greatly reduces health-care costs by controlling levels of stress (van Dixhoorn & Duivenvoorden, 1999). U.S. research has also confirmed the effectiveness of TM in lowering hypertension (Herron, Schneider, Mandarino, Alexander, & Walton, 1996). If it can be shown that inexpensive CAM interventions reduce the need for surgery, the savings could be enormous. More research is needed on whether CAM could help patients heal faster, use less medication, and leave the hospital sooner.

8.4.2 Consumer Demand Shaping

The AHC was created through a grassroots movement of artists who were frustrated with the current health-care system. However, the question of whether consumers could reshape hospitals by demanding integrative services cannot be answered by this study. More needs to be
known about the services to be adopted, how they would be organized in the hospital structure, and whether these integrative services would be retained.

8.4.3 Artists as an Occupational Group/Occupational Identity of Artists

A theoretical understanding of artists’ health could be developed, by making connections between artists’ health and other occupations with similar occupational work hazards. This could be connected to an exploration of how the concept of an occupational identity relates to artists.

8.4.4 Education and Training

Given the extensive training within most of the health-care disciplines, it may be difficult, if not impossible, for health-care practitioners to have a comprehensive understanding of each and every approach. Instead, links could be made between the existing literature on interprofessional education for collaborative patient-centred practice (IECPCP) (Health Canada, 2006) and how it might be applied to promote a culture of IHC in an educational environment.

8.5 Summary

This chapter reviewed the purpose of the study and summarized the findings of the study. The limitations of this research and suggestions for further research were listed.
Reference List


APPENDICES


### APPENDIX A

#### RESULTS OF SEARCH STRATEGY

1. Ovid MEDLINE(R) 1966 to February Week 3 2006

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Result 1.
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Authors Barr F.
Title Quality in practice.
Local Messages Check Virtual Library for availability at UHN.
Abstract Under the new GP contract, nurses can have a significant role in ensuring quality of patient care and even become partners in their practices.
Publication Type Journal Article.
Abstract PURPOSE: To describe the benefits of a physician-nurse practitioner (NP) collaborative practice model, specifically that of a tandem practice model, using a neurosurgeon and a primary care NP in the clinic and inpatient setting. DATA SOURCES: Selected journal articles from Medline and CINAHL, and anecdotal clinical experience. CONCLUSIONS: This collaborative practice model, in which the physician and NP deliver patient care in tandem, is beneficial to patients and their families because they receive comprehensive care that is patient oriented and holistic. Further, the model benefits multiple disciplines across the healthcare continuum by providing efficient communication of patient needs, accessibility of the specialty team, and timely implementation of patient interventions. The collaboration of the physician specialist and primary care NP provides a holistic approach to the care of diverse and challenging patient populations. IMPLICATIONS FOR PRACTICE: Patients seen in a specialty practice, particularly that of neurosurgery, often have little understanding of their problem and may be frightened or confused because of their perceptions of the unknown. Providing care to such specialized patient populations in a constantly changing healthcare environment may prove demanding to the specialist. The introduction of a primary care NP into such specialty settings offers patients, their families, consultants, and staff members an additional resource for evaluation, intervention, education, and communication, improving the continuity and comprehensiveness of care to challenging patient populations. This model is an option for physician specialists interested in augmenting their practice and provides further resources for meeting the holistic needs of selected patient populations regardless of the setting.

Abstract We compared the frequency of performance of three patient education and three drug therapy monitoring activities across practitioner types and assessed the influence of practitioner characteristics, practice setting, and health care environment on performance of these activities. A mail survey was sent to a random sample of 1300 practitioners in a Midwestern state. Numbers of elderly patients for whom the practitioner performed each of the activities were the dependent variables. Independent variables for the multiple regressions were measures of practitioner characteristics, practice setting, and health care environment. Based on 320 usable responses, prescribers were more likely than pharmacists to perform three of the activities. Minutes per patient contact was positively associated with two of the monitoring activities. Other practitioners in a practice affected the number of patients for whom five activities were performed. Practitioners interested in improving the medication use process for ambulatory elderly patients need to consider multidisciplinary strategies.

Publication Type Journal Article.

Result 4.
Unique Identifier 15842080
Authors Gibson T. Heartfield M.
Institution University of South Australia, School of Nursing & Midwifery, Adelaide, South Australia 5000.
Title Mentoring for nurses in general practice: an Australian study. [Review] [16 refs]
Local Messages Check Virtual Library for availability at UHN.
Abstract This paper presents findings from a project conducted to recommend a national framework for mentoring for general practice nurses in Australia. The first phase identified challenges and key issues; the second and third phases (reported here) engaged practice nurses and general medical practitioners in discussion to advance thinking on the topic. Outcomes revolved around seven core areas: role confusion and diversity of practice nursing; lack of a defined career pathway for practice nurses; professional isolation of practice nurses; need for general practitioner support; expectations of mentoring; importance of resourcing and infrastructure; and roles, skills and qualities of mentors. Implications of these for the development of a systemic approach to supporting nurses in general practice are discussed, taking into account the interprofessional context and special working relationship between nurses and doctors. Findings revealed keen support for the idea of mentoring for nurses in general practice and indicate success will depend on appropriate resourcing and infrastructure through national, state and local coordination processes. [References: 16]

Publication Type Journal Article. Review.

Result 5.
Unique Identifier 15624641
Authors Goudreau J. Boucher S.
Institution Faculte des sciences infirmieres, Universite de Montreal.
Title [Family practice group nurse: an emerging role]. [Review] [14 refs] [French]
Publication Type Case Reports. Journal Article. Review.

Result 6.
Unique Identifier 15624379
Authors Duffin C.
Title New kid in town.
Local Messages Check Virtual Library for availability at UHN.
Publication Type Journal Article.

Result 7.
Unique Identifier 15588220
Authors Reid SL.
Title Practice nurses.
Local Messages Check Virtual Library for availability at UHN.
Publication Type Letter.

Result 8.
Unique Identifier 15382553
Authors Harding-Price D.
Institution National Substance Misuse Training Programme, Royal College of General Practitioners.
Title How can I help?.
Local Messages Check Virtual Library for availability at UHN.
Publication Type Journal Article.
Result 9.
Unique Identifier 15328503
Authors Saxe JM. Burgel BJ. Stringari-Murray S. Collins-Bride GM. Dennehy P. Janson S. Humphreys J. Martin H. Roberts B.
Institution Department of Community Health Systems, University of California-San Francisco School of Nursing, 2 Koret Way, San Francisco, CA 94143-0608, USA. joanne.saxe@nursing.ucsf.edu
Title What is faculty practice?. [Review] [14 refs]
Local Messages Check Virtual Library for availability at UHN.
Publication Type Journal Article. Review.

Result 10.
Unique Identifier 15318677
Authors Rockman P. Salach L. Gotlib D. Cord M. Turner T.
Institution Department of Family and Community Medicine, University of Toronto, ON.
Title Shared mental health care. Model for supporting and mentoring family physicians.[see comment].
Local Messages Check Virtual Library for availability at UHN.
Abstract PROBLEM BEING ADDRESSED: Family physicians lack access to psychiatrists and mental health services for patients with serious and persistent mental illnesses. OBJECTIVE OF PROGRAM: To develop a mentoring program to provide FPs with education and e-mail, telephone, and face-to-face support for managing patients with mental illness. PROGRAM DESCRIPTION: The Ontario College of Family Physicians' Collaborative Mental Health Care Network developed a mentoring program. Family physicians are grouped according to clinical interest with psychiatrist and general practice psychotherapist mentors whom they can contact for help. Communication is established via e-mail, telephone, fax, or listserv, or even face to face. Monitoring and evaluation is carried out through surveys and chart audits to examine use of, satisfaction with, and effectiveness of the program. CONCLUSION: Mental health care can be enhanced through collaborative at-a-distance relationships between FPs and psychotherapists and psychiatrists. Family physicians can get timely consultation in the areas of psychotherapy and pharmacotherapy, and access to community resources.
Publication Type Journal Article.

Result 11.
Unique Identifier 15239315
Authors Martin-Misener R. McNab J. Sketris IS. Edwards L.
Abstract Recently attention has been focussed on the significance of primary care to the Canadian healthcare system. Nova Scotia. Like other provinces, is seeking ways to improve the healthcare that it provides within a financially constrained publicly funded system. The Strengthening Primary Care Initiative in Nova Scotia (SPCI) was a primary care demonstration project to evaluate specific goals related to primary care. Although the provincial government conceived the SPCI, the approach to its planning and implementation was participatory and consultative. Funded through the federal Health Transition Fund (HTF) (Health Canada 2002) and the government of Nova Scotia, the SPCI involved changes in four communities over a three-year period (2000-2002). These changes included the introduction of a primary healthcare nurse practitioner in collaborative practice with one or more family physicians; remuneration of the family physician(s) with methods other than a solely fee-for-service (FFS) arrangement; and the introduction and utilization of a computerized patient medical record. The SPCI was committed to a consultative process with stakeholders, and this gave rise to several challenges. Initially there was disagreement on the requirement for nurse practitioners at each of the demonstration sites. The Minister of Health confirmed that a nurse practitioner was a required component at each demonstration site. Differences in perspectives on the role of allied health professionals in the SPCI were encountered, and the significance of the role pharmacists have in primary care was not fully appreciated until after the SPCI had started. At the time the SPCI began there was no legislation for nurse practitioners in Nova Scotia; therefore, an approval mechanism for nurse practitioner practice was authorized through the provincial regulatory bodies for nursing and medicine. Malpractice and liability issues, particularly on the part of providers who had never worked with nurse practitioners before, were an initial concern. Recruitment of nurse practitioners into the three rural sites mirrored the difficulties with recruitment of healthcare providers encountered in other parts of rural Canada. The authors discuss their perspectives on the challenges related to interdisciplinary collaboration in health systems change that were encountered during the planning and implementation of the SPCI. Although nurse practitioner Legislation has existed in Ontario and Newfoundland and Labrador for several years, many provinces are grappling with the challenges associated with the introduction of nurse practitioners and collaborative practice. This paper conveys the experience of one province and will be of interest to administrators, educators and practitioners elsewhere in Canada who are engaged in primary healthcare renewal. [References: 20]
Title Australian nurses in general practice based heart failure management: implications for innovative collaborative practice. [Review] [89 refs]


Abstract BACKGROUND: The growing global burden of heart failure (HF) necessitates the investigation of alternative methods of providing co-ordinated, integrated and client-focused primary care. Currently, the models of nurse-coordinated care demonstrated to be effective in randomized controlled trials are only available to a relative minority of clients and their families with HF. This current gap in service provision could prove fertile ground for the expansion of practice nursing [The Nurse in Family Practice: Practice Nurses and Nurse Practitioners in primary health care. 1988, Scutari Press, London: Impact of rural living on the experience of chronic illness. Australian Journal of Rural Health, 2001. 9: 235-240]. AIM: This paper aims to review the published literature describing the current and potential role of the practice nurse in HF management in Australia. METHODS: Searches of electronic databases, the reference lists of published materials and the internet were conducted using key words including 'Australia', 'practice nurse', 'office nurse', 'nurs*', 'heart failure', 'cardiac' and 'chronic illness'. Inclusion criteria for this review were English language literature; nursing interventions for heart failure (HF) and the role of practice nurses in primary care. RESULTS: There is currently a paucity of data evaluating the potential role for practice nurses in a reconfigured, collaborative health care system. Those studies that were identified were, largely, of a descriptive nature. In addition to identifying the practice nurse as a largely unexplored resource, key themes that emerged from the review include: (1) current general practice services face significant barriers to the implementation of evidence-based HF practice; (2) there is considerable variation in the practice nurse role between general practices; (3) there are significant barriers to the expansion of the practice nurse role; (4) multidisciplinary interventions can effectively deliver secondary prevention strategies; (5) practice nurses can potentially facilitate these multidisciplinary interventions; and (6) practice nurses are favorably perceived by consumers although there is some confusion about the nature of their role. CONCLUSION: On the basis of this literature review, practice nurses represent a potentially useful adjunct to current models of service provision in HF management. Further research needs to comprehensively investigate the role of the practice nurse in the Australian context with a view to developing effective and sustainable frameworks for clinical practice. In particular, high-level evidence is required to evaluate the efficacy of the practice nurse role compared to current disease management strategies. [References: 89]

Publication Type Journal Article. Review.

Result 13.

Unique Identifier 15060962

Authors Chatterjee M.

Title GP contract reveals nursing opportunity.


Local Messages Check Virtual Library for availability at UHN.

Publication Type Journal Article.
Result 14.
Unique Identifier 14708141
Authors Albert E.
Title The development of family health nurses and family nurse practitioners.
Publication Type Letter.

Result 15.
Unique Identifier 14613603
Authors Resnick B. Bonner A.
Institution University of Maryland, School of Nursing, Baltimore, Maryland 21201, USA.
Barbresnick@aol.com
Title Collaboration: foundation for a successful practice. [Review] [13 refs]
Local Messages Check Virtual Library for availability at UHN.
Publication Type Journal Article. Review.

Result 16.
Unique Identifier 14507802
Authors Clemence ML. Seamark DA.
Institution Physiotherapy Department, Torbay Hospital, Torquay TQ2 7AA, UK.
mclemente@connectfree.co.uk
Title GP referral for physiotherapy to musculoskeletal conditions--a qualitative study.
Abstract BACKGROUND: Little is known about the dynamics of GP referral for physiotherapy. Better understanding of this process is important because of the growing number of physiotherapy referrals by GPs. OBJECTIVES: Our aim was to achieve insight into the experiences and views of patients, GPs and physiotherapists in relation to physiotherapy referral for musculoskeletal conditions. METHOD: The study involved qualitative methodology using 22 semi-structured in-depth interviews. The interviews were recorded and transcribed verbatim. The transcripts were coded and analysed using the methods developed in grounded theory. Interviews were undertaken with GPs in primary care, Health Authority and hospital locations. Interviews with physiotherapists and patients were undertaken within community and district hospital locations. RESULTS: Three classifications of referral type were developed by the authors from the data, 'appropriate referral', 'load-sharing referral' and 'dumping referral'. There are descriptions of influences on GP referral behaviour, physiotherapists' response to appropriateness and expectations from the perspective of GPs and physiotherapists. Communication was shown as important in determining appropriate referral, but the quality of communication was variable. GPs' past experience of physiotherapy significantly affected
referral. Patients' expectations about physiotherapy were described as variable and sometimes unrealistic. CONCLUSIONS: The selection of appropriate referrals by GPs could be helped by improved communication and better definitions of appropriateness. Closer working between the two professions would result in the better management of problematic patients and prevent wasted resources through avoiding inappropriate referral. Written guidelines appeared to be of less use than direct contact. The concept of expectations appeared relevant to multiple aspects of physiotherapy referral.

Publication Type Journal Article.

Result 17.
Unique Identifier 12929253
Authors Ulrich C. Soeken K. Miller N.
Institution Department of Clinical Bioethics, at the National Institutes of Health, Bethesda, Maryland, USA. culrich@cc.nih.gov
Title Predictors of nurse practitioners' autonomy: effects of organizational, ethical, and market characteristics.
Local Messages Check Virtual Library for availability at UHN.
Abstract PURPOSE: To identify the predictors of autonomy of nurse practitioners (NPs) affiliated directly and/or indirectly with managed-care systems (e.g., HMOs). DATA SOURCES: A mailed survey sent to a stratified random sample of 254 NPs certified and licensed to practice in the state of Maryland. The measures consisted of selected organizational characteristics; market factors of HMO penetration and percentage of client population enrolled in managed care; and factors of ethical concern, such as ethical ideology, ethics education, and autonomy. The County Surveyor Database was used to assess market penetration in the state. CONCLUSIONS: Although NPs were ethically concerned about their autonomy in a managed-care environment (70.2%), actual autonomy scores were high. The higher the percentage of HMO penetration, percentage of client population enrolled in managed care, and perceived ethical concern, the lower the perceived autonomy of NPs. IMPLICATIONS FOR PRACTICE: Findings may be used for future research to address the complexity of variables that influence the autonomous practice of NPs.
Publication Type Journal Article.

Result 18.
Unique Identifier 12881974
Authors Nemeth LS.
Institution Care Management, Research and Evaluation, Medical University of South Carolina, 169 Ashley Avenue, Box 250347, Charleston, SC 29425, USA. nemethl@musc.edu
Title Implementing change for effective outcomes. [Review] [24 refs]
Local Messages Check Virtual Library for availability at UHN.

Abstract Change is rapidly becoming an integral component of healthcare improvement. To implement change effectively, it is necessary to provide clear vision, leadership, and adequate time to develop followers. Coordination of activities and integration of changes in practice to promote positive outcomes are needed for success. This article analyzes the concept of change illustrated though a quality improvement intervention-based research project. [References: 24]

Result 19.
Unique Identifier 12861097
Authors Likis FE.
Institution Frontier School of Midwifery and Family Nursing, Hyden, KY, USA.
Title A novel model for collaborative practice guidelines.

Result 20.
Unique Identifier 12856500
Authors Kaissi A. Kralewski J. Dowd B.
Institution Division of Health Services Research and Policy, School of Public Health, University of Minnesota, Minneapolis, USA. kais0072@umn.edu
Title Financial and organizational factors affecting the employment of nurse practitioners and physician assistants in medical group practices.

Abstract This study examines the financial and organizational factors that are associated with the employment of nurse practitioners (NPs) and physician assistants (PAs) in medical group practices. The source of the data is a survey of 128 medical group practices in Minnesota. The findings suggest that the employment of NPs and PAs and their ratios to primary care physicians (PCPs) in practices that employ them are influenced by the organizational characteristics of the group practice but not by the degree of financial risk sharing for patient care. Although neither the number of years of experience in financial risk sharing nor more revenue from capitation payment contracts were related to employment of these midlevel practitioners (MLPs), large practices, those located in rural locations, not-for-profit practices, and those that scored low on cohesive cultural traits were more likely to employ MLPs. The data provide insights into the market for MLPs and the potential for these clinicians in the future health care system. As medical group practices become larger and have more organizational capacity, they can likely be expected to increase the employment of MLPs and integrate them into their organizations.
Result 21.
Unique Identifier 12850875
Authors Price A. Williams A.
Institution The Ashgrove Surgery, Pontypridd, Mid Glamorgan, University of Wales Swansea, Swansea, UK. anne_prince@lineone.net
Title Primary care nurse practitioners and the interface with secondary care: a qualitative study of referral practice.
Abstract In the United Kingdom nurse practitioners are assuming responsibilities traditionally considered to be within the domain of general practitioners. Important amongst these is the referral of patients to medical consultants in secondary care, a responsibility commonly associated with the general practitioner's role as 'gatekeeper' to health care. This paper describes a study designed to identify issues raised by the challenge that a developing nursing role presents to interprofessional working at the interface between primary and secondary care. When invited to comment, study participants (nurse practitioners, nurse educators, medical consultants and general practice registrars) related nursing referrals to issues associated with professional boundary changes, namely: teamwork, regulation of practice, communication, professional conflict and professional relationships. This paper discusses the views of primary and secondary care practitioners about who should take responsibility for the referral of patients in the light of concerns raised about professional competence and accountability. Individual nurse practitioners and their colleagues have found pragmatic ways to manage their work however, although UK government policy supports development of advanced clinical nursing, there remains much work to be done to provide the professional and legal infrastructure to support the role.
Publication Type Journal Article.

Result 22.
Unique Identifier 12836597
Authors Bekaert S.
Institution City and Hackney Young People's Services, London. Sarah.bekaert@chpct.nhs.uk
Title Developing adolescent services in general practice. [Review] [24 refs]
Abstract BACKGROUND: Adolescence is recognised as a time of risk-taking behaviour, yet it is also a crucial time for laying down the foundations for future health. This literature review examines current adolescent healthcare provision in the community, particularly general practice. The role of the practice nurse in meeting adolescents' healthcare needs is also
explored. CONCLUSION: Although health professionals and teenagers see general practice as an appropriate location for health promotion activity, generally it is not the first choice for health information for young people. There is no consensus on effective interventions in teenage health care, as different methods work in different areas. The stigma of adolescent healthcare provision, where young people are seen as a difficult group that requires specialist provision, should be removed. However, there should be specific healthcare provision for this age group. [References: 24]

Publication Type Journal Article. Review.

Result 23.
Unique Identifier 12808744
Authors O'Dowd A.
Title The primary care revolution.
Local Messages Check Virtual Library for availability at UHN.
Publication Type Journal Article.

Result 24.
Unique Identifier 12771698
Authors Bradley PJ. Bray KH.
Institution Texas Christian University, TCU Box 298620, Fort Worth, TX 76219, USA.
p.bradley@tcu.edu
Title What we can learn from the British maternal child health system. [Review] [24 refs]
Local Messages Check Virtual Library for availability at UHN.
Abstract Infants born in Great Britain have a better chance of living until their first birthdays than do infants born in the United States. Although Great Britain spends less than half what the United States spends on healthcare, its estimated infant mortality rate was 5.5 as compared to 6.8 in the United States in 2001 (Central Intelligence Agency [CIA], 2001). What is different about healthcare in Great Britain? This article details some of the differences, suggesting that there are ways the United States can improve its infant mortality rates. [References: 24]
Publication Type Journal Article. Review.

Result 25.
Unique Identifier 12752747
Authors Blumenfeld A. Tischio M.
OBJECTIVE: To evaluate the effectiveness of a disease management model for primary headache by: (1) assessing improvement in patients’ quality of life, (2) decreasing headache-related visits to primary care and emergency departments, and (3) maintaining high levels of patient and physician satisfaction. BACKGROUND: Patients with headache regularly seek health care but, in general, are dissatisfied with the care they receive. Patients with primary headaches utilize resources and cost health plans more than patients with other chronic diseases. Primary care visits are time restricted, prohibiting adequate headache evaluation and management. Practice guidelines are inconsistently followed, and access to headache specialists is limited. This headache management program implemented an alternative means of delivering care to manage large volumes of patients with headache. A multidisciplinary team approach coordinated by a neurologist, utilizing education and a nurse practitioner as the main provider of care, was the central process of the program. METHODS: This was a pilot study involving a prospective cohort with defined outcome measures. Inclusion criteria were adult patients with primary headaches. Patients initially attended an educational session instructed by a neurologist and a nurse practitioner. The patient was subsequently evaluated by the nurse practitioner who developed and coordinated a comprehensive individual treatment plan. The Migraine-Specific Quality of Life and the Medical Outcomes Study 36-Item Short Form Questionnaires were completed at baseline, at follow-up visits, and 6 months after completion of the program. Subjective patient assessment of improvement in their headaches, chart review for tabulation of headache-related visits, and primary care physician satisfaction surveys were measured. RESULTS: Both the Migraine-Specific questionnaire and the Short Form-36 measurements demonstrated a statistically significant improvement at 8 weeks, and this was maintained for 6 months after completing the program. At completion of the program, 92% of patients reported subjective improvement. Patient visits for headaches to primary care and emergency departments showed a significant decrease. High levels of satisfaction for primary care physicians were achieved. CONCLUSIONS: A disease management model using a multidisciplinary team improved individualized patient care. This model increased patient/provider rapport and communication through an educational class. It empowered the patient to take control of their health care by utilizing shared decision making. Patient satisfaction improved and overall health care utilization was reduced.
Abstract OBJECTIVE: To describe barriers and facilitators to effective generalist-subspecialist communication in the care of children with chronic conditions. METHODS: We conducted 5 focus groups with 14 general pediatricians and 10 pediatric specialty providers to discuss factors that facilitate or obstruct effective communication. The specialty groups included 2 nurse practitioners; the rest were pediatricians from an academic medical center and the surrounding community. We performed a content analysis to generate groups of themes and classify them as barriers or facilitators, and we returned to the participants to solicit their feedback. RESULTS: We identified 201 themes in 6 domains: the method, content, and timing of communication; system factors; provider education; and interpersonal issues. Barriers to communication mostly involved the method of communication and system factors. Most facilitating themes promoted timely communication, understanding of the reasons for referral and the nature of the child's condition, or appropriate definition of generalist and specialist roles. Participants described numerous examples where communication had direct effects on patient outcomes. Generalists and specialists agreed on many issues, although specialists discussed the pros and cons of curbside consults at length whereas generalists emphasized the importance of their own education in the referral-consultation process. CONCLUSIONS: Efforts to improve communication between pediatric generalists and specialists in the care of children with chronic conditions should emphasize the importance of timely information transfer. The content of messages is important, but lack of receipt when needed is more of a problem. Improving generalist-subspecialist communication has great potential to improve the quality of care.

Result 27.
Unique Identifier 12683172
Authors Nagelkerk J. Ryan M.
Institution Grand Valley State University, Grand Rapids, Mich., USA.
Title The family advanced practice nurse. A blending of the CNS and NP roles.
Publication Type Journal Article.

Result 28.
Unique Identifier 12862408
Authors Ee-Ming Khoo. Kidd MR.
Institution Department of Primary Care Medicine, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia.
Title Primary health care and general practice--a comparison between Australia and Malaysia.
Abstract The Australian and Malaysian systems of general practice were examined and compared. The issues of similarity and difference identified are discussed in this paper. Quality clinical practice and the importance of compulsory vocational training prior to entry into general practice and continuing professional development is one important area. A move towards
preventive health care and chronic disease management was observed in both countries. Practice incentive programmes to support such initiatives as improved rates of immunisation and cervical smear testing and the implementation of information technology and information management systems need careful implementation. The Medicare system used in Australia may not be appropriate for general practitioners in Malaysia and, if used, a pharmaceutical benefit scheme would also need to be established. In both countries the corporatisation of medical practice is causing concern for the medical profession. Rural and aboriginal health issues remain important in both countries. Graduate medical student entry is an attractive option but workforce requirements mean that medical education will need individual tailoring for each country. Incorporating nurses into primary health care may provide benefits such as cost savings. The integration model of community centres in Malaysia involving doctors, nurses and allied health professionals, such as physiotherapists, in a single location deserves further examination.

Publication Type Journal Article.

Result 29.
Unique Identifier 12745907
Authors de Lusignan S, Wells SE, Russell C, Bevington WP, Arrowsmith P.
Institution Primary Care Informatics, Department of General Practice and Primary Care, St George’s Hospital Medical School, London, UK.
Title Development of an assessment tool to measure the influence of clinical software on the delivery of high quality consultations. A study comparing two computerized medical record systems in a nurse run heart clinic in a general practice setting.
Abstract A rating scale was developed to assess the contribution made by computer software towards the delivery of a quality consultation, with the purpose of informing the development of the next generation of systems. Two software programmes were compared, using this scale to test their ability to enable or inhibit the delivery of an ideal consultation with a patient with heart disease. The context was a general practice based, nurse run clinic for the secondary prevention of heart disease. One of the programmes was customized for this purpose; the other was a standard general practice programme. Consultations were video-recorded, and then assessed by an expert panel using the new assessment tool. Both software programmes were oriented towards the implementation of the evidence, rather than facilitating patient-centred practice. The rating scale showed, not surprisingly, significantly greater support from the customized software in the consultation in five out of eight areas. However, the scale’s reliability measured by Cronbach’s Alpha, was sub-optimal. With further refinement, this rating scale may become a useful tool that will inform software developers of the effectiveness of their programmes in the consultation, and suggest where they need development.


Result 30.
Unique Identifier 12526278
Authors Blair KA.
Title Collaborative interdisciplinary team practice: a dream or reality?.
Publicaton Type Journal Article.

Result 31.
Unique Identifier 12510524
Authors Midy F.
Title [Economic impact of the physician/nurse substitution in community health care sector]. [French]
Publication Type Journal Article.

Result 32.
Unique Identifier 12447118
Authors Neal R. Linnane J.
Institution Public Health Medicine, Walsall Primary Care Trust.
Title Improving access to continence services: action in Walsall.
Abstract New government guidelines state that primary care trusts should be moving towards an integrated continence service. In Walsall a study was undertaken to inform the development of care pathways and to support a move to a single specialist continence service. The study looked at accessibility to services, and the opinions of patients (suffering from urinary incontinence), and professionals about the two existing specialist continence services. Over a period of approximately 3 months primary care staff, particularly GPs and practice nurses, and patients filled in questionnaires. Overall the primary care team and patients were satisfied with the help they had received from the current services. The study identified a need to raise awareness and provide more information about incontinence and the services available. There is also an opportunity to get practice nurses more involved in the management of incontinence. The recommendations of this study have been incorporated into the changes being made to the local service.
Publication Type Journal Article.

Result 33.
Unique Identifier 12432730
Authors Burns D.
Institution Pennine Medical Centre, Mossley, Greater, Manchester.
Title Nurse prescribing. Nurses' influence on GPs' prescribing.
Local Messages Check Virtual Library for availability at UHN.
Abstract This is the third Part in a series on a range of topics aimed at helping you to update your knowledge and assist you with your continuing professional development (PREP requirements). The number of hours you spend studying the material in this article should be recorded in your professional portfolio (see Study Hours panel overleaf).

Result 34.
Unique Identifier 12429668
Authors Wilson A. Pearson D. Hassey A.
Institution University of Leeds and Research Capacity Development, Department of Health Research School of Medicine, Leeds, UK.
Title Barriers to developing the nurse practitioner role in primary care-the GP perspective.
Abstract BACKGROUND: Opportunities exist to develop an advanced nursing role in general practice and there is growing evidence that appropriately trained nurses can reduce cost and GP workload without compromising quality of care or patient satisfaction. Despite the shortfall of doctors entering British general practice and the difficulties doctors report in managing an increasing workload in primary care, few British practices have chosen to adopt this potential solution. An exploration of the barriers to the development of a nurse practitioner role is therefore timely. OBJECTIVE: To explore the views of British GPs regarding their attitudes towards developing an advanced nursing role in general practice. METHODS: A focus group study of GPs from four general practices in Yorkshire selected purposefully to represent a spectrum of experience in working with different nursing roles in general practice. Each focus group consisted of between 6 and 8 participants. A structured framework was used to elicit views, the group meetings were recorded and subjected to content analysis by two independent assessors. Inter-rater reliability was high (K = 0.921; 95% confidence limits 0.86-0.98). RESULTS: The study highlighted significant concerns by GPs with regard to the nurse practitioner role in general practice. Four themes were identified that may be impeding the development of advanced nursing roles in general practice. These are concerned with threats to GP status, including job and financial security, nursing capabilities, including training and scope of responsibility, and structural and organizational barriers. CONCLUSIONS: There is a need to acknowledge GP concerns and encourage a more widespread debate about the appropriate mix of skills required in primary care. Joint educational events and the development of GP preceptorship may help to develop a greater understanding of the potential value of advanced nursing roles in general practice.
Publication Type Journal Article.

Result 35.
Unique Identifier 12400360
Authors Martin S.
Institution Rural Health Technologies Inc., Springerville, Ariz., USA.
Title Choosing a business structure. Beyond the standard employer-employee relationship.
Publication Type Journal Article.

Result 36.
Unique Identifier 12191074
Authors Dowswell T. Wilkin D. Kirk S. Banks-Smith J.
Institution National Primary Care Research and Development Centre, University of Manchester, UK.
Title Primary care groups and trusts: a threat or an opportunity for the development of community-based nursing in England.
Local Messages Check Virtual Library for availability at UHN.
Abstract AIMS OF THE STUDY: To examine the role of Primary Care Groups and Trusts (PCG/T) in relation to nurses working in general practice and community health services. BACKGROUND: Over the past two decades there have been rapid changes in the numbers and roles of nurses working in primary care and community based settings. The establishment of Primary Care Groups offers health care professionals, including nurses, the chance to develop local primary care services and to integrate community and primary care nursing. These developments may offer opportunities or pose threats to nursing staff. RESEARCH METHODS: Data are drawn from a longitudinal study of a randomly selected sample of Primary Care Groups in England (n = 72). In a second survey of Groups carried out in autumn/winter 2000, Primary Care Group chairs and chief officers were interviewed by telephone. RESULTS: Response rates were 97% for both chairs and chief officers (69 of each). Chairs indicated that in most areas Primary Care Groups were consulting with local nurses to develop policy. Fifty-seven (85%) reported that investment in nursing staff and nursing services was a high priority in their area. Twenty-eight (41%) indicated that nurse-led services designed to increase patient access had already been established in their area, and 20 (29%) were planning new nurse-led services. Many developments had been initiated by Primary Care Groups. Initiatives to integrate community and general practice based staff were underway in most areas. CONCLUSIONS: Primary Care Groups and Trusts are initiating changes in general practice and community based services which are likely to have long-term and important implications for nurses in terms of their roles, conditions of work and future careers. It is important that nurses are consulted and are involved in developing and implementing policy change.
Publication Type Journal Article.

Result 37.
Unique Identifier 12130620
Authors Baraniak C.
Title Can nurse practitioners provide equivalent care to GPs? Nurses and doctors working together can complement each other.[comment].
Comments Comment on: BMJ. 2002 Apr 6;324(7341):819-23; PMID: 11934775
Local Messages Check Virtual Library for availability at UHN.
Publication Type Comment. Letter.

Result 38.
Unique Identifier 12087783
Authors Buchanan L.
Institution Adult Health and Illness Department, College of Nursing, University of Nebraska Medical Center, Omaha, NE, USA. lbuchanan@unmc.edu
Title Implementing a smoking cessation program for pregnant women based on current clinical practice guidelines.
Local Messages Check Virtual Library for availability at UHN.
Abstract PURPOSE: To describe the U.S. Department of Health and Human Services clinical practice guideline for treating tobacco use and dependence and demonstrate how the guideline was utilized in a pilot program for a small sample of pregnant women (n = 20) to help them decrease smoking. DATA SOURCES: A convenience sample of 20 pregnant women was recruited from a health maintenance organization at their initial prenatal contact either by telephone or in person. A comparison group of pregnant women (n = 28) was used for analysis of outcomes. CONCLUSIONS: Clinical results showed better outcomes for women in the pilot program when compared to a similar group who did not participate in the program. There was a statistically significant difference between the two groups in average number of cigarettes smoked per day at delivery and two weeks after delivery with pilot program participants reporting less smoking (p < .05). Women in both groups showed a pattern of returning to smoking after delivery of the baby. IMPLICATIONS FOR PRACTICE: Although a few tobacco users achieve permanent abstinence in first or second attempts, the majority continue to use tobacco for many years and typically cycle through many lapse and relapses before permanent abstinence. Ambulatory care systems need to be developed and funded to treat tobacco use and dependence over the life span. Recognition of the chronic nature of the problem and development of long term care delivery systems are needed to assist clients to achieve goals of permanent abstinence and better personal and family health. This cycle of lapse and relapse before permanent abstinence is typical and demonstrates the chronic nature of tobacco use and dependence and the need for long term follow-up.
Publication Type Clinical Trial. Controlled Clinical Trial. Journal Article.

Result 39.
Unique Identifier 12053843
Authors Johnson GP.
Institution TRICARE Southwest, 7800 IH-10 West, Suite 400, San Antonio, TX 78247-4750, USA.

Title Primary care enrollment levels in staff- and group-model health maintenance organizations: a standard to compare military enrollment with civilian organizations. [Review] [10 refs]

Abstract A literature review was conducted to determine civilian staff- and group-model health maintenance organization (HMO) primary care provider staffing. Civilian staff- and group-model HMOs enroll an average of 1,473 members per primary care physician. When physician extenders are considered, the average enrollment is 1,156 members per primary care provider. Despite the similarities between the staff- and group-model HMO and military medicine, military medical care is significantly different and may decrease the capability for enrollment as a result of mission support, occupational medicine, and other military-unique factors. Comparisons between military and civilian enrollment should be tempered with these considerations.

[References: 10]

Publication Type Journal Article. Review.

Result 40.
Unique Identifier 11997984
Authors Godfrey K.

Title Primary care. It's no contest.

Local Messages Check Virtual Library for availability at UHN.
Publication Type Journal Article.

Result 41.
Unique Identifier 11979203
Authors Scott H.

Title Patients like nursing aspects of the nurse practitioner role.

Local Messages Check Virtual Library for availability at UHN.
Publication Type Editorial.

Result 42.
Unique Identifier 11791815
Abstract Against a background of government calls for a radical change in the way the medical workforce is planned and trained, the concept of skill mix seeks to match clinical presentation to an intervention based on an appropriate level of skill and training. Health economics is not the only framework within which these changes can be analysed. However unless the economic issues are thought through clearly there is a danger that resources may be used inefficiently. The aims of this paper are to outline the economic issues in the area of doctor/nurse skill mix and the problems of obtaining correct solutions from the perspective of efficiency. It concludes by offering a pragmatic framework which can facilitate decisions in this area. Although this paper is written from the perspective of primary care, it is equally relevant to skill mix in the secondary care sector. [References: 26]
my opinion, the most important therapist for torture victims is their general practitioner, who should work with nurses, physiotherapists, dentists and psychologists.

Publication Type Case Reports. Journal Article.

Result 45.
Unique Identifier 11785281
Authors McWilliam CL. Stewart M. Sangster J. Cohen I. Mitchell J. Sutherland C. Ryan B.
Institution School of Nursing, Faculty of Health Sciences, University of Western Ontario, London. cmcwill@uwo.ca
Title Work in progress. Integrating physicians' services in the home.
Abstract OBJECTIVE: While increasing acuity levels and the concomitant complexity of service demand that physicians be involved in in-home care, conflicting evidence and opinions do not show how this can best be achieved. DESIGN: A phenomenologic research design was used to obtain insights into the challenges and opportunities of integrating physicians' services into the usual in-home services in London, Ont. SETTING: Home care in London, Ont. PARTICIPANTS: Twelve participants included three patients, two family caregivers, two family physicians, the program's nurse practitioner, two case managers, and two community nurses. METHOD: In-depth interviews with a maximally varied purposeful sample of patients, caregivers, and providers were analyzed using immersion and crystallization techniques. MAIN FINDINGS: Findings revealed the potential for enhanced continuity of care and interdisciplinary team functioning. Having a nurse practitioner, interdisciplinary team-building exercises and meetings, regular face-to-face contact among all providers, support for family caregivers, and 24-hour coverage for physicians were found to be essential for success. CONCLUSION: Integration of services takes time, money, and sustained commitment, particularly when undertaken in geographically isolated communities. Informed choice and a fair remuneration system remain important considerations for family physicians.

Publication Type Journal Article.

Result 46.
Unique Identifier 11458594
Authors McKernon M. Jackson C.
Institution Mater UQ Centre for General Practice and Primary Health Care Integration, Mater Hospitals, Brisbane, Queensland.
Title Is it time to include the practice nurse in integrated primary health care?.
Abstract BACKGROUND: The new '700 series' Medical Benefit Schedule (MBS) items for general practice introduce greatly increased potential for collaboration between general practitioners and other health professionals in patient care. AIM: To investigate the current
perceptions of Australian GPs with respect to the desirability and impact of 'sharing care' with nurses and other health professionals. METHOD: Survey of a sample of GPs in Queensland and NSW participating in the Department of Veterans' Affairs Preventive Care Trial. RESULTS: Fifty-two percent of GPs surveyed worked in a practice where a nurse was employed. The main role of the practice nurse was to do electrocardiograms, apply dressings, and triage duties. Practice nurses played only a minor role in health promotion and education. Seventy percent of GPs identified 'cost' and 58% 'lack of a Medicare item' as the major disincentives to the employment of a practice nurse. Seventy percent of GPs were satisfied with the level of communication with community based health professionals outside the practice, with 'time' nominated as the greatest barrier to optimal contact. Eighty-two percent of GPs considered other health professionals had a role in conducting preventive home visits for the older population, with 70% of GPs identifying that these health professionals had the potential to identify additional health problems, previously unaddressed. CONCLUSION: Study findings demonstrate an acceptance by GPs of the nurses role and other health professionals in integrated patient care. Funding is seen as the major impediment to the greater utilisation of practice nurses in the general practice setting.

Result 47.
Unique Identifier 11299889
Authors Grief SN.
Title Elbow-to-elbow with my NP "roommate".
Publication Type Journal Article.

Result 48.
Unique Identifier 11975288
Authors House N.
Title Seaside story.
Local Messages Check Virtual Library for availability at UHN.
Publication Type Case Reports. Journal Article.

Result 49.
Unique Identifier 11963091
Authors Coombes R.
Title Professional boundaries. It's time to bury the hatchet--but not in each other.[see comment].
Result 50.
Unique Identifier 11930589
Authors Bonnel W. Belt J. Hill D. Wiggins S. Ohm R.
Institution University of Kansas Medical Center, Kansas City, KS, USA. wbonnel@kumc.edu
Title Challenges and strategies for initiating a nursing facility practice. [Review] [31 refs]
Abstract PURPOSE: To provide a summary analysis of five case reports describing the challenges and strategies of nurse practitioners' (NPs') first-year experiences on initiating an effective role in a nursing facility practice. DATA SOURCES: Original qualitative research analyzing written journals of five NPs and written notes from two loosely structured group discussions among project participants. CONCLUSIONS: Two broad themes emerged: Figuring it Out and Responding/Getting a Handle on Things. Common sense and good resources were identified as critical. IMPLICATIONS FOR PRACTICE: Strategies to promote ease of role transition are essential for NPs in the nursing facility. Further, in addition to a focus on care of frail older adults, emphasis on the culture of and strategies for nursing facility visits, ethical issues, and ethical decision making are important components of NP educational programs. [References: 31]
Publication Type Journal Article. Review.

Result 51.
Unique Identifier 11930441
Authors Shuler PA. Hunter L. McDowell L. Shearer L.
Title Development of a local advanced practice nurse coalition.
Abstract PURPOSE: To describe the experiences of a group of advanced practice nurses (APNs) in a rural area in developing an APN Coalition. DATA SOURCES: Selective review of literature and documents from the newly developed organizational framework for the coalition. CONCLUSION: Professional connections can begin at the local level through the development of local APN coalitions and then expand to involvement in state and national organizations. IMPLICATIONS FOR PRACTICE: Guidelines for establishing the coalition organizational structure are included and can be used as a template by similar evolving APN coalitions.
Publication Type Journal Article.
Result 52.
Unique Identifier 11858453
Authors Amundsen SB. Corey EH.
Institution Cardiovascular Consultants of Maine, P.A., Portland, USA.
Title Decisions behind career choice for nurse practitioners: independent versus collaborative practice and motivational-needs behavior.
Abstract Nurse practitioners (NPs) can take an active role in defining and establishing their careers. Prepared as advanced practice nurses with specific assessment skills, primary care NPs have the opportunity to become independent or collaborative practitioners. This report examines the published work in the area of practice choice and motivational-needs behavior. Interviews with collaborative and independent primary care NPs were conducted. Against the framework of well-established personality testing methods, open-ended interview questions were developed to elicit specific motivational-needs-based behavior characteristics. The motivational needs examined included the need for achievement, power, and affiliation. The interview findings were then synthesized using needs-based behavior theory. This new platform for role decision ultimately can prepare NPs to make informed career choices.
Publication Type Journal Article.

Result 53.
Unique Identifier 11120732
Authors Offredy M. Townsend J.
Institution Faculty of Health and Human Sciences, University of Hertfordshire, Hatfield, Hertfordshire AL10 9AB, UK.
Title Nurse practitioners in primary care.
Abstract OBJECTIVES: Recent policy emphasizing the role of primary care has increased the workload of general practitioners (GPs) while simultaneously placing nurse practitioners (NPs) as key providers in the delivery of health care. There is need to examine the latter's work practices. The purpose of this article is to explore the role and practice of NPs in general practice. METHODS: DESIGN: Thirty-six semi-structured interviews with GPs, NPs, receptionists and patients were analysed. SETTING: Four general practices in south-east England. MAIN OUTCOME MEASURES: Data from semi-structured interviews relating to allocation, prescribing and referral practices of NPs in primary care. RESULTS: These include the differences in presenting problems of patients seen by GPs and NPs, prescribing and referral practice and legal issues of the nurse practitioner. A wide range of practice is reported. CONCLUSION: This study highlights the variation in how patients are allocated for NP consultation and in NP autonomy, prescribing and referral, which raises issues for clinical governance of protocols and risk management.
Publication Type Journal Article. Multicenter Study.
Result 54.
Unique Identifier 11040671
Authors Moser SS. Armer JM.
Institution Eastwood Family Clinic, Marshall, Missouri, USA.
Title An inside view. NP/MD perceptions of collaborative practice.
Source Nursing & Health Care Perspectives. 21(1):29-33, 2000 Jan-Feb.
Abstract The pressing dilemma in this era of health care reform is how to provide cost-effective, high quality health care for all Americans. At the present time, due to a number of complex factors, including attrition and economic disincentives, a shortage of primary care physicians exists in certain medically underserved areas of the country. At the same time, however, primary care nurse practitioners are increasing in number.
Publication Type Journal Article.

Result 55.
Unique Identifier 10987782
Authors White P.
Title Doctors and nurses. Let's celebrate the difference between doctors and nurses.[comment][erratum appears in BMJ 2000 Sep 30;321(7264):835].
Local Messages Check Virtual Library for availability at UHN.
Publication Type Comment. Letter.

Result 56.
Unique Identifier 10916716
Authors Henley E. Glasser M. May J.
Institution Department of Family and Community Medicine, University of Illinois College of Medicine at Rockford, USA. ehenley@uic.edu
Title Medical student evaluation of family nurse practitioners as teachers.
Local Messages Check Virtual Library for availability at UHN.
Abstract BACKGROUND: Demands on family medicine faculty to generate clinical revenue may negatively impact the undergraduate medical education program. To minimize this possibility and better model interprofessional education, family nurse practitioners (FNPs) were hired as clinicians and teachers as part of a longitudinal family medicine clerkship. This paper reports the results of a pilot study of student evaluations of nurse practitioner teaching. METHODS: All M3 and M4 students were asked to evaluate one of three FNPs who had precepted them multiple times during their previous year of ambulatory care practice. Two previously studied closed-ended questionnaires were used to assess quality of teaching by the FNPs. Students also responded to a series of open-ended questions. RESULTS: Ninety-one percent of 97 students responded to the survey. Responses to the closed-ended questions as well as comments by the students and physicians were positive regarding the teaching by FNPs. The teaching skills most highly regarded by the students tended to be different than those most highly regarded in physicians. CONCLUSIONS: This pilot study suggests FNPs can be successfully integrated into undergraduate medical education settings, offering teaching strengths that complement those of physicians. Integrating the two professions in a family medicine clerkship may prove beneficial to students and expand departmental teaching resources without further straining finances. Efforts at evaluating the teaching contributions of FNPs at other institutions are needed to substantiate the present study results.

Publication Type Journal Article.

Result 57.

Unique Identifier 10912561

Authors Lucas K. Bickler G.

Institution East Sussex, Brighton and Hove Health Authority, Lewes.

Title Altogether now? Professional differences in the priorities of primary care groups.


Abstract BACKGROUND: Little is known about the similarities or differences with which Primary Care Group (PCG) Board members view the relative importance of the three functions with which they are charged, or how representative these views are of local primary care teams in general. This project explores the priorities of medical and nursing PCG Board members in relation to those of local General Practitioners (GPs) and practice nurses they represent. METHODS: Postal questionnaires were sent to GPs (n=236) and practice nurses (n= 137); structured telephone interviews were carried out with PCG Board members (n=61) in East Sussex, Brighton and Hove. RESULTS: There are large differences between the views of GPs and those of their nursing colleagues on how PCG Board members should determine priorities in their work. There are also marked differences in the priorities of PCG Boards (of whom the majority are GPs) and non-Board member GPs. Whereas around two-thirds of PCG Board members believe that improving health generally and reducing inequalities in particular are the most important tasks before them, this view is not shared by most GPs in the same localities, who are generally more concerned about commissioning services. There is some doubt among GPs generally about the suitability of PCG Board members as a vehicle for the tasks they have been set, and this doubt is also found among PCG Board members themselves. CONCLUSIONS: The priorities of PCG Board members of different disciplines need to be aligned in order that they have a clear focus on the tasks before them. PCG Boards must also have priorities that are consistent with the local practitioners who elected them. Effective systems of communication will need to be developed between PCG Board members, Health
Authorities and individual Primary Care Groups. Local flexibility is essential to the success of Primary Care Groups, but tackling inequalities in health must always be at the forefront of their role.

Publication Type Journal Article.

Result 58.
Unique Identifier 10758082
Authors Westcott R. Sweeney G. Stead J.
Institution East Street Surgery, South Molton, Exeter EX36 3BU, 4 Parkfield Way, Topsham, Exeter EX3 0DP and Wyndham House Surgery, Silverton, Exeter EX5 4HZ, UK.
Title Significant event audit in practice: a preliminary study.
Abstract BACKGROUND: While well described and promoted as a useful activity, there remains a paucity of evidence on the process and experience of significant event audit (SEA) in primary care. To date, the most comprehensive evaluation of the process has been produced by comparing SEA with conventional audit. The current study intends to contribute to the debate by examining the attitudes and perceptions of a range of primary care staff who have been involved in the process. OBJECTIVES: The aim of this study was to identify participants' perceptions of the benefits and problems associated with SEA in the context of primary care, and to derive suggestions which might improve the process of SEA. METHODS: Semi-structured interviews of 12 participants from a variety of primary care disciplines were conducted, using grounded theory to analyse the results. RESULTS: A set of six perceptions and seven recommendations for the facilitation of SEA were produced. CONCLUSIONS: SEA constitutes a powerful tool, which can contribute to team building, enhanced communication and improved patient care, and represents a vital contributor to the development of clinical governance in primary care. However, its implementation and sustenance require sensitive handling for optimal benefit and to minimize difficulties. Our research has enabled us to propose suggestions to facilitate these processes.

Publication Type Journal Article.

Result 59.
Unique Identifier 9171543
Authors Wise M.
Institution Cardiff Royal Infirmary, UK.
Title Inappropriate attendance in accident and emergency. [Review] [34 refs]
Abstract Patients who attend Accident and Emergency (A & E) departments with problems that could be dealt with by their general practitioners (GPs) use time and resources of the department that could be otherwise used for patients with more appropriate needs. Definitions used for inappropriate attendance are drawn from the literature, and the usefulness of the term is discussed in the light of evidence that these patients have logical reasons for attending.
Methods of improving the service offered to these patients are discussed, including emergency nurse practitioners, minor injuries units and GPs in the A & E department. The reluctance of GPs to treat minor injuries in their surgeries is noted. The implications of changing the service provided in A & E to accommodate or deter patients with primary care problems are discussed. [References: 34] 

Publication Type Journal Article. Review.

Result 60.
Unique Identifier 7630834
Authors Calnan M.
Institution Centre for Health Services Studies, University of Kent, Canterbury, UK.
Title The role of the general practitioner in health promotion in the UK: the case of coronary heart disease prevention.
Local Messages Check Virtual Library for availability at UHN.
Abstract This paper examines the approach taken to health promotion and disease prevention in primary care in the UK, using coronary heart disease prevention (CHD) as an illustration. The paper considers the approach taken by the UK's government, the level of involvement of general practitioners (GP) and community nurses in CHD prevention, the factors that influence variation in involvement and the evidence for effectiveness.
Publication Type Journal Article.

Result 61.
Unique Identifier 1471432
Authors Ambs-Dapperger M. Senn E.
Institution Institut fur Medizinische Balneologie und Klimatologie, Munchen.
Title [The role of the family physician in cooperation and coordination management of chronic rheumatic patients]. [German]
Abstract Rheumatoid arthritis (RA) is a disease that confronts the primary care practitioner with medical and organizational problems. There are only few experiences in diagnosis and therapy of (early) RA because of the low prevalence rate. Especially in rural districts there is a deficit in physiotherapists, ergotherapists, and psychologists with knowledge in rheumatology. The cooperation with rheumatologists is an organizational problem. In a study of 817 RA patients it could be shown that organizational help and, the offer of complementary therapy in the vicinity of a patient's home led to an increase of well-being and decrease in costs and severity of the disease.
Publication Type Journal Article.
Result 62.
Unique Identifier 2867508
Authors Johnson RE. Freeborn DK.
Title Comparing HMO physicians’ attitudes towards NPs and PAs.
Local Messages Check Virtual Library for availability at UHN.
Abstract This study examined the attitudes of physicians working in health maintenance organizations toward the use of nurse practitioners and physician assistants. It also explored some of the underlying reasons for these attitudes: effect upon quality of care, risk of malpractice, role threat and gender bias. The setting was a health maintenance organization serving 270,000 members. The data were derived from a survey of physicians' attitudes and behavior. Physicians from internal medicine, pediatrics and obstetrics-gynecology were the study population. Internists and pediatricians had favorable attitudes toward both nurse practitioners and physician assistants. Obstetrician-gynecologists had somewhat less favorable attitudes. Physicians in all three specialties favored nurse practitioners more than physician assistants. Physicians felt that nurse practitioners were more likely to increase the quality of care and less likely to increase the risk of malpractice. Nurse practitioners were not seen as a greater role threat. Some gender bias appeared to be present, but it did not appear to constrain the use of nurse practitioners. Large, multi-specialty, prepaid group practice health maintenance organizations may be favorable settings for nurse practitioners and physician assistants to practice primary care.
Publication Type Journal Article.

Result 63.
Unique Identifier 722260
Authors Bibace R. Comer R. Cotsonas CE.
Title Ethical and legal issues in family practice.
Local Messages Check Virtual Library for availability at UHN.
Abstract The unique goal of family practice, that of caring for the entire family's broadly defined health needs, places the family physician in an especially uncomfortable position when there is intrafamily conflict. In particular, the question of "whose agent (physician) are you?" when a family is in conflict often creates a serious ethical dilemma for the family physician. The roles of three experts who deal with family conflict, the psychotherapist, the lawyer, and the family physician, are compared and contrasted. The physician as expert is a useful approach only insofar as there are clearcut answers to a particular problem. But the ambiguity inherent in ethical problems makes this approach less than satisfactory. The role of the physician as teacher/facilitator is explored as an alternative to resolving the ethical dilemmas of intrafamily conflict.
Publication Type Journal Article.
APPENDIX B

CATEGORIZATIONS FOR SYSTEMATIC REVIEW (74 ARTICLES)

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<tr>
<th>Study</th>
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<tr>
<td>Title: Aligning the interests of osteopathic and allopathic teachers of family medicine. Authors: Morzinski J, Henley C</td>
<td>No abstract available</td>
<td>Yes</td>
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<td>Title: Interprofessional referral patterns in an integrated medical system. Authors: Coulter ID, Singh BB, Riley D, Der-Martirosian C</td>
<td>OBJECTIVE: To determine the interreferral patterns among physicians and complementary and alternative medicine (CAM) providers in an independent practice association integrated medical system. METHOD: Data from a 1-year period were collected on referral patterns, diagnosis, number of visits, cost, and qualitative aspects of patient care. The independent practice association provided care for approximately 12,000 patients. RESULTS: In the selected integrative network, there are those primary care physicians (PCPs) who refer and those who do not. Among those PCPs that refer to CAM, a preference is shown for a limited number of providers to whom they refer. Although doctors of chiropractic get more referrals, they are also more concentrated among selected providers than are doctors of oriental medicine. CONCLUSION: This study shows the interreferral patterns among the PCP and CAM providers working within an integrated medical system. One effect of being in the network for doctors of chiropractic and doctors of oriental medicine might be the possible interreferrals between each other.</td>
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<td>Title: Supporting the scientific foundation of integrative medicine. Interviewed by Karolyn A. Gazella and Suzanne Snyder. Authors: Jonas WB</td>
<td>Interview- no abstract</td>
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<tr>
<td>Title: Multidisciplinary work to provide cardiac rehabilitation for patients. Authors: Hussain F, Wooller D</td>
<td>Cardiac rehabilitation is an important aspect of cardiac care strategies. This article outlines the importance of such care using a case-study approach to highlight the impact that rehabilitation programmes can have on individual patients.</td>
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<td>Title: Designing relational models of collaborative integrative medicine that support healing processes. Authors: Bolles S, Maley M</td>
<td>The concept of optimal healing environments (OHE) includes a variety of elements that require exploration, definition, measurement, and interpretation. One key element is the relationships between healer and patient/client and between healers themselves. These complexities mean that</td>
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| **Title**: The traditional healer as part of the primary health care team  
Authors: Meissner O | Editorial- no abstract | No |
| **Title**: Complementary medicine at Exeter: the first 10 years.  
Authors: Kanji N, Huntley A | Editorial- no abstract | No |
| **Title**: Student nurses' perceptions of alternative and allopathic medicine.  
Authors: Joudrey R, McKay S., Gough J | This exploratory study of student nurses is based on the results of the responses to one question on an open-ended questionnaire: How would you define the relationship between alternative medicine and allopathic (conventional) medicine? A specific goal of the study was to find out how the surveyed respondents conceptualized the relationship between allopathic and alternative medicine. Three themes were identified: (a) "They are not at all alike," (b) "The two can or should be used together," and (c) "Those who practice alternative medicine and those who practice allopathic do not get along very well." The discussion suggests some reasons for these perceptions and considers some implications for future health care. | Yes |
| **Title**: Analysis and modelling of the multi-professional treatment process: preliminary results.  
Authors: Ehlers F, Ammenwerth E, Haux R., Pohl U., Resch F | This paper presents first results of a research project aimed at improving co-operative work initiatives in hospitals. A holistic analysis of the treatment process is presented as a precondition for process reengineering, quality measurements and improvement of multi-professional co-operation. Treatment process modelling attempts within the last years have concentrated on specialised points of views, such as business process modelling or communication modelling. In contrast, we have developed a framework consisting of several views of the treatment process. We tested our framework in a broad system analysis within the Department of Child and Adolescent Psychiatry of the Heidelberg University Hospitals. Our preliminary results support the framework. Weaknesses were | No |
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<td>Title: The psychologist's role in the collaborative process of psychopharmacology. Authors: Weene, KA</td>
<td>This is a discussion of a collaborative approach between psychologists, physicians, patients, and others in the administration of psychotropic medication. It is based on a systems point of view. In that perspective, not only are the people indicated above a system, but also the patient is considered from a holistic-systems point of view. It requires that the psychologist not only be a member of the system, and a well-versed in medication member at that; (s)he must also be an observer of the system, be able to take a meta perspective, in order to be able to exercise some unique functions--functions for which psychologists are well-trained.</td>
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<td>Title: The attitude of community health nurses towards integration of traditional healers in primary health care in north-west province. Authors: Peu MD,. Troskie R, Hattingh SP</td>
<td>South Africa is called &quot;the rainbow nation&quot; because it has so many different cultures. These have an impact on the provision of primary health care. The purpose of this research is to foster good relationships between community health nurses and traditional healers and to explore, identify and describe the attitude of community health nurses towards the integration of traditional healers into primary health care. A non-experimental, explorative and descriptive research strategy was designed to explore the working relationship between community health nurses and traditional healers. Data was collected using a structured questionnaire. Quantitative as well as qualitative data analysis techniques were adopted to interpret the findings. The results indicated that respondents demonstrated positive attitudes towards working with traditional healers, especially in the provision of primary health care. Positive opinions, ideas and views were provided about the integration of traditional healers into primary health care. Respect, recognition and sensitivity were emphasized by respondents.</td>
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<td>Title: Integrated medicine. Integrated medicine means doctors will be in charge. Authors: St George, D</td>
<td>Letter- no abstract</td>
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<td>Title: UK's first 'wellness centre' takes preventive action. Authors: Roche, K</td>
<td>Case report- no abstract</td>
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<td>Study</td>
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<td><strong>Title:</strong> Comprehensive versus holistic care. Case studies of chronic disease. &lt;br&gt;Authors: Romeo, JH</td>
<td>Persons with chronic disease often experience an involvement of multiple body systems. A comprehensive care approach to patient care is often used with the belief that a health care team will ensure that a patient's needs will be covered. Instead, this approach is reductionist in practice and leads to fragmentation of care, and the difficult patients often slip through the cracks of the health care system. However, a holistic theory-based approach puts a patient's perceived needs first and offers care not only for the body but also for the human spirit. Two case studies of patients with chronic disease are reviewed, both of whom began in a comprehensive care model and ended up with holistic care. Suggestions for assisting in the movement of a comprehensive care model toward a holistic model are offered for the practicing nurse.</td>
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<td><strong>Title:</strong> Alternative therapies. Health professionals' attitudes. &lt;br&gt;Authors: Montbriand, MJ</td>
<td>Most patients are reluctant to talk with their health professionals about alternative products and therapies. Unfortunately, alternative products may interact with prescription products, and alternative therapies may affect the course of care recommended by the health professional. Compounding these concerns is the fact that the three health providers with greatest access to information on patients' medication use--nurses, physicians and pharmacists--often do not communicate with each other about additional therapies or products that patients use on their own.</td>
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<td><strong>Title:</strong> Primary health care transformed: complementary and orthodox medicine complementing each other. &lt;br&gt;Authors: Paterson, C</td>
<td>Charlotte Paterson is a general practitioner and researcher at Warwick House Medical Centre in Taunton, Somerset. This is a group practice where, since 1991, complementary practitioners have worked on a private sessional basis in the centre. This collaboration was the stimulus for an ongoing research programme into various aspects of complementary medicine and primary care, and the practice is now an NHS funded Research General Practice. Charlotte Paterson has taken a keen interest in different models of integrating complementary and orthodox medicine with the aim of making complementary medical provision equitable and accessible.</td>
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<td><strong>Title:</strong> Mind-body innovations--an integrative care approach. &lt;br&gt;Authors: Helene B, Ford P</td>
<td>Integration of behavioral health and medicine has gained increased support recently within the new field of complementary medicine. Providers from both disciplines are acknowledging the &quot;mind-body&quot; connection and recognizing the value of treating the &quot;whole&quot; patient through working</td>
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<td>Title: The Marino Center for Progressive Health: a team approach to coordinated care. Authors: Muscat, M</td>
<td>Editorial- no abstract</td>
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<td>Title: Opening the legal door to unconventional medicine or opening the legal door to a new era in healthcare? Authors: Gaudet, TW</td>
<td>Comment- no abstract</td>
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<td>Title: Will the GP commissioner role make a difference? Exploratory findings from a pilot project offering complementary therapy pt people with musculo-skeletal problems Authors: Emanuel, J</td>
<td>The paper focuses on the interprofessional relationships which developed between general practitioners (GPs) and complementary practitioners (CPs) during a pilot project where GPs referred to acupuncturists, osteopaths and chiropractors. It is based on interviews with GPs and CPs, that took place at the beginning and end of an evaluative study on patients referred with musculoskeletal conditions. Referrals to hospital orthopaedic outpatients departments and pain clinics were also examined. The most common relationship that developed was where the GP delegated responsibility for treatment to the CP. One CP and GP developed a more interactive relationship which included a shared diagnostic role. The NHS reforms offer opportunities for different types of working relationships to develop between health professionals. They also offer opportunities for professionals who have not traditionally worked in the NHS to do so. The findings discussed here are exploratory. Further research to identify the types of relationships developing between CPs and GPs and to establish whether the type of relationship has an impact on secondary referrals and treatment outcomes is recommended.</td>
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<td>Title: Complementary practitioners as part of the primary health care team: consulting patterns, patient characteristics and patient outcomes. Authors: Paterson, C</td>
<td>BACKGROUND: Complementary medicine is increasingly popular with patients and with GPs, although it still remains mainly in the private sector. Few data are available from the private sector about patient-consulting patterns and outcome. OBJECTIVES: We aimed to describe detailed consulting patterns, help-seeking behaviour and outcome of care for patients</td>
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attending a group of private complementary practitioners in a single general practice surgery.

METHOD: Prospective data on consulting patterns were collected from all 147 new patients attending complementary practitioners over a 12-month period. For the first 30 weeks of this period, additional information on help-seeking behaviour and outcome, as measured by the SF-36 health survey and Measure Yourself Medical Outcome Profile (MYMOP), was collected by questionnaires from 46 out of the 68 new patients. The same information was collected from a systematic one-in-seven sample of GP patients. RESULTS: Patients seen by complementary practitioners did not vary significantly in sex and age from GP patients, except in the low numbers of children. Almost half the patients had been symptomatic for over a year and musculoskeletal disorders accounted for 66% of problems; but there was much variation between the therapies. The average number of visits per patient was three for osteopathy and homeopathy but eight for acupuncture and reflexology. The change in MYMOP scores after four weeks showed a statistically significant improvement in both complementary and GP patients, which was to similar degrees except that the mean change in well-being was significantly greater for complementary patients. CONCLUSION: Prospective data collection in single settings adds valuable information to a little-researched area. This study illustrates how individual each complementary therapy is in its patient characteristics, problem category and length of treatment. The particular improvement in well-being with complementary therapy requires confirmation in other studies.

Title: Referrals between GPs and complementary practitioners
Authors: Ernst E, Reshe KL, Hill, S

Title: General practitioners’ assessment of and interest in alternative medicine in Canada
Authors: Verhoef MJ, Sutherland LR

Canadian physicians’ opinions about alternative medicine have, as yet, not been assessed. The objectives of this pilot study were to assess general practitioners’: (1) desired involvement in alternative medicine; (2) perceived demand for alternative medicine; and (3) beliefs about the efficacy of different alternative approaches. The study design was a cross-sectional survey of 400 randomly selected Alberta and Ontario general practitioners. Of the 384 eligible physicians, 200 (52%) completed the questionnaire. Seventy-three percent of physicians felt that they should have
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| **Title:** Complementary and conventional cancer care: the integration of two cultures  
**Authors:** Burke C, Sikora K  
**Abstract:** Some knowledge about the most important alternative treatments. However, with respect to other issues, physicians desired less involvement with alternative medicine. Sixty-five percent perceived a demand for alternative medicine from their patients, in particular chiropractic. Alternative medicine was perceived to be needed most for musculoskeletal problems and chronic pain or illness. Chiropractic, hypnosis and acupuncture (for chronic pain) were believed to be most efficacious, while homeopathy and reflexology were considered to be least efficacious. Undergraduate, graduate clinical and continuing medical education will need to address alternative treatments in order to provide physicians with up-to-date and relevant information. | Yes |
| **Title:** Beyond the boundaries: relationship between general practice and complementary medicine  
**Authors:** Pietroni PC  
**Abstract:** There is now increasing evidence that many cancer patients are seeking unorthodox forms of support and treatment. These range from measures to enhance the quality of life, such as counselling and relaxation therapy, through to alternative cancer remedies, such as extreme diets with detoxification by coffee enemas. Much of complementary care is provided outside the hospital setting, often without the knowledge of the health care professionals involved in a patient's treatment. The Bristol Cancer Help Centre was founded in 1980 to provide an alternative approach to cancer treatment. It became the leading British centre for such therapies, although, from its outset, it had an uneasy relationship with conventional medicine. Some clinicians were highly critical of its perceived methods even though very few actually visited the centre to examine the evolving programmes of care offered. In 1988, a group of oncologists from Hammersmith Hospital visited the Bristol Centre. A joint development programme was conceived in which the lessons from Bristol were integrated into a busy academic oncology unit prior to the design and construction of a new cancer centre. Many problems emerged in trying to merge the two cultures, one driven by technology, the other by human need. Several other oncology units are adopting complementary strategies within their services. Here we describe our joint experience and outline the Hammersmith supportive care model currently in use. | Yes |
<p>| No abstract available | Yes |</p>
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| **Title:** A dialogue between practitioners of alternative (traditional) medicine and modern (western) medicine in Norway  
Authors: Christie VM | This paper tells about a 'dialogue group', consisting of alternative and modern health practitioners, that was started in Norway in 1989, how it works and what has been achieved up to now. WHO has strongly advocated promotion of cooperation between traditional and modern health practitioners. In Botswana, where one of the general practitioners in the group has practiced, 'United Health Committees' have been established aiming at creating a dialogue between the different types of health professionals. In industrialized countries little seems to have been done so far. Many patients in Norway, as in many other countries, consult ordinary doctors as well as alternative practitioners. In Norway, members of these two professions almost never meet, other than as opponents. They receive information about each other mostly through discontented patients who have been unsuccessfully treated by the other part. In this way practitioners get an insufficient and biased report of one another's practices, as well as an unrealistic and distorted picture. If patients know that both parts respect one another, then most of them dare to tell that they use both types of practitioners. Otherwise many patients conceal this. | Yes |
| **Title:** A model of cooperation between complementary and allopathic medicine in a primary care setting  
Authors: Budd C, Fisher B, Parrinder D, Price L | This paper describes an acupuncture and osteopathy service offered free of charge to patients at a National Health Service general practice. The background to the setting up of this service, its organization, funding, aims and philosophy, and the ethical and legal implications for the general practitioners whose patients are treated by complementary therapists are discussed. This service provides a model of cooperation between allopathic and complementary medicine in a primary care setting and could be copied elsewhere. | Yes |
| **Title:** Alternative medicine and general practitioners in the Netherlands: toward acceptance and integration  
Authors: Visser GJ, Peters L | A questionnaire on alternative medicine was sent to 600 general practitioners in the Netherlands. Most of the 360 (60%) GPs who replied expressed interest in alternative practice; and 47% revealed that they used one or more alternative methods themselves, most often homoeopathy. However, the number of patients given alternative treatment by each doctor was small. Almost all (90%) of the GPs referred patients to alternative practitioners. There is no reason to assume that GPs make use of alternative methods just to meet their patients' wishes. A majority of the respondents thought that these therapies included ideas and methods from which the regular methods | Yes |
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| **Title:** Complementary medicine and the general practitioner: a survey of general practitioners in the Wellington area  
Authors: Hadley CM | A questionnaire was sent to 226 general practitioners in the Wellington region to determine the relationship between the general practitioner and complementary medicine. A 77% response rate was achieved. Twenty-four % of doctors had received training and 54% wanted further training in a complementary therapy; 27% currently practised at least one therapy. The majority of doctors (94%) knew of complementary practitioners in their locality; 77% indicated they referred to other medical practitioners for complementary therapies and 80% to nonmedical practitioners. Acupuncture, hypnosis and chiropractic were the most popular therapies. The general practitioner's role was perceived as ranging from comprehensive provider of both conventional and complementary medicine to selective practitioner of some options. It is concluded that complementary medicine is of considerable interest to general practitioners; there is demand for more training and information to be made available for doctors and for better referral networks to be developed between the practitioners. | Yes |
| **Title:** A revisionist theory for the integration of behavioral science into family medicine departments  
Author: Shapiro J | This article describes the common cycle of infatuation and disillusionment which occurs when the family physician meets the behavioral scientist. Some inherent problems are involved in the relationship between physicians and psychologists. For physicians, these problems are related to prior training, time pressures, perceptions of the patient role, and their attitude toward role innovation. For behavioral scientists, problems include their expectations and prior training, conceptual rigidity, psychological mindedness, their views of physician and patient, and their sense of displacement and isolation in a medical setting. Suggestions are made for future collaboration, curriculum development, problem solving, and the elimination of biases and stereotypes. | No |
<p>| <strong>Title:</strong> Rational and irrational clinical Individual practitioners and health care |  | Yes |</p>
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| strategies for collaborative medicine  
Author: Hammerly M | systems/organizations increasingly understand the rationale for collaborative medicine. An absence of collaboration can compromise the quality and safety of patient care. But having a rationale to provide collaborative medicine without also having a rational clinical strategy can be equally compromising to the quality and safety of patient care. Reasonable evidentiary criteria must be used to determine whether specific therapies merit inclusion or exclusion in a collaborative medicine model. Ranking therapies hierarchically on the basis of their risk-benefit ratio simplifies matching of therapies with the needs of the patient. A unifying taxonomy that categorizes all therapies (complementary/alternative and conventional) on the basis of how we think they work (presumed mechanisms of action) facilitates development of a clinical strategy for collaborative medicine. On the basis of these principles, a rational clinical strategy for collaborative medicine is described to help optimize the quality and safety of patient care. | Yes |
| Title: Uncharted ground: patterns of professional interaction among complementary/alternative and biomedical practitioners in integrative health care settings  
Author: Hollenberg D | The development of "integrative health care" (IHC) settings combining various aspects of Western biomedicine and complementary/alternative medicine (CAM) is a relatively recent phenomenon among biomedical and CAM professions. While IHC is recognised internationally and occurs in many different contexts (e.g. clinic or hospital), patterns of interaction between biomedical and CAM practitioners, and the nature of IHC settings, are largely unknown. This paper presents findings from a research study of two newly established IHC settings in Canada. The main research question was: how are biomedical and CAM practitioners integrating or not integrating with each other at the level of professional interaction in IHC settings? Using a case study design, in-depth interviews were conducted with 13 biomedical and eight CAM practitioners during 2002-2003, and ethnographic observation and document analysis was conducted at each site. Drawing from closure theory of the professions, comparative analysis of the sites revealed that biomedical practitioners enact patterns of exclusionary and demarcationary closure, in addition to the use of "esoteric knowledge", by: (a) dominating patient charting, referrals and diagnostic tests; (b) regulating CAM practitioners to a specific "sphere of competence"; (c) appropriating certain CAM techniques from less powerful CAM professions; and (d) using biomedical language as the primary mode of communication. CAM practitioners, in turn, | Yes |
Perform usurpationary closure strategies, by: (a) employing their own "esoteric knowledge" in relation to biomedicine and other CAM professions; (b) appropriating biomedical language and terminology; (c) increasing their professional status by working with biomedicine; and (d) referring among CAM practitioners to increase patient flow. The findings suggest that when attempts are made to integrate biomedicine and CAM, dominant biomedical patterns of professional interaction continue to exist. Despite continued patterns of social closure, biomedical and CAM practitioners continue to provide a certain form of integrative care that may be of benefit to patients, albeit not as integrative as current models of integration would prefer.

Title: Integrative care and bridge building among health care providers in Norway and Denmark
Authors: Gamst A, Haahr N, Kristoffersen AE, Launso L

Background: Patients in Norway and Denmark with the medical diagnoses of cancer, multiple sclerosis (MS), and HIV/AIDS use complementary and alternative treatment (CAT) in growing numbers, most often in addition to receiving conventional treatment. At the same time, the interest and demand from patients for more holistic-oriented care is strongly increasing. Following this, there is a desire and need for better communication and cooperation among the conventional medical establishment, CAT practitioners, and patients. This development raises new demands on research designs to incorporate complexity and diversity concerning the intervention, effect mechanisms, and outcomes.

Discussion: This article outlines different models used to combine conventional, complementary, and alternative treatment (CCAT), describing various degrees of integration among therapies. The authors are closely involved in three current and planned research projects in Norway and Denmark focusing on cancer, MS, and HIV/AIDS. These research projects are briefly introduced as examples of bridge-building efforts dealing with integrative care. Despite explicit political good will in Norway and Denmark, initiatives to enhance integration face challenges connected to lack of knowledge; resistance toward CCAT; lack of time, space, and economic resources; and patients left without any claim on insurance in the case of treatment failure. These challenges are outlined based on the researchers' experience from being involved in the research projects.

Conclusions: To optimize treatment outcomes in the future, it is argued that the need for closer cooperation among conventional and alternative therapists across professional boundaries in an interactive
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<td>Title: Working toward a model of integrative health care: critical</td>
<td>OBJECTIVE: The objective of this study was to assess what factors the Tzu Chi Institute (TCI) practitioners identified as supports and barriers to providing care within an integrative health care setting. DESIGN: Qualitative data were collected by means of in-depth, semi-structured interviews with 16 practitioners who worked at a comprehensive integrative care clinic in Vancouver, Canada over 5 years. RESULTS: Practitioners identified four elements critical to forming and sustaining an effective integrative care team: (1) effective communication tools, (2) personal attributes (3) satisfactory compensation, and (4) a supportive organizational structure. CONCLUSIONS: Because of the influence practitioners have on the outcomes of patients in an integrative care program, attention must be focused not only on creating optimal healing environments for patients but also towards establishing and nurturing optimal working environments for practitioners.</td>
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<td>elements for an effective team</td>
<td>Authors: Mulkins AL, Eng J, Verhoef MJ</td>
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<td>Title: Integration of complementary and alternative medicine in a</td>
<td>OBJECTIVE: To describe the establishment of a multidisciplinary team of complementary and alternative medicine (CAM) providers and educators in an urban pediatric hospital and affiliated medical school. BACKGROUND: Pediatric CAM use is increasing. Physicians are interested in CAM-related education but few programs had been developed in pediatrics. In 1998, Children's Hospital Boston established the Center for Holistic Pediatric Education and Research (CHPER), a CAM multidisciplinary team providing clinical services, education, and research. METHOD: A retrospective review describing data from patient consultation notes, CAM lectures, clinical practice guidelines, curriculum materials, team meeting minutes, and team member manuscripts and publications. RESULTS: Over 5.5 years, CHPER staff provided over 2100 consults: acupuncture, massage, holistic pediatrician, relaxation therapies, biofeedback, hypnosis, and bio-pharmaceutics. Acupuncture and massage therapies were incorporated into a Clinical Practice Guideline. Formal education was delivered through didactic sessions, workshops, self-learning modules, clinical observation, and clinical practice. CHPER faculty published 1 book and 64 articles on CAM-related topics.</td>
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<td>major pediatric teaching hospital: an initial overview</td>
<td>Authors: Highfield, ES, McLellan, MC, Kemper, KJ, Risko, W, Woolf, AD</td>
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<td>Title: Integrative medicine in the hospital setting: an interview with Bryce Milam, DC Authors: Devitt M</td>
<td>Integration of conventional and complementary care in the United States is driven by the growing use of complementary therapies by patients, limitations in the effectiveness of conventional care for a variety of chronic conditions, a growing emphasis on patient satisfaction as a legitimate outcome of care, and an awareness on the part of insurers and practitioners that complementary approaches can offer a broad array of options that may significantly enhance healing and promote more active patient participation in health maintenance. Many models of integrative care are possible, ranging from the informed practitioner, to fully integrated group practices, to hospital-based and academic center systems of integration. A variety of barriers and challenges can slow the process of integration, including limited personal financial and temporal resources, negative peer opinion, legislative hindrances, and reimbursement shortfalls. This review describes seven models of integrative health care and offers recommendations to conventional-care providers for moving toward the practice of integrative medicine.</td>
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<td>Title: Moving toward integrative care: rationales, models, and steps for conventional-care providers Authors: Mann D, Gaylord S, Norton S</td>
<td>Integration of conventional and complementary care can be integrated into an urban pediatric teaching hospital to provide CAM medical education and clinical services.</td>
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<td>Title: Policy and business. Building an integrative medical centre: an interview with Donald W. Novey, MD</td>
<td>Interview- no abstract</td>
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<td>Title: Viewpoint. Exploring the interface between complementary and alternative medicine (CAM) and rural general practice: a call for research Author: Adams J</td>
<td>Viewpoint- no abstract</td>
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<td>Title: Issues, barriers, and solutions regarding integration of CAM and conventional health care Author: Mootz RD, Bielinski LL</td>
<td>Integrated care has a variety of meanings to different constituencies. Providers and consumers of complementary and alternative medicine (CAM) services tend to view integration as access to such services within existing conventional delivery systems along with third-party reimbursement for them. The article presents a regulatory effort in Washington State that brought carrier medical directors, CAM providers, and policy makers</td>
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| Title: Interprofessional referral protocols  
Author: Mootz RD  
Method: The project represents a "regulatory case study" involving facilitated workgroup training and informal consensus development among diverse constituents. Summary: Carrier medical directors and CAM providers can work together in a constructive fashion to identify common interests, establish dialogue, and respond to each other's needs. Numerous recommendations covering diverse issues resulted from the effort.  
Over the past decade, there has been a significant increase in awareness of alternative medicine therapies and documented growth in utilization. However, due perhaps to the strained political relations between alternative care providers and organized medicine, many patients have avoided communicating their use of such services to physicians. As a result of more research and exchange of information, the opportunity for better communication among all providers has never been better. Consequently there is the need to establish clear ground rules for interdisciplinary communication. | Yes |
| Title: Collaborative relationships in integrative medicine: conversations across the boundaries of different educations  
Authors: Aagenes N  
This study considers social contexts in which complementary and biomedical healthcare providers practice in common organizational structures. The empirical data are drawn from Israel where there has been an ongoing proliferation in the number and variety of practitioners as well as in the consumers of complementary medicine. Using qualitative methods, four out-patient clinics were selected in two cities in which physicians and nurses worked collaboratively with a wide variety of alternative healthcare specialists. Semi-structured interviews were carried out with 14 biomedical and alternative practitioners. The theoretical themes considered focus on boundary and authority issues between biomedical and complementary practitioners which are highlighted | Yes |
| Title: Evaluating integrated healthcare delivery models: a holistic approach  
Authors: Verhoef MJ, Findlay B, Yeomans T, Boon H  
This study considers social contexts in which complementary and biomedical healthcare providers practice in common organizational structures. The empirical data are drawn from Israel where there has been an ongoing proliferation in the number and variety of practitioners as well as in the consumers of complementary medicine. Using qualitative methods, four out-patient clinics were selected in two cities in which physicians and nurses worked collaboratively with a wide variety of alternative healthcare specialists. Semi-structured interviews were carried out with 14 biomedical and alternative practitioners. The theoretical themes considered focus on boundary and authority issues between biomedical and complementary practitioners which are highlighted | Yes |
| Title: Collaborative relationships of alternative practitioners and physicians in Israel: an exploratory study  
Authors: Shuval JT  
This study considers social contexts in which complementary and biomedical healthcare providers practice in common organizational structures. The empirical data are drawn from Israel where there has been an ongoing proliferation in the number and variety of practitioners as well as in the consumers of complementary medicine. Using qualitative methods, four out-patient clinics were selected in two cities in which physicians and nurses worked collaboratively with a wide variety of alternative healthcare specialists. Semi-structured interviews were carried out with 14 biomedical and alternative practitioners. The theoretical themes considered focus on boundary and authority issues between biomedical and complementary practitioners which are highlighted | Yes |
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<td>Title: Interactions between academic oncology and alternative/complementary/integrative medicine: complex but necessary Authors: Markman M</td>
<td>when such practitioners work in a common setting. The apparent weakening of the traditional monopoly is examined in the context of the social construction of legitimacy, authority and status, and some implications for professional practice are considered.</td>
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<td>Title: A quest to integrate alternative medicine into conventional practice: an interview with Woodson C Merrell, MD Author: Coulter AH</td>
<td>Interview- no abstract</td>
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<td>Title: A case study in integrative medicine: alternative theories and the language of biomedicine Authors: Anderson R</td>
<td>In this case study, a diverse panel of 6 practitioners of mainstream and/or alternative medicine plus a moderator convened as an experiment in practicing integrative medicine to examine, diagnose, and prescribe for a patient suffering from chronic, severe, treatment-resistant back pain. Although panel members represented a wide range of theories of health and healing, they were able to communicate easily with one another by limiting themselves to the scientific language of biomedicine. From the perspective of medical anthropology, this can be interpreted as an unplanned and unconscious process of cultural imitation in a medical marketplace in which cultural differentiation formerly prevailed. Although the shift from differentiation to imitation was limited in this experiment to the sharing of a single language of discourse and to recommendations of mutually compatible treatment options, it raises an important question. With the institutionalization of integrated medical practice, will alternative medical systems survive only if they are stripped down to being no more than alternative therapeutic modalities?</td>
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<td>Title: Integrative medicine: the team approach Authors: WhiteHorse E</td>
<td>Letter- no abstract</td>
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<td>Title: An assessment of the Tzu Chi Institute for complementary and alternative medicine as an optimal healing environment Authors: Mulkins A, Verhoef M, Eng J</td>
<td>Integrative medicine appears to have come closest to meeting the criteria of an optimal healing environment (OHE). However, to date, we have little insight as to how OHE can be designed or promoted. The purpose of this study was to explore which aspects of integrative healthcare delivery at</td>
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<td>the Tzu Chi Institute facilitated and which were barriers to achieving an OHE. The study is a descriptive analysis of the wide range of data collected between October 1998 and January 2003. Data were collected on demographics, health history, clinical utilization, goal attainment and six standardised outcome measures that include the Short Form Health Status Survey, General Perceived Self-Efficacy Scale, Multidimensional Health Locus of Control Scale and MOS (Medical Outcome Study) Social Support Survey. Several variables were identified as having the potential to influence individuals’ experiences in an integrative care programme. There included participation in the mind/body programme, number of clinic visits, degree of social support, sense of control over health and specific disease conditions. This study has generated important findings that will be useful in the further development of OHEs.</td>
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<td>Integrated clinics have already been established in response to community demand. The growing evidence base for complementary and alternative medicine (CAM) and its widespread community use compels doctors to understand complementary therapies and to refer patients to CAM practitioners where appropriate. Most general practitioners have patients with chronic illness who could benefit from the services of CAM practitioners, and virtually all CAM practitioners have patients who require access to mainstream diagnosis and therapy. Collaboration requires shared respect and trust, and education. Dangers of not integrating care include delaying or depriving patients of safe and effective management, and the potential for harmful interactions. Integration is currently being supported by government initiatives such as the new MedicarePlus package, as well as by initiatives from organisations such as the Australian Medical Association, the Royal Australian College of General Practitioners and the Australasian Integrative Medicine Association.</td>
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<td>Background: The use of Complementary and Alternative Medicine (CAM) in primary care is growing, but still not widespread. Little is known about how CAM can/should be integrated into mainstream care. Objectives: To assess primary</td>
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Nickel I, Jakob A, Fisher PAG

care health professionals' perceptions of need and of some ways to integrate CAM in primary care.

Method: Questionnaire survey of primary health care workers in Northwest London. General Practitioners (GPs) were targeted in a postal survey, other members of the primary care team, such as district and practice nurses, were targeted via colleagues. The questionnaire assessed health care professionals' perspective on complementary medicine, referrals, ways to integrate complementary medicine into primary care and interest in research on CAM. Results: Responses were obtained from 149 GPs (40% response rate after one reminder) and 24 nurses and 32 other primary care team members. One hundred and seventy-one (83%) respondents had previously referred (or influenced referral) for CAM treatments, the main reasons cited were: patients request (68%), conventional treatments failed (58%) and evidence (36%) (more than one reason could be given). Acupuncture and homoeopathy were the therapies for which patients were most frequently referred, followed by manual therapies. There was a significant interest in more training/information on CAM (66%). Only 12 respondents (6%) were against any integration of CAM in mainstream primary care. Most respondents felt that CAM therapies should be provided by doctors (66%) or other health professionals trained in CAM (82%). Twenty-six percent of respondents agreed with provision of CAM by non-state-registered practitioners. It was felt that the integration of CAM could lead to cost savings (70%), particularly in conditions involving pain, but also cost increases (55%) particularly in 'poorly defined conditions'. Fifty-six percent of respondents would consider participating in studies investigating CAM. The greatest interest was in acupuncture (41% of those who expressed an interest in research), homoeopathy (30%) and therapeutic massage/aromatherapy (26%).

Conclusions: There is considerable interest in CAM among primary care professionals, and many are already referring or suggesting referral. Such referrals are driven mainly by patient demand and by dissatisfaction with the results of conventional medicine. Most of our respondents were in favour of integrating at least some types of CAM in mainstream primary care. There is an urgent need to further educate/inform primary care health professionals about CAM.

Title: Complementary practitioners as part of the primary health care team: Background. A four-partner, non-fundholding, urban practice with 6000 patients has since

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<td>Nickel I, Jakob A, Fisher PAG</td>
<td>care health professionals' perceptions of need and of some ways to integrate CAM in primary care. Method: Questionnaire survey of primary health care workers in Northwest London. General Practitioners (GPs) were targeted in a postal survey, other members of the primary care team, such as district and practice nurses, were targeted via colleagues. The questionnaire assessed health care professionals' perspective on complementary medicine, referrals, ways to integrate complementary medicine into primary care and interest in research on CAM. Results: Responses were obtained from 149 GPs (40% response rate after one reminder) and 24 nurses and 32 other primary care team members. One hundred and seventy-one (83%) respondents had previously referred (or influenced referral) for CAM treatments, the main reasons cited were: patients request (68%), conventional treatments failed (58%) and evidence (36%) (more than one reason could be given). Acupuncture and homoeopathy were the therapies for which patients were most frequently referred, followed by manual therapies. There was a significant interest in more training/information on CAM (66%). Only 12 respondents (6%) were against any integration of CAM in mainstream primary care. Most respondents felt that CAM therapies should be provided by doctors (66%) or other health professionals trained in CAM (82%). Twenty-six percent of respondents agreed with provision of CAM by non-state-registered practitioners. It was felt that the integration of CAM could lead to cost savings (70%), particularly in conditions involving pain, but also cost increases (55%) particularly in 'poorly defined conditions'. Fifty-six percent of respondents would consider participating in studies investigating CAM. The greatest interest was in acupuncture (41% of those who expressed an interest in research), homoeopathy (30%) and therapeutic massage/aromatherapy (26%). Conclusions: There is considerable interest in CAM among primary care professionals, and many are already referring or suggesting referral. Such referrals are driven mainly by patient demand and by dissatisfaction with the results of conventional medicine. Most of our respondents were in favour of integrating at least some types of CAM in mainstream primary care. There is an urgent need to further educate/inform primary care health professionals about CAM.</td>
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| Evaluation of one model  
Authors: Patterson C, Peacock W | September 1991 worked closely with nine complementary practitioners working part time on a private, fee-paying basis. Aim. This study set out to describe and evaluate a model of integrating complementary practitioners into the primary health care team. Method. A description of the model operating in the practice was compiled. Qualitative analysis was carried out of semistuctured interviews with all members of the primary health care team using the method of a cooperative enquiry. Retrospective quantitative data on patients attending complementary practitioners were also examined. Results. The model allowed patients to refer themselves or be referred by a team member, encouraged communication between team members, and did not require any specific funding. After two years the model had been largely successful in preventing conflict over power, control and decision making; had maintained commitment to the idea of integrating complementary and allopathic medicine; and was self-funding. However, despite varied mechanisms set up to share knowledge and ideology, the rate of change in this area was slower than expected and referral rates were varied The dilemma of charging patients for complementary medicine in an environment where health care is free emerged as a major concern among the doctors and practice staff. Conclusion. The method of cooperative inquiry allowed the whole team to gain an understanding of other viewpoints and to use the research to tackle the problems raised. This model could be adopted and used by any enthusiastic general practice. | Yes |

| Title: Complementary practice at Phoenix Surgery: First steps in cooperative inquiry  
Authors: Reason P | This paper reports briefly on a cooperative inquiry into collaboration between general and complementary practitioners at Phoenix Surgery in Cirencester. From the experience of the co-researchers it is clear complementary practices have a place in primary health care, and that time and energy need to be devoted to developing communication and understanding for a full benefit to be realized. | Yes |

| Title: Power and conflict in multidisciplinary collaboration  
Authors: Reason P | Over the past few years, a considerable increase in complementary and alternative medicine (CAM) has been observed, particularly in primary care. In contrast little is known about the supply of CAM | Yes |

| Title: The supply of complementary and alternative medicine in Swiss hospitals  
Authors: Widmer M, Donges A, | Over the past few years, a considerable increase in complementary and alternative medicine (CAM) has been observed, particularly in primary care. In contrast little is known about the supply of CAM | Yes |
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<td>Wapf V, Busato A, Herren S</td>
<td>in Swiss hospitals. This study aims at the investigation of amount and structure of CAM activities of Swiss hospitals. MATERIALS AND METHODS: We designed a cross-sectional survey using a 2-step, questionnaire-based approach acquiring overview information form hospital managers in a first questionnaire leading to detailed information on CAM usage at medical department level (head of department). This second questionnaire provides data of physician-based and non-physician-based CAM supply. RESULTS: The size of hospitals was significantly associated with the provision of CAM. 33% of the hospital managers indicated 1 or more medical doctor (MD) using CAM in their hospital compared to 37% of confirmation on department level (Kappa value 0.5). Mostly different CAM methods were applied. Acupuncture was used most frequently. However only 13 hospitals (11%) occupied more than 3 CAM MDs and only 5 hospitals had more than 2 full-time equivalents for MDs. Furthermore, 74.7% of these personnel resources were dedicated for outpatient care. In terms of CAM methods anthroposophic medicine accounted for more than half of the total personnel costs. On the other hand usage of non-physician based CAM accounted for 41% according to hospital managers compared to 64% of CAM usage according to medical departments (Kappa values 0.31). Reflexology of the foot was used most frequently. CONCLUSION: Total supply of CAM in Swiss hospitals is low and concentrates on few hospitals. Acupuncture is the widest spread discipline but anthroposophic medicine spends the most resources. The study shows that a high patient demand for CAM faces low supply in hospitals.</td>
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<td>Title: C.A.M.: complementary &amp; alternative medicine. More CAM available to patients: a growing number of U.S. hospitals are offering complementary and alternative medicine. Author: Ananth S</td>
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<td>Title: The integration of complementary therapies in North and South Thames Regional Health Authorities' critical care units Authors: Hayes JA., Cox CL</td>
<td>Subsequent to the rising interest in complementary therapies, a survey was conducted to determine the extent of integration of complementary therapies in critical care units in the North and South Thames Regional Health Authorities in the Greater London area. In total, 45 critical care units were surveyed at random. The results of the survey indicated Neonatal Intensive Care Units showed the greatest</td>
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<td>Title: Patient visits to a hospital-based alternative medicine clinic from 1997 through 2002: Experience from an integrated healthcare system. Authors: Bracha Y, Svendsen K, Culliton P</td>
<td>Efforts to integrate complementary and alternative medicine (CAM) into conventional healthcare systems raise questions about expected levels of CAM use and its cost in an integrated system. This paper documents actual patient usage of a hospital-based alternative medicine clinic that has been operating on a conventional healthcare campus since 1993. Setting: Hennepin Faculty Associates (HFA) is a multispecialty physician organization serving the Hennepin County Medical Center (HCMC), a public teaching hospital in downtown Minneapolis. In 1993, HFA opened an alternative medicine clinic, primarily providing acupuncture. The clinic has since expanded services to offer chiropractic, massage/bodywork, and herbs. Administrative claims data showing visit dates, treatment received, payment source, charges, and patient complaints are available from 1997 through 2002. Results: Of all HFA patients who received conventional care on the HCMC campus every year (1997-2002), 6.5% also received care at the Alternative Medicine Clinic (AMC). Nearly 80% of AMC patients received third-party reimbursement for AMC services. Averaged over 6 years, self-pay patients had 3.2 visits per year and incurred $173 in charges per year; patients with a mixture of third-party payment sources had 8.0 visits per year and incurred $634 in charges per year. Number of visits per patient per year remained relatively constant over the 6 years, except for patients aged 65 or older, who showed an increase in number of visits, particularly for acupuncture. Conclusions: This report contributes a new perspective on use of CAM in the general population. Results from this perspective differ markedly from those provided by published survey data, showing a lower prevalence of use and lower charges incurred. Concern that insurance coverage for CAM would increase healthcare costs dramatically are not substantiated by these data.</td>
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<td>Title: The signifiance of alternative medicine at a University Hospital. Authors: Siegenthaler M, Adler RH</td>
<td>Three hundred randomly selected nurses employed at the university hospital of Berne were asked by means of a questionnaire as to the application of complementary methods (CM) in patients of this</td>
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<td><strong>Title:</strong> A qualitative study of patient's views on the consultation at the Glasgow Homoeopathic Hospital, an NHS integrative complementary and orthodox medical care unit. [see comment].&lt;br&gt;<strong>Authors:</strong> Mercer SW, Reilly D</td>
<td>We investigated consultations at the Glasgow Homoeopathic Hospital (GHH), by the use of in-depth, semi-structured interviews with a purposive sample of 14 patients. Interviews (lasting 1-2 h) were taped and transcribed verbatim. Analysis was based on a grounded theory approach. Two main categories of themes emerged: (1) those &quot;outside&quot; the consultation, related to expectations, initially formed from experiences of family and friends, but then strengthened by ongoing attendance at GHH; and (2) themes &quot;inside&quot; the consultation including length of consultations, the whole-person approach, being treated as an individual, and telling and having their &quot;story&quot; listened to in depth. Equality of relationship, mutual respect, and sharing decisions were also prominent themes. In conclusion, patients attending the GHH highly value the holistic approach, and view time, empathy, and the therapeutic relationship as being of key importance.</td>
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<td><strong>Title:</strong> An integrative medicine clinic in a community hospital.&lt;br&gt;<strong>Authors:</strong> Scherwitz L, Stewart W, McHenry P, Wood C, Robertson L, Cantwell M</td>
<td>We report on the creation of an integrative medicine clinic within the setting of a medical research and tertiary care hospital. The clinical audit used a prospective case series of 160 new patients who were followed by telephone interviews over a 6-month period. Patients' demographic characteristics, presenting symptoms and diagnoses, physician treatment recommendations, extent of understanding and adherence to treatment recommendations, changes in symptom intensity, and progress toward</td>
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<td>Title: Use of and attitudes about alternative and complementary therapies among outpatients and physicians at a municipal hospital. Authors: Boutin PD, Buchwald D, Robinson L, Collier AC</td>
<td>To survey outpatients and physicians about their use of, knowledge of, and interest in alternative therapies. DESIGN: Anonymous self-administered survey. SETTINGS/LOCATION: Outpatient clinics at a major municipal medical center. SUBJECTS: Outpatients visiting clinics and staff physicians. INTERVENTIONS: Patient survey about overall use of 7 categories and 19 types of alternative therapies, and their desire to have specific therapies offered at the institution. Survey to physicians about whether their patients used the same categories and types of alternative therapies, whether they provided or recommended their use, and their interest in having them available at the institution. OUTCOME MEASURES: Frequency of use of different alternative therapies by gender and race. Frequency of patient use of alternative therapies according to their physicians and frequency of physicians who provide or recommend alternative therapies. RESULTS: A total of 567 outpatients completed questionnaires during the survey week. When given a list of alternative therapies, 85% of patients acknowledged use of one or more alternative therapies. When Diet/Nutrition was excluded, 42% reported use of alternative therapies. No differences in overall use were seen by age, sex, or race; but when Diet/Nutrition was excluded, women were more likely to use alternative therapies, and use of Manual Healing and Herbal Medicine differed by race. Of the 85 responding physicians, 86% reported that their ambulatory patients used alternative therapies. Similar proportions (35%-38%) of patients and physicians wanted Manual Healing and Mind/Body Control therapies to be available. CONCLUSIONS: Frequency of use of alternative therapies was high, and similar according to patients and physicians. Overall use did not differ by gender and race, except when Diet/Nutrition was excluded. Patients and physicians had similar interests in having alternative therapies provided, and both were hampered by lack of information about many therapies.</td>
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<td>Title: Integrating complementary and alternative therapies in an outpatient university hospital setting. Authors: Enebo BA, Corbin L, Gilkey DP, Vela-Acosta MS, Keefe TJ, Bigelow PL</td>
<td>As the use of complementary and alternative medicine (CAM) therapies increases, the integration of these therapies requires collaboration with conventional medicine and healthcare disciplines. The purpose of this article was to characterise the profile of patients seeking CAM therapies at the University of Colorado Hospital's outpatient Center for Integrative Medicine. Methods: Data were collected on demographic and disease characteristics, methods of payment and referral sources to assess comparison with previous studies. Results: A total of 853 patients were seen for integrative therapies in a 23-month time period. Patients ranged in age from 14 to 89 years old and were predominately female (75%). Thirty-two percent of patients were referred by a hospital-based clinic. The majority of patients sought care for symptoms related to pain disorders, with musculoskeletal diagnoses comprising the majority of cases. Cancer patients most often sought treatment in the form of acupuncture/traditional Chinese medicine and massage therapy. Discussion/conclusion: An integrative medicine programme can exist in a hospital-based setting and provide meaningful cross-disciplinary treatment and dialogue. Although there are differences among populations, locations and treatment centres as to the types of conditions for which CAM therapies are sought, the forecast for continued integration of CAM services in a university hospital is promising.</td>
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<td>Title: Implementation of an osteopathic manipulative medicine clinic at an allopathic teaching hospital: a research-based experience. Authors: Przekop PR Jr., Tulgan H, Przekop A, DeMarco WJ, Campbell N, Kisiel S</td>
<td>Mastery of osteopathic palpatory skills and the skilled delivery of osteopathic manipulative treatment is a life-long venture that demands from practitioners increasingly sophisticated manual skills. Specific receptors and neural networks within the brain allow for the gradual development of refined manual skills that parallel responsive alterations and refinements that develop with repeated experience. During clinical training, most graduates of colleges of osteopathic medicine are not given opportunities to hone their palpatory skills. This is unfortunate because there is an increasing public demand for the nonpharmacologic treatment modalities osteopathic physicians could supply. At Berkshire Medical Center in Pittsfield, Mass, a major teaching affiliate of the University of Massachusetts Medical School in Worcester, the authors assembled a team of osteopathic and allopathic physicians to found an osteopathic manipulative medicine clinic. In this article, the</td>
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<tr>
<td>Title: Developing an integrative therapies program in a tertiary care cardiovascular hospital. Authors: Sendelbach S, Carole L, Lapensky J, Kshettry V</td>
<td>This article describes one hospital's approach to developing an inpatient integrative therapies program and the foundation for a broader integrative healthcare vision. Since the program's inception, additional evidence has accumulated in the literature supporting the impact of integrative therapies strategies on patients' quality of life during inpatient stays. These findings and our own evaluation processes have encouraged continued program growth. Several elements were critical to the program's success. Review of the literature and investigation of other programs served as preparation before the actual program started. It was necessary to have administrative, nursing, and physician champions who were able to envision the program and see the value of this approach for patients. We appreciated the need for evidence-based outcomes research and demonstrable patient outcomes. Finally, a program manager was hired who was able to understand the culture of the hospital and the organizational change process. Each of these basic steps, which called for interdisciplinary collaboration, allowed us to accomplish the goal of using integrative therapies as adjuncts to conventional medical care and thereby supported an integrative approach. Consistently linking the integrative vision to patient needs and requirements helped us to identify many new avenues to expand upon this work. The process of program development described may be useful to other inpatient cardiovascular programs inclusive of critical care settings. Adaptations of our experience to other populations in critical care and across other hospital settings may be possible.</td>
</tr>
<tr>
<td>Title: The integrative hospital explored via acupuncture. Authors: Schuster DM</td>
<td>To integrate complementary and allopathic medicine within a single hospital requires close attention to models of health care delivery, economics, and medical philosophy. The practice of acupuncture can be used as a heuristic device to examine these issues and how solutions may apply to other complementary modalities in the creation of such a hospital facility.</td>
</tr>
<tr>
<td>Title: Integration of complementary and alternative medicine in a major pediatric teaching hospital: an initial overview. Authors: Highfield ES, McLellan MC, Kemper KJ, Risko W, Woolf</td>
<td>To describe the establishment of a multidisciplinary team of complementary and alternative medicine (CAM) providers and educators in an urban pediatric hospital and affiliated medical school. BACKGROUND: Pediatric CAM use is increasing. Physicians are</td>
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<td>interested in CAM-related education but few programs had been developed in pediatrics. In 1998, Children's Hospital Boston established the Center for Holistic Pediatric Education and Research (CHPER), a CAM multidisciplinary team providing clinical services, education, and research. METHOD: A retrospective review describing data from patient consultation notes, CAM lectures, clinical practice guidelines, curriculum materials, team meeting minutes, and team member manuscripts and publications. RESULTS: Over 5.5 years, CHPER staff provided over 2100 consults: acupuncture, massage, holistic pediatrician, relaxation therapies, biofeedback, hypnosis, and bio-pharmaceutics. Acupuncture and massage therapies were incorporated into a Clinical Practice Guideline. Formal education was delivered through didactic sessions, workshops, self-learning modules, clinical observation, and clinical practice. CHPER faculty published 1 book and 64 articles on CAM-related topics. CONCLUSION: An interdisciplinary team of CAM clinicians and educators can be integrated into an urban pediatric teaching hospital to provide CAM medical education and clinical services.</td>
</tr>
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</table>

Title: Healthy practice. Development of a hospital-based integrative health center.
Author: Harris M

Title: Preliminary initiatives in a bridge building project between conventional and alternative practitioners in Denmark.
Authors: Haahr N, Launso L

A growing number of the approximately 7,400 persons with multiple sclerosis (MS) in Denmark use alternative treatments. The Danish Multiple Sclerosis Society has been experiencing an increasing demand for research on the effects of combined conventional and alternative treatments. For this reason, the Society has initiated a bridge building project to be implemented from 2004-2011 at a specialized MS hospital. In that project, a team of five conventional and five alternative practitioners works together and offers integrative treatments to a total of 400 MS patients. Objective: The overall purpose of the project is to examine if integrative treatments may optimize treatment results for people suffering from MS, and to develop a model for a bridge building cooperation of conventional and alternative practitioners in the future. Material and Methods: In this article we give an overview of the steps taken before establishing the hospital-based team of practitioners: (1) a public hearing attended by conventional and alternative practitioners experienced in treating MS patients; (2) qualitative
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<th>Study</th>
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<th>Study Included?</th>
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<tr>
<td>Title: Integrative medicine: implementation and evaluation of a professional development program using experiential learning and conceptual change teaching approaches. Authors: Hewson MG, Copeland HL, Mascha E, Arrigain S, Topol E, Fox JEB</td>
<td>To meet the increasing patient interest in complementary and alternative medicine (CAM), conventional physicians need to understand CAM, be willing to talk with their patients about CAM, and be open to recommending selected patients to appropriate CAM modalities. We aimed to raise physicians' awareness of, and initiate attitudinal changes towards CAM in the context of integrative medical practice. We developed and implemented a professional development program involving experiential learning and conceptual change teaching approaches. Methods: A randomized controlled study with a pre-post design in a large academic medical center. The 8-hour intervention used experiential and conceptual change educational approaches. Forty-eight cardiologists were randomized to participant and control groups. A questionnaire measured physicians' conceptions of, and attitudes to CAM, the likelihood of changing practice patterns, and the factors most important in influencing such changes. The questionnaire included an embedded control question on a topic that was not the focus of this program. We administered the questionnaire before (pretest) and after (posttest) the intervention. We compared differences in pre- and post-intervention scores between the participant (N = 20) and control (N = 16) groups. We used both groups to identify factors that influenced their practice patterns. The study was NIH-funded and IRB-exempt. Results: Both groups initially had little knowledge about, and negative attitudes to CAM. The participant group had significant positive changes in their conceptions about, and attitudes to CAM after the program, and significant improvements when compared with the control group. Participant physicians significantly increased in their willingness to integrate CAM in their practices. Physicians (combined groups) rated research evidence as the most important factor influencing their willingness to integrate CAM. They requested more research evidence for CAM efficacy, and more information on non-conventional pharmacology. Participants reflected enthusiasm</td>
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<td>Study</td>
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<tr>
<td>Title Integrating complementary and alternative medicine into academic medical centers: Experience and perceptions of nine leading centers in North America. Authors: Vohra S, Feldman K, Johnston B, Waters K, Boon H</td>
<td>Patients across North America are using complementary and alternative medicine (CAM) with increasing frequency as part of their management of many different health conditions. The objective of this study was to develop a guide for academic health sciences centers that may wish to consider starting an integrative medicine program. Methods: We queried North American leaders in the field of integrative medicine to identify initial sites. Key stakeholders at each of the initial sites visited were then asked to identify additional potential study sites (snowball sampling), until no new sites were identified. We conducted structured interviews to identify critical factors associated with success and failure in each of four domains: research, education, clinical care, and administration. During the interviews, field notes were recorded independently by at least two investigators. Team meetings were held after each visit to reach consensus on the information recorded and to ensure that it was as complete as possible. Content analysis techniques were used to identify key themes that emerged from the field notes. Results: We identified ten leading North American integrative medical centers, and visited nine during 2002-2003. The centers visited suggested that the initiation of an integrative medicine program requires a significant initial outlay of funding and a motivated 'champion'. The centers had important information to share regarding credentialing, medico-legal issues and billing for clinical programs; identifying researchers and research projects for a successful research program; and strategies for implementing flexible educational initiatives and establishing a functional administrative structure. Conclusion: Important lessons can be learned from academic integrative programs already in existence. Such initiatives are timely and feasible in a variety of different ways and in a variety of settings.</td>
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<td>Study</td>
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<td><strong>Study</strong>&lt;br&gt;Title: Blending the boundaries: Steps toward an integration of complementary and alternative medicine into mainstream practice.&lt;br&gt;Authors: Giordano J, Boatwright D, Stapleton S, Huff L</td>
<td>Complementary and alternative medicine (CAM) is growing in popularity among patients traditionally seen in an allopathic setting. A literature review and information search was conducted to determine the trend in demand for and the availability of CAM in the United States. The best predictor of CAM use is higher level of education. In addition, findings reveal that the field of CAM is poorly researched. Many studies in CAM therapies have flaws such as insufficient statistical power, poor controls, inconsistent treatment, and lack of comparisons. The national Centre for Complementary and Alternative Medicine of the National Institutes of Health, has declared their top strategic priority to be investing in research. Currently, more than 70 medical schools offer some type of training in alternative medicine, although there are few guidelines for curriculum and there is considerable heterogeneity in context format, and requirements among CAM courses. As patients have greater access to information, their needs and values change. They become more involved in their overall health care and are taking a more natural and holistic approach to achieving well-being. Health care practitioners, both allopathic and alternative must be well informed. There is an imperative to make ACM research a high priority. Valid and reliable empirical data must document the clinical efficacy and safety of CAM practices. In order to integrate CAM into the mainstream, there must be a coordinated effort among all the entities involved. Physicians need to be familiar with proven CAM therapies in order to advise patients about these modalities and the potential benefits and limitations. CAM practitioners should be licensed and regulated in scope of practice to provide a high standard of care and be sufficiently educated in convention medical science(s) in order to recognize how, where, and why their respective complementary practice is most effective for integration.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Study</strong>&lt;br&gt;Title: Entering the well-guarded fortress: Alternative practitioners in hospital settings&lt;br&gt;Authors: Shuval J, Mizrachi N, Smetannikov E</td>
<td>There is a growing evidence that alternative health care practitioners and physicians are working together in collaborative patterns. The paper examines there collaborative patterns in hospital settings in Israel. On the theoretical level, the specific issues related to theories concerning relationships between dominant institutional structures which enjoy the benefits of epistemological legitimacy as well as extensive, supportive social structures and groups on non-conformists who see to attain many of the same</td>
<td>Yes</td>
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Study

Abstract
goals by utilizing different methods based on other epistemologies. In the most general sense, the issues involved concern processes of accommodation and social change. Data were collected by means of semi-structured, qualitative interviews in four general hospitals in Jerusalem during 2000. Nineteen persons were interviewed including 10 alternative practitioners working in a variety of fields and 9 biomedical practitioners who worked with them (six physicians and three nurses). Interviews focused on background and training, reasons for entry into the hospital, length of practice, status in the hospital system, mode of remuneration, content of work modes of interaction with others in the hospital and problems encountered. The findings suggest a dual process of simultaneous acceptance and marginalization of alternative practitioners. While small numbers of alternative practitioners were found to be practicing in a wide variety of hospital departments and in a broad spectrum of specialties, there were in no way accepted as regular staff members and their marginality was made clear by a variety of visible structural, symbolic and geographical cues. There is a division of labour expressed by focusing on the biomedical practitioners on the diagnosis and treatment of specific disease entities, while the alternative practitioners work in the illness context, concentrating on feelings and affective states involving the alleviation of pain, suffering and efforts to improve the quality of life.
APPENDIX C

CATEGORIZATION OF EXISTING REVIEWS
### Parameters

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Design details</th>
<th>Key findings</th>
<th>Conclusions</th>
<th>Overview</th>
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<tbody>
<tr>
<td>Focus: Strategy and approach for integrating CAM by primary care practitioners</td>
<td>Study design: Descriptive and exploratory design. Design not used as an inclusion criterion. Participants: CAM providers, physicians and patients from 10 small rural family practice clinics and one large urban medical centre. Used as an inclusion criterion. Intervention: Not intervention studies. Described existing guidelines on referrals for CAM. Outcomes: not clear Period: not specified</td>
<td>A physician should first initially evaluate patients before integrating CAM modalities into their health care. Advice on referrals should be based on the safety of the method in question, current knowledge on indications and contraindications of that modality, and familiarity and an open dialogue with the specific therapist</td>
<td>There is an increasing need to address how CAM therapies can be integrated into conventional medical systems. These suggestions should respond to patient’s expectations and needs but at the same time maintain accepted standards of medical and scientific principles of practice.</td>
<td>Not systematic Summarizes descriptive studies Future work on this review: Extract reliable controlled studies and incorporate them directly into a systematic review.</td>
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### Tovey et al (2001): Primary care as intersecting social worlds [Review- 77 references]

<table>
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<tr>
<th>Parameters</th>
<th>Design details</th>
<th>Key findings</th>
<th>Conclusions</th>
<th>Overview</th>
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<tr>
<td>Focus: Using a social worlds theory (SWT) to understand issues in primary healthcare. Search strategy: Not specified. Researcher initiated review, UK.</td>
<td>Study design: Design not used as an inclusion criterion. Participants: None. Interventions: Describing how SWT provides the key to understanding the intersection of CAM and primary care. Outcomes: Mainly learner self-reports. Period: Not stated.</td>
<td>Qualitative review of the literature. Methodological critique offered. Most studies were of poor quality, using invalidated survey instruments. No meta-analysis, no statistical methods.</td>
<td>Positive findings for self reported student satisfaction with the learning experience, self reported skill and knowledge acquisition, changes in behaviour and in professional practice.</td>
<td>Summarizes low quality studies. Future work on this review: Extract reliable controlled studies and incorporate them directly into a systematic review.</td>
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<tr>
<td>Parameters</td>
<td>Design details</td>
<td>Key findings</td>
<td>Conclusions</td>
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<td>Focus: Attitudes of younger and older physicians regarding the use of CAM.</td>
<td>Study design: No reference to inclusion criterion</td>
<td>53 studies were included of 220 retrieved.</td>
<td>Most outcomes were assessed on self-reports of physician perceptions and of attitudes.</td>
<td>Few studies with reliable methods.</td>
</tr>
<tr>
<td>Search strategy specified: Not specified</td>
<td>Participants: Unclear</td>
<td>Reviewed qualitative and quantitative studies.</td>
<td></td>
<td>Future work: Extract reliable controlled studies and incorporate into a systematic review.</td>
</tr>
<tr>
<td>Researcher initiated review, US.</td>
<td>Intervention: Survey of doctors’ attitude toward CAM</td>
<td>Methodological critique offered.</td>
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<td></td>
<td>Outcomes: Mainly physician self-reports.</td>
<td>No meta-analysis, simple study count summary.</td>
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<td>Period: Not stated</td>
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### Friedman R (1997): Behavioral medicine, complementary medicine and integrated care [Review- 36 references]

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<th>Parameters</th>
<th>Design details</th>
<th>Key findings</th>
<th>Conclusions</th>
<th>Overview</th>
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<tr>
<td>Focus: To appreciate the relationship among unconventional, alternative, or complementary therapies and the cost of healthcare.</td>
<td>Study design: Design used as an inclusion criterion. Participants: Faculty at 62 US medical schools. Intervention: Literature review and questionnaire. Outcomes: Mainly self-reports. Period: 1972-97</td>
<td>Methodological critique offered.</td>
<td>Health care concepts and practices are changing dramatically. Routine integration of behavioural and biomedical care is completely compatible with these changes. Integration would provide clinical and economic benefits to patients and to society.</td>
<td>Few studies described their methods adequately Future work on this review: Extract reliable controlled studies and incorporate them directly into a systematic review.</td>
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Lorenz AD (1999): Models of collaboration [Review- 14 references]

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<th>Parameters</th>
<th>Design details</th>
<th>Key findings</th>
<th>Conclusions</th>
<th>Overview</th>
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<tr>
<td>Focus: Primary care clinicians must be able to collaborate with mental health professionals to address the complex needs of their patient population</td>
<td>Study design: Unclear. Participants: Unclear. Intervention: Literature review, historical perspective. Outcomes: Descriptive review of the benefits of collaboration. Period: Not stated</td>
<td>Methodological critique not offered. Mainly descriptive designs.</td>
<td>It will become ever more important to have all care providers, including family be “on the same page”. This active sharing of care should increase patient satisfaction and improve outcomes while containing costs.</td>
<td>Not systematic. Summarizes descriptive studies. Future work on this review: Extract reliable controlled studies and incorporate them directly into a systematic review.</td>
</tr>
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APPENDIX D

RECRUITMENT SCRIPT (E-MAIL OR TELEPHONE)

Hello, my name is Sophie Soklaridis and I am a PhD candidate at the University of Toronto and a research associate at the University Health Network, Toronto Western Hospital. I am conducting focus groups to learn about how biomedical and alternative approaches of health care currently co-exist at the AHC and how will they shift to accommodate incoming complementary and alternative health practitioners? Your name was given to me by:

- [For clients of the AHC] Your health care practitioner, with your permission.
- [For Hospital Administrators] The Artist Health Centre Foundation (AHCF) and various health practitioners that work at the AHC as a key person to consult and be included as a participant in our study.

Briefly, the study is about learning more about teamwork and integrative health care (IHC) in a hospital setting. We are calling some key players at the Toronto Western Hospital, the AHC (health-care practitioners and clients), and the AHCF to explore some of the barriers and opportunities faced by health practitioners as they work together in their clinical setting.

The focus group will take about 1.5 hours. I will provide refreshments and a light snack. The group will be held at Toronto Western Hospital on a day/time that is convenient for most participants. The group will consist of about 6 to 8 people, as well as myself (as the focus group facilitator) and an assistant. We will discuss about five open-ended questions in the group. At the beginning of the group we will obtain what is called “informed consent,” which is a process where participants read a consent form and sign it, signifying that they understand the purpose of the research and that any questions they may have had have been answered. Your participation is anonymous and your name will be removed from anything you say in the group.

Are you interested in participating in a focus group?
If **no**, thank potential participant, give them contact number in case they change their mind.

If **yes**, go on:

- What day/time works best for you?
- I will be calling participants to inform them of the confirmed date. Then, one day before the group takes place, I will call to remind you about the group, as well as its location and time.

Here is my contact information in case you have any questions:

Sophie Soklaridis  
University Health Network, Toronto Western Hospital  
Department of Family and Community Medicine, 3W-438  
399 Bathurst Street  
Toronto, Ontario  
M5T 2S8  
Phone: 416-603-5800 x 3907  
E-mail: sophie.soklaridis@uhn.on.ca

Thank you for your interest.
APPENDIX E

FOCUS GROUP GUIDE

This is a preliminary guide which will be further refined as the literature review progresses. The following questions will help inform the research focus:

- How do hospital administrators/health-care practitioners/clients define integrative health care?
- What are the key hospital administrative barriers to integrating biomedical and alternative approaches of care at the AHC?
- What are the key drivers for the integrative approach to care?
- What are the key issues with respect to boundaries for diagnosis and treatment between health practitioners working in a group practice?
- How are epistemological differences between health-care practitioners resolved when traditional and alternative approaches to health care co-exist, especially in the hospital setting?
- What are the medico-legal implications of integrative health care?
- How do the AHC health practitioners/hospital administrators/clients currently handle differences of opinions when it comes to care plans?
APPENDIX F

CONSENT FORMS
Title:
A Qualitative Research Project Exploring How Integrative Medicine Exists in an Occupational Health Clinic within a Hospital Setting: The Artists’ Health Centre Finds a Home at the Toronto Western Hospital

Investigator:
Sophie Soklaridis, Research Associate Toronto Western Hospital

Sponsor:
Artists’ Health Centre Foundation

You are being asked to take part in a research study. Before agreeing to participate in this study, it is important that you read and understand the following explanation of the proposed study procedures. The following information describes the purpose, procedures, benefits, and risks associated with this study. It also describes your right to refuse to participate or withdraw from the study at any time. In order to decide whether you wish to participate in this research study, you should understand enough about its risks and benefits to be able to make an informed decision. This is known as the informed consent process. Please ask the investigator of this study to explain any words you don’t understand before signing this consent form. Make sure all your questions have been answered to your satisfaction before signing this document.
Background:

Briefly, the study is about learning more about teamwork and integrative medicine in a hospital setting. We are calling some “key players” at the Toronto Western Hospital, the AHC (health care providers and clients) and the AHCF to explore some of the barriers and opportunities faced by health professionals as they work together in their clinical setting. During the focus group you will be asked questions related to barriers/challenges to integrative medicine.

Purpose:

The purpose of this study is threefold. First, it will explore some of the barriers/challenges to integrative medicine. Second, it will examine how traditional and alternative approaches of health care currently co-exist at the AHC. Lastly, it will explore how current practice will shift to accommodate incoming complementary and alternative health professionals.

Procedures:

A maximum of 5 focus groups in total will be conducted. Each focus group will be approx 1.5 hours long and will occur at a convenient time and place. You are being invited to participate in one of these focus groups. During the focus group session, you may refuse to answer any questions that you are not comfortable answering.

This study involves a purposeful and convenience sample where participants are recruited from key stakeholder groups. You were judged to be a valuable representative of one of the following categories:

- Key Hospital Administrator
- Health care provider from the Artists’ Health Centre (AHC)
Key Advocate involved in the development of the AHC from the Artists’ Health Centre Foundation

Confidentiality and Privacy:

All information obtained during the study will be held in strict confidence. No names or identifying information will be used in any publication or presentations. No information identifying you will be transferred outside the investigators in this study or this hospital.

Although 100 percent confidentiality cannot be guaranteed with focus group research, the principal investigator will be bound by the University Health Network and University of Toronto ethics standards and will remind all participants that discussing the content of the focus group and identifying individuals to others is not permitted.

The focus groups will be audiotaped and transcribed. The transcriber will also be bound by the University Health Network and the University of Toronto’s ethics standards of confidentiality. The audio taped focus group and data collected will be housed in a secure, locked place in a research office at the Toronto Western Hospital. Only the principal investigator will have access to this confidential data. The audiotapes will be destroyed immediately after transcription.

A summary of the results of the study will be made available upon completion of the project to those who request a copy.

Compensation:

There will be no compensation for participating in this study.

Potential Risks:

Potential risks in this study are expected to be minimal. However, as a result of participation in the focus groups, other participants will be aware of your participation in the study and of the input you provide during the focus group sessions.
Potential Benefits:

There is no direct benefit to you as a result of participation in this study.

Participation:

Your participation in this study is voluntary. You can choose not to participate or you may withdraw at any time without affecting your medical care.

Questions:

If you have any questions about the study, please contact Sophie Soklaridis (Principal Investigator) at: 416 603-5800 x 3907 or e-mail at: sophie.soklaridis@uhn.on.ca

If you have any questions about your rights as a research participant, please call Dr. R. Heslegrave, Chair of the University Health Network Research Ethics Board at (416) 340-4557.

Consent:

I have had the opportunity to discuss this study and my questions have been answered to my satisfaction. I consent to take part in the study with the understanding I may withdraw at any time without affecting my medical care. I have received a signed copy of this consent form. I voluntarily consent to participate in this study.

Signature of Participant     Name (please print)

___________________________   __________________________

Date

__________________________
Signature of Witness

__________________________   ____________________________

Name (please print)

__________________________   ____________________________

Date

__________________________
FOCUS GROUP CONSENT FORM:

CLIENTS OF THE AHC

Title:

A Qualitative Research Project Exploring How Integrative Medicine Exists in an Occupational Health Clinic within a Hospital Setting: The Artists’ Health Centre Finds a Home at the Toronto Western Hospital

Investigator:

Sophie Soklaridis, Research Associate Toronto Western Hospital

Sponsor:

Artists’ Health Centre Foundation

You are being asked to take part in a research study. Before agreeing to participate in this study, it is important that you read and understand the following explanation of the proposed study procedures. The following information describes the purpose, procedures, benefits, and risks associated with this study. It also describes your right to refuse to participate or withdraw from the study at any time. In order to decide whether you wish to participate in this research study, you should understand enough about its risks and benefits to be able to make an informed decision. This is known as the informed consent process. Please ask the investigator of this study to explain any words you don’t understand before signing this consent form. Make sure all your questions have been answered to your satisfaction before signing this document.
Background:

Briefly, the study is about learning more about teamwork and the way medical care is provided at the Artists Health Centre (AHC). We are calling some “key players” at the Toronto Western Hospital, the AHC (health care providers and clients) and the AHCF to explore some of the barriers and opportunities faced by health professionals as they work together in their clinical setting. As part of the study, we will be conducting Focus Groups to ask questions related to barriers/challenges to integrative medicine.

Purpose:

The purpose of this study is threefold. First, it will explore some of the barriers/challenges to integrative medicine. Second, it will examine how traditional and alternative approaches of health care currently co-exist at the AHC. Lastly, it will explore how current practice will shift to accommodate incoming complementary and alternative health professionals. As a client of the AHC, we have invited you to participate in this study so that you can tell us about your experience in receiving care at the AHC.

Procedures:

A maximum of 5 focus groups in total will be conducted. Each focus group will be approx 1.5 hours long and will occur at a convenient time and place. You are being invited to participate in one of these focus groups. During the focus group session, you may refuse to answer any questions that you are not comfortable answering.

Confidentiality and Privacy:

All information obtained during the study will be held in strict confidence. No names or identifying information will be used in any publication or presentations. No information identifying you will be transferred outside the investigators in this study or this hospital.
Although 100 percent confidentiality cannot be guaranteed with focus group research, the principal investigator will be bound by the University Health Network and University of Toronto ethics standards and will remind all participants that discussing the content of the focus group and identifying individuals to others is not permitted.

The focus groups will be audiotaped and transcribed. The transcriber will also be bound by the University Health Network and the University of Toronto’s ethics standards of confidentiality. The audio taped focus group and data collected will be housed in a secure, locked place in a research office at the Toronto Western Hospital. Only the principal investigator will have access to this confidential data. The audiotapes will be destroyed immediately after transcription.

A summary of the results of the study will be made available upon completion of the project to those who request a copy.

Compensation:

As a client of the AHC you will receive $15 to compensate for travel costs and time as you are making an effort to attend the focus group.

Potential Harms and Benefits:

There is no direct benefit from participating in this study. There are no risks anticipated from participating in this study, but if you have questions or concerns, either before or following my participation, you can call Sophie Soklaridis (416-603-5800 x 3907) or Alex Kerr, Ethics Coordinator, University Health Network (416- 416-946-4501 x 3829).

Consent:

I have had the opportunity to discuss this study and my questions have been answered to my satisfaction. I consent to take part in the study with the understanding I may withdraw at any
time without affecting my medical care. I have received a signed copy of this consent form. I voluntarily consent to participate in this study.

Signature of Participant

___________________________

Name (please print)

___________________________

Signature of Witness

Name (please print)

___________________________

Date
FOCUS GROUP CONSENT FORM:

INDIVIDUAL INTERVIEWS

Title:
A Qualitative Research Project Exploring How Integrative Medicine Exists in an Occupational Health Clinic within a Hospital Setting: The Artists’ Health Centre Finds a Home at the Toronto Western Hospital

Investigator:
Sophie Soklaridis, Research Associate Toronto Western Hospital (tel. 416.603.5800 x 3907, e-mail sophie.soklaridis@uhn.on.ca)

Sponsor:
Artists’ Health Centre Foundation

You are being asked to take part in a research study. Before agreeing to participate in this study, it is important that you read and understand the following explanation of the proposed study procedures. The following information describes the purpose, procedures, benefits, and risks associated with this study. It also describes your right to refuse to participate or withdraw from the study at any time. In order to decide whether you wish to participate in this research study, you should understand enough about its risks and benefits to be able to make an informed decision. This is known as the informed consent process. Please ask the investigator of this study
to explain any words you don’t understand before signing this consent form. Make sure all your questions have been answered to your satisfaction before signing this document.

**Background:**

Briefly, the study is about learning more about teamwork and integrative medicine in a hospital setting. We are calling some “key players” at the Toronto Western Hospital, the AHC (health care providers and clients) and the AHCF to explore some of the barriers and opportunities faced by health professionals as they work together in their clinical setting. During the focus group you will be asked questions related to barriers/challenges to integrative medicine.

**Purpose:**

The purpose of this study is threefold. First, it will explore some of the barriers/challenges to integrative medicine. Second, it will examine how traditional and alternative approaches of health care currently co-exist at the AHC. Lastly, it will explore how current practice will shift to accommodate incoming complementary and alternative health professionals.

**Procedures:**

You participated in a focus group and now you are being asked to participate in a 30-minute face-to-face interview.

A maximum of 10 individual interviews in total will be conducted. You are being invited to participate in one of these interviews.

Participation in this study means that you will be answering questions related to barriers/challenges to integrative medicine. The individual interview is a follow-up to the focus group. The individual interviews will take approximately 30-minutes and will occur at a
convenient time and place. During the interview, you may refuse to answer any questions that you are not comfortable answering.

Confidentiality and Privacy:

All information obtained during the study will be held in strict confidence. No names or identifying information will be used in any publication or presentations. No information identifying you will be transferred outside the investigators in this study or this hospital.

Although 100 percent confidentiality cannot be guaranteed with individual interviews as a research tool, the principal investigator will be bound by the University Health Network and the University of Toronto’s ethics standards and will remind all participants that discussing the content of the interviews and identifying individuals to others is not permitted.

The interviews will be audiotaped and transcribed. The transcriber will also be bound by the University Health Network and the University of Toronto’s ethics standards of confidentiality. The audio taped focus group and data collected will be housed in a secure, locked place in a research office at the Toronto Western Hospital. Only the principal investigator will have access to this confidential data. The audiotapes will be destroyed immediately after transcription.

A summary of the results of the study will be made available to me upon completion of the project to those who request a copy.

Compensation:

There will be no compensation for participating in this study.

Potential Harms and Benefits:

There is no direct benefit from participating in this study. There are no risks anticipated from participating in this study, but if you have questions or concerns, either before or following
your participation, you can call Sophie Soklaridis (416-603-5800 ext 3907) or Alex Kerr, Ethics Coordinator, University Health Network (416-416-946-4501 x 3829).

Consent:

I have had the opportunity to discuss this study and my questions have been answered to my satisfaction. I consent to take part in the study with the understanding I may withdraw at any time without affecting my medical care. I have received a signed copy of this consent form. I voluntarily consent to participate in this study.

Signature of Participant

Name (please print)

___________________________   __________________________

Signature of Witness

Name (please print)

___________________________   __________________________

Date

___________________________
Calling all Artists! Are you an Artist and willing to participate in a brief Research Study?

The Artists’ Health Centre Foundation is trying to learn more about the community it was created to serve: ARTISTS!

We would like to hear your thoughts on how well the Artists’ Health Centre is doing at integrating complementary and alternative therapies with the more traditional therapies. To do this, we are conducting focus groups with professional artists. The focus group will be approx. 1.5 hours and will be conducted at the Toronto Western Hospital at a time convenient for most participants.

If you’re interested or would like more information, feel free to drop by my office, which is located right next to the Artists’ Health Centre, room 3W438, or you can call me at 416-603-5800 ext. 3907 to learn more. Refreshments, sandwiches (let me know what you like), and a small payment to cover transportation/parking will be provided.

Thank you!

Sophie