

COMPLEMENTARY AND ALTERNATIVE MEDICAL PROVIDERS
AND THE EXPERIENCE OF INTEGRATION:
A CASE STUDY

DISSERTATION

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ABSTRACT

With the continued trend towards a more integrative medicine, Complementary and Alternative medicine practitioners have started working alongside their biomedical counterparts in integrative facilities. This study explores the experiences of CAM practitioners working in an integrative facility and the strategies used to facilitate this process. An in-depth case study was conducted with various practitioners working in this field and interviews were the main vehicle for this investigation. The analysis reveals that CAM practitioners' experiences are largely influenced by tensions with leadership and a changing organizational structure. Processes and barriers inhibiting integration are also discussed.

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CHAPTER 1

INTRODUCTION

Background to the study

The steady increase in the research conducted on the consumption of alternative medicine since the 1990s has demonstrated that complementary or alternative medicine is making an imprint on society (Kessler, Davis, Foster, Rompay, Walters, Wilkey & 2001). In 1993, Eisenberg conducted a hallmark study that revealed approximately one third of the participants reported using an alternative modality of some kind (D. Eisenberg et al., 1993). Because this research confirmed the notion that patients use of alternative practices was more than initially conceived, it became clear that patients were demanding alternative health care options. Thus, a flurry of research began on complementary healing and the reasons for why complementary healing has become so popular.

There are at least four main reasons why complementary medicine has increased in popularity, which explains why people turn to CAM. First, many people embrace CAM due to the exorbitant cost of biomedicine or for its failure to effectively resolve certain ailments. Secondly, there is the perception among CAM users that biomedicine neglects other definitions or aspects of health by focusing exclusively on biological markers of disease or illness. Thirdly, some patients attempt to develop deeper and more

intimate connections with CAM practitioners as a result of the diminished quality of the doctor-patient relationship. Lastly, it is speculated that CAM therapies have grown in popularity due to the emergence of a value system consistent with the philosophies of alternative medicine.

The first explanation suggests that biomedicine has been criticized for spiraling costs of health care, high fees, and the inability to solve chronic health issues (Guttmacher, 1979). In fact, one study which compared health care in 13 countries found that the U.S average ranked 12th on sixteen health indicators (Starfield, 2000, 1998). There is also a sense that despite the massive amount of funds being spent on health care, our nation, as a whole, is not necessarily healthier.

Despite the fact that expenditures for medical care now constitute almost 10 percent of the GNP in the US and are growing at a rate almost twice that of the rest of the economy, it is not at all clear that health is improving. Medicine is largely ineffective against the leading causes of death for those under 45 (accidents, suicide, and homicide) as well as those over 45 (heart disease, cancer and stroke) not so much because of the biological origin (if any) of these problems is misunderstood as that their social aspects have been relatively unexplored and unincorporated into medical practice (Berliner & Salmon, 1980: 137).

Another reason explaining the increase in CAM use is related to the criticism biomedicine has received for neglecting social, emotional, and psychological contributions to health and wellness (Engle, 1977). Because of its exclusive reliance on biological phenomenon, biomedicine is often seen as an incomplete approach to healthcare. Almost thirty years ago, Engle proposed a new kind of medicine to address the inadequacies of the biomedical model. The new approach, the biopsychosocial model, was devised to incorporate social, psychological and behavioral dimensions of illness, which have long been absent from the biomedical model. CAM, like the

biopsychosocial model, is a more comprehensive or systematic approach to medicine and users are attracted to it for this reason since CAM practitioners attend to the mind, body and spirit of their clients. .

CAM use became an active way for patients to express their dissatisfaction with biomedicine. Because of the increase in CAM use as noted by Eisenberg and colleagues, there is evidence suggesting that the public is demanding alternative health care. In response to this, biomedicine took notice of studies like Eisenberg's and began to incorporate holistic care into their facilities. Wolpe (2002) points out that there was the perception among biomedical practitioners that the incorporation of CAM was to be a lucrative endeavor, one that would not only produce financial rewards, but would also allow biomedicine to control and regulate alternative modalities. The decision to integrate, then, seems to be more motivated by financial matters, rather than the desire to create a more comprehensive style of health care. As CAM has continued to grow in popularity, biomedicine has made continued efforts to integrate in order to align with its success.

A great deal of patient dissatisfaction has recently affected doctor-patient relationships and it is believed that the third reason inspiring many turn to CAM is due to negative or ineffective experiences with physicians (Barrett, Marchand, Scheder, Applebaum, Chapman, Jacobs, Westergaard, & Clair, 2000; Furnham & Smith, 1988; Shumay, Maskarinec, Kakai, & Gotay, 2001; Vincent & Furnham, 1996). For some, using CAM is viewed as a way to make a statement to express one's dissatisfaction with biomedicine.

But the rise of alternative medicine over the past few decades was due as much to its cultural symbolism and philosophical framework as to its healing potential. In a time

of stuffy, close-minded medical thinking, "going alternative" was symbolic of the rejection of establishment medicine, a counterculture political display akin to bra-burning or wearing a pink triangle" (Wolpe, 2002: 170).

Additionally, Kelner (2000) argues that patients no longer are satisfied with the paternalistic model of care provided by physicians and prefer a model that emphasizes shared decision making processes. There is also the perception that physicians do not communicate sufficiently with their patients and that biomedical treatments produce adverse effects (Shumay et al. 2001; Vincent & Furnham, 1996). Because of these issues, patients seek alternative remedies because they perceive CAM providers to be more collaborative, and possibly even more effective in addressing chronic complaints than their biomedical counterparts.

There has been some research to suggest that users of CAM share common values. In one study, CAM use was predicted by education, a holistic orientation of health and also membership to a cultural group characterized by involvement with environmentalism, feminism, spirituality, or interest in personal growth psychology (Astin, 1998; Astin, J., Pelletier, K., Hansen, E., & Haskell, 1998). Similarly, Kaptchuk & Eisenberg (1998) propose that people are attracted to CAM because its themes overlap with nature, vitalism, and spirituality, which provide a sense of empowerment, authenticity and identity to its users. Put another way, Shiahpush (1998) presents the idea that postmodern values regarding nature, science and technology, health, authority, individual responsibility and consumerism, align with the philosophies, beliefs and assumptions of CAM. The authors found that a set of postmodern values rather than unsatisfactory experiences with biomedicine is a better predictor of attitudes towards CAM use.

A great deal of research has since been conducted on the efficacy of various aspects of alternative modalities (Ernst, 2004; Hoiriis et al., 2004; Khoury, 2004; MacKay, 2004; Ulrich, 2004). While much research has focused on the effectiveness of alternative practices, the continued trend in consumption has produced many funding opportunities provided by the National Institute of Health, and subsequently, many traditional educational institutions have been incorporating alternative modalities into their curricula. Other research has addressed the issues around education and alternative practices. The bulk of this research has focused on the implications for medical education (Wetzel, Kaptchuk, Haramati, & Eisenberg, 2003), training and attitudes of faculty on alternative practices (Konefal, 2002; Levine, Weber-Levine, & Mayberry, 2003), communication (Caspi, 2000), and teaching courses involving alternative modalities in US medical schools (Brokaw, Tunnicliff, Raess, & Saxon, 2002; Maizes, Koffler, & Fleishman, 2002; M. Wetzel, Eisenberg, & Kaptchuk, 1998).

Because of the persistent trend in consumption, some allopathic physicians have begun to embrace alternative modalities. With this movement, additional research has been conducted on the integration of allopathic and alternative modalities (Astin, 1998; Cohen & Eisenberg, 2002; Dalen, 1998; Frenkle & Borkan, 2003; Udani, 1998). While this body of research has significantly enhanced our understanding of alternative practices, a gap remains. Most of this research has privileged the perspective of the traditional hegemonic medical model and few studies have addressed the perceptions or implications of the paradigmatic clash from the perspective of the alternative practitioner.

There have been a few notable papers that explore integration. Ian Coulter has acknowledged the philosophical differences between biomedicine and CAM, also

referred to as a paradigm clash, and has attempted to analyze it by briefly summarizing the tenets of each healing system (Coulter, 2004). He provides three reasons explaining why integration is occurring. Coulter proposes that the primary motive behind integration is financial, meaning that allopathic medicine integrates alternative practices because they are perceived to be lucrative. Integration also occurs under the guise of safety concerns. Because of the past stigma associated with alternative practices, patients did not always inform their allopathic provider of alternative practices. Physicians perceived this to be a risky practice since alternative modalities can sometimes interfere or interact with allopathic treatments. As a result, the second reason for integrating was seen a way to protect the patient from any inadvertent risks of combining the two systems. Coulter concludes by stating that evidence based medicine is the mechanism needed to integrate alternative modalities and to justify its efficacy.

Of course, there are a number of problems associated with evidence-based medicine. Coulter says,

...such an approach implies that a standard of research which has taken conventional medicine close to a century to achieve (dating from the Flexnor Report in 1910), should be met by the CAM group. The latter has had no research funding from the National Institutes of Health or the National Research Council until very recently, it is for the most part not located in the university system, and is practiced in isolated, solo practices by individuals not trained as researchers. To expect CAM to compete on a level playing field with conventional medicine in research is unrealistic. (Coulter, 2004)

Coulter points out that the process of subjecting CAM to evidence based practices makes an epistemological claim, which implies that one form of knowledge is superior to another. It has also been acknowledged that this epistemological claim carries the assumption that evidence based medicine can be applied to all healing modalities

(Tonelli & Callahan, 2001). While Coulter's work is indeed informative, it is merely theoretical meaning that there has been little exploration as to how integration actually works in an applied sense until recently.

A recent study funded by the NCCAM was arranged to identify barriers and facilitators to the integrative process by exploring the partnership between CAM and biomedicine in a hospital setting. With this research agenda in mind, Coulter, Ellison, Hilton, Ryodes & Ryan (2007) followed the development, creation and demise of a hospital-based Integrative Medical center. The authors discovered that the center's design and location thwarted the center's progress, but other barriers, such as the failure to anticipate the challenges of practicing CAM in a hospital environment, the absence of a sound business plan, and also the lack of infrastructure for research, restricted its success as well. Coulter and colleagues identified a few factors that promote the integrative process including strong support from the board of directors and medical staff and the reputation of the hospital. With this scholarship, we can begin to identify some of the barriers associated with integration, but these may differ depending on the setting, location, or environment of a center.

Judith Shuval and Nissim Mizrachi have written extensively on integration, and their work tends to focus heavily occupational boundaries. Shuval, Mizrachi & Smetannikov examined the collaborative patterns between allopathic and alternative practitioners in a hospital setting in Israel. This study collected qualitative evidence to demonstrate that alternative practitioners operating within the confines of traditional medicine were both accepted and marginalized within a hospital setting (Shuval,

Mizarchi & Smetannikov, 2002). Findings reveal that a division of labor exists between the two groups: alternative practitioners work in the illness context while allopathic practitioners diagnose and treat specific pathologies.

Another work explores organizational boundaries and their permeability as they relate to the recent processes of integration (Shuval & Mizrachi, 2004). The findings replicate the notion that alternative practitioners are seemingly equal, yet separate to their allopathic counterparts. This suggests that while alternative practitioners have been granted access into allopathic arenas, their engagement in allopathic activities is indeed restricted to certain treatments or procedures.

These concepts led Shuval (2006) to explore strategies nurses partake when integrating alternative practices into their work. Using the notion of boundaries to explore instances of separation and exclusion, researchers investigated nurses' experiences negotiating territorial, epistemological, authority and social boundaries. Results revealed that nurses using CAM practices did not attempt to challenge the epistemological and authority boundaries of biomedicine. Nurses did believe, however, that crossing the cognitive boundary would result in improved patient care, yet they also believed that physicians "keep the cognitive boundaries of biomedicine closed" (p. 1793). While the experiences of CAM practitioners crossing the boundary into biomedicine are hypothesized, there is no direct evidence to explore this theory.

A recent study sought to develop a conceptual framework of integrative medicine at the provider level (Hsiao et al., 2006). Researchers selected 50 practitioners from both CAM and biomedicine to inquire about their experiences regarding the structure and

practice of working in integrative facilities. The results yielded four themes which include: provider attitude toward integrative medicine, knowledge of integrative medicine, referral to other practitioners and practice of integrative medicine.

The first theme, provider attitude toward integrative medicine, highlighted four domains including: faith in integrative medicine, confidence in CAM and conventional medicine, philosophical scope and practitioner's openness. Because the degree to which practitioners tolerate other modalities is of particular interest to this study, it is important to point out that differences were observed in the degree of openness practitioners felt towards other modalities. In this study, the degree of openness refers to the "ability [of a practitioner] to see advantages of both CAM and conventional medicine" from their own medical paradigms and the potential benefits of combining them" (p. 2978). Findings indicate that some practitioners, such as physician acupuncturists and chiropractors, are more tolerant and accepting towards other modalities when compared the to physicians participating in the study. Additionally, those who appeared to be more close-minded about integrative medicine were more likely to stereotype CAM practitioners as being charlatans eager to take their patient's money.

The second theme, knowledge of integrative medicine, describes the methods used to acquire knowledge and level of proficiency regarding CAM practices. Hsiao et al (2006) point out that both informal and formal training paths exist as routes to obtain knowledge of integrative medicine. They also note that some formal paths are considered inadequate in the eyes of some practitioners due to differences in standards.

The third theme, patterns within the referral processes, revealed that physicians were more reluctant than other providers in the study to refer patients. Physicians were likely to refer to other practitioners only after they determined conventional medicine was largely ineffective for a specific patient. Furthermore, it was also suggested that a practitioner's willingness to share patients could be related to their beliefs about patient-centered or collaborative care. If practitioners are willing to give their patients a voice in crafting treatment plans, then perhaps they are more inclined to listen to or seek input from colleagues outside their modality.

The fourth and last theme, the practice of integrative medicine, highlights the notion that integrative medicine frequently involves the practice of co-management or the process of "communicating and coordinating their patient's care with practitioners outside their medical paradigm" (p.2984). A lack of collaboration was identified as a barrier inhibiting the co-management process.

Even though allopathic and alternative healing systems are beginning to integrate, there has been little research conducted that seeks to understand how conflicting healing philosophies affect the practice of complementary medicine in an integrated environment. As Davis-Floyd & St. John (1998) point out biomedical practitioners primarily rely on reductionism to understand the body and see the body as something that can be repaired or maintained. Alternative practitioners conversely view the body holistically, or as an integrated system. Diagnostic procedures also differ. Allopathic physicians tend to incorporate a standard procedure for evaluating illness where as alternative practitioners tend to use a more intuitive approach that often results in different treatment outcomes for people with the same pathology. Given these fundamental differences, it would seem

that both sets of practitioners, allopathic and alternative, would have to negotiate their healing philosophy for the sake of integrating.

The research agenda for this proposal seeks to explore the perceptions of integration from the perspective of the alternative practitioner. Although the United States was once a home to a pluralistic medical model during much of the nineteenth century, biomedicine became a dominant force shortly thereafter due to corporate-sponsored philanthropies, the rise of the American Medical Association and changes in licensing laws (Baer, 2001). The United States now appears to be moving back towards a pluralistic medical model, or is it? According to Baer, “when heterodox medical systems are granted partial legitimacy, they often undergo a subtle co-optative process as they incorporate aspects of the biomedical model and thereby inadvertently contribute to biomedical dominance” (Baer, 2001: 38). This research will identify whether or not alternative modalities are merely being co-opted or if there is indeed some degree of collaboration where both systems impact and change the other.

Baer’s insight brings forth many unanswered questions such as: What does each group gain and/or lose in the process of blending alternative modalities with biomedicine? How do these various practices merge into one? What are the philosophical and paradigmatic conflicts practitioners negotiate as this process unfolds? Is the dominant allopathic model becoming reinforced? This dissertation will explore some of these gaps in the literature.

Purpose of the study

One of the unique features of this study is that it will consider the perceptions of integrating from the perspective of CAM practitioners. In the attempt to provide evidence to substantiate the efficacy of nontraditional practices, most of the decisions about how alternative practices should fit into an allopathic model are determined by physicians or others outside of the nontraditional model. For example, if we look at how acupuncture is regulated we know that, “only 14 states have an independent board of acupuncture or Oriental medicine; in other states, acupuncturists are under the board of medical examiners or regulated by the departments of commerce or health” (D. Eisenberg, Cohen, M., Hrbek, A., Grayzel, J., Van Rompay, M, and Cooper, R., 2002). Surprisingly, many physicians make decisions about the regulation of alternative modalities but have little to no training in these practices. In 2003, the Institute of Medicine sought experts in alternative modalities to create a CAM panel. Ultimately, most of the candidates selected to participate in this panel were conventional physicians and were not the CAM advocates the CAM community had anticipated (Hammerly, 2003).

In addition to having little voice in the regulation of their own practices, occupational boundaries of alternative modalities are easily permeated by physicians since physicians can easily obtain CAM credentials. Physicians are able to partake in professional development sessions that quickly legitimize them into the alternative arena. For example, in order for physicians to become medical acupuncturists, they must undergo 200-300 hours of training and are not required to do an internship (D. Eisenberg, Cohen, M., Hrbek, A., Grayzel, J., Van Rompay, M, and Cooper, R., 2002) A typical

program in acupuncture in the United States is roughly 3-4 years. In Asia, acupuncture is an ancient system of healing that takes years, if not decades to master. In the United States, however, physicians can master it in a few hundred hours even though the healing paradigm for acupuncture is a direct contrast to allopathic medicine. Physicians are posed in such a way to grant access to the alternative modalities, yet most physicians have not undergone extensive training on alternative practices. I speculate that most physicians practicing alternative modalities might not have adopted some kind of practice to cultivate a sense of inner awareness, which is central to most nontraditional healing modalities (Yuasa, 1987). One latent goal of this research is to capture how alternative practitioners feel about the porous nature of their profession and whether or not they feel that having a somatic practice is central to their ability to heal.

Significance of the study

There are a number of reasons why this research is important. The use and consumption of CAM is growing substantially and because of this interest, CAM can no longer be ignored. Medical institutions have reconsidered their opposition to CAM in part because their patients are fueling the trend towards acceptance. Patients have greater access to medical knowledge and are becoming quite savvy about researching medical alternatives. With this sense of empowerment, patients realize they have more options and are probing their physicians about other modalities. Faced with the threat that their patients might take their health care dollars elsewhere, traditional medicine is responding by embracing CAM. Given that alternative practices are in a sense becoming more common, research should be conducted to witness this trend.

This study focuses on the experiences of alternative practitioners since their perspectives have mostly been ridiculed in mainstream academic medical journals (Winnick, 2005), and have been excluded for the most part in the emerging CAM literature. Because CAM practitioners represent the voices of the modalities that are being integrated into traditional medicine, it is crucial to assuage their input. A few decades ago, most physicians generally felt that CAM was quackery and should be avoided. Since the early 1990s, the trend has been to embrace CAM and the population that once rejected it is now in a position to make changes that affect the future of CAM. If research continues to neglect CAM perspectives, their voices will be forever silenced from this process.

Not only is the landscape of medicine changing, but the methods examining alternative modalities are changing as well. There is a movement to include alternative modalities in clinical trials and also in Evidence-Based Medicine (EBM), but quite often these methods are inappropriate due to the inherent differences in healing assumptions. As noted above, many alternative treatments are individualistic, that is, they vary from patient to patient. Because of this, clinical trials are not the most useful method to capture the effectiveness of alternative practices. Researchers are beginning to realize this problem and are responding by developing qualitative research and mixed methods to investigate efficacy of alternative practices (Miller & Crabtree, 2000). This change represents a real shift towards the acceptance of holism since both quantitative and qualitative methodologies are utilized. It is necessary to capture insight from alternative healers, so researchers can better understand these practices to create more effective research methodologies.

Although alternative practices have provided some impetus for changing research methodologies, changes have been slow in medical education. Most of the research related to CAM and medical education has focused on doctor-patient relationships. Currently, most CAM education occurs outside the university, so it is practically excluded from the academy. Clearly in this vein, alternative modalities are marginalized by mainstream medicine. If CAM is truly being integrated into mainstream medicine, then we should expect over time to see its presence in major academic institutions. Thus far, this process has been extremely slow and acceptance will continue to be hindered until alternative practitioners are included in research.

Methods

A qualitative, rather than a quantitative design, was utilized for this study. Since there are not many studies investigating the effects of integration in the United States, the topic was considered exploratory. Exploratory studies tend to favor a qualitative design and it is believed that the processes related to integration are best understood by those individuals who are currently experiencing integration. Even though integration is occurring within mainstream medicine, the actual population of alternative healers in these settings is quite small. The use of surveys or the use of secondary data does not make sense given the small population in which to draw sample.

A case study was used as the method for collecting data. A case study is defined as, “an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident”(Yin, 2003). Case studies provide rich textual descriptions and rely on multiple

source of evidence. For this reason, documents and observations were collected and considered, but the primary mechanism for collecting data for this study was individual interviews.

In order to explore the perceptions of CAM practitioners operating within traditional medicine, a setting was needed to provide the context for this phenomenon. An integrative facility was selected to provide a group of practitioners to interview. Because integrative facilities are still relatively rare, the decision to select one facility to study was mostly out of necessity. The singular setting also provided some consistency to triangulate the experience of the practitioners. The setting for this case was a family practice clinic within a university setting and is a relatively young enterprise employing both biomedical and CAM practitioners. Due to my status as a practitioner at this facility, gaining access to a population of practitioners to study was quite simple. Implications of this role and other limitations will be discussed in more detail in Chapter Three of this study.

For roughly two years, I observed what it was like to be a practitioner in this facility. Due to my status as an insider, I frequently attended center meetings and events, which provided the bulk of my observational data. Two rounds of in-depth interviews were conducted with CAM practitioners. The first round of interviews focused on experiences related to integration and interactions with colleagues. A second round of interviews was conducted with the same group of practitioners and inquired about the processes CAM practitioners experienced related to integration. Interviews were eventually transcribed and were read multiple times prior to sorting text into various

themes. The themes represented the major findings were reported as a case study. A concluding summary provides an overview of the major findings and implications of this study.

Outline of Chapters

Including this introduction, the study is comprised of 5 chapters. An overview of each chapter is presented below.

Chapter 2 – Integration as Mergers and Acquisitions. This chapter situates CAM and biomedical practitioners as belonging to two separate occupational cultures. Differences between the cultures are discussed and the concept of integrative medicine is introduced as a way to blend the two cultures. The chapter concludes by identifying the best strategies used for successful mergers and acquisitions as a way to develop a conceptual framework for beginning to understand the processes related to integration.

Chapter 3 – Methodology. The methodological approach and design of this study is explained in this chapter. Research questions are identified and the methods of data collection and analysis are presented. The role of the researcher, limitations of research design and trustworthiness are explored in this section.

Chapter 4 – Analysis. The focus of this chapter is to describe participants' general experiences and attitudes about working in an integrative environment. The second section uses the best strategies identified for integration as a lens to understand what processes were used to lessen the impact of a cultural collision between CAM and biomedical practitioners. The chapter concludes by identifying some of the issues and challenges practitioners experience working in an integrative environment.

Chapter 5 - Findings and Conclusion. This chapter summarizes the major highlights and implications of this case study. Suggestions for future research are provided.

CHAPTER 2

INTEGRATION AS MERGERS AND ACQUISITIONS

Tenets of Biomedicine & Holism

To understand a healing system and the processes associated with integration, it is necessary to identify the assumptions, forces and cultures that inform such systems.

The overall framework informing a given healing system can vary significantly and is largely dependent on the culture in which it is situated. Although there are numerous healing philosophies, for the purposes of this study we are interested in two, biomedicine and holistic medicine. Davis-Floyd and St. John (1998) used paradigmatic models to explore differences between holistic and biomedical orientations. A paradigm is essentially a collection of ideas that shape the way problems are defined, understood, and ultimately solved. Paradigms are guides, models or conceptual frameworks that inform and shape disciplines, and science is the paradigm upon which biomedicine relies.

The era of integrative medicine now beckons us to consider the possibility of the clash of paradigms, biomedicine and holism.

Since biomedical and holistic paradigms are forces shaping the process of integration, it should be noted that each system is guided by a distinct set of principles that often oppose the other. While science is not the central tenet of holistic practitioners,

it is indeed a staple of biomedicine. Because biomedicine is rooted in the application of scientific principles, its overall philosophy and orientation is quite different from holism. In fact, prior to the 1990s, biomedicine completely eschewed holistic medicine (Winnick, 2005). There has been a change of heart however as a result of studies like Eisenberg's that demonstrated the popularity of such systems. Despite the fact that one system relies upon science and the other may or may not, there have been numerous attempts to integrate these paradigms. In the early 1990s, the federal government provided funds to evaluate the effectiveness of CAM modalities, which also lead to the creation of the National Center for Complementary and Alternative Medicine (NCCAM). As a result of this initiative, grants suddenly became available to study this once taboo subject. A number of these grants provided seed money to various universities for the creation of academic centers to study specific aspects of CAM largely through biomedicine. This movement is commonly referred to as Integrative Medicine since it attempts to incorporate elements from the holistic paradigm into the biomedical paradigm. More on Integration will be discussed in an upcoming section.

Davis-Floyd & St. John (1998) mapped out the major tenets representing three distinct healing systems: technocratic medicine, humanistic medicine, and holistic medicine; when describing the transformative journey some physicians took to reinvent themselves as holistic practitioners. These paradigms, as the authors explain, have diffuse boundaries since actual physician practices may reside within one of these paradigms or sprawl across all three. Put another way, each tenet resides along a continuum and are comprised of shifting focal points and blurred boundaries. The major tenets of each healing systems are represented in Table. 1.

Given characterization of the tenets of both holistic and biomedicine as outlined in Table 1, it is apparent that each healing system operates with a distinct set of practices that sometimes stand in contrast, or opposition to the other. For example, the biomedical model relies on the machine metaphor, principles of separatism, reductionism, and objectivity, and also dispenses standardized treatments to its patients. Holistic medicine, in contrast, emphasizes unity of the body, embodies principles such as holism and subjectivity, and creates individualized treatment plans for its patients. Differences between the two healing systems also exist in terms of structure and in patient relations. Biomedicine tends to follow a technocratic model of organization, and doctor-patient relationships typically are characterized by hierarchal differences in knowledge and power. The structure of holistic medicine is more diffuse or web-like, and relationships between holistic clients and providers are often based on negotiation and collaboration. Clearly, the two systems are different in a number of ways.

Technocratic Medicine	Humanistic Medicine	Holistic Medicine
Mind/body separation	Mind/body connection	Oneness of body-mind-spirit
The body as machine	The body as organism	The body as an energy system interlinked with other energy systems
The patient as object	The patient as relational subject	Healing the whole person in whole-life context
Alienation of practitioner from patient	Connection and caring between practitioner and patient	Essential unity of practitioner and client
Diagnosis and treatment from the outside in	Diagnosis and healing from the outside in and from the inside out	Diagnosis and healing from inside out
Hierarchical organization and standardization of care	Balance between the needs of the institution and the individual	Networking organizational structure that facilitates individualization of care
Authority and responsibility inherent in practitioner, not patient	Information, decision making, and responsibility shared between patient and provider	Authority and responsibility inherent in each individual
Supervaluation of science and technology	Science and technology counterbalanced with humanism	Science and technology placed at the service of the individual
Aggressive intervention with emphasis on short-term results	Focus on disease prevention	A long-term focus on creating and maintaining health and well-being
Death as defeat	Death as an acceptable outcome	Death as a step in a process
A profit-driven system	Compassion-driven care	Healing as the focus
Intolerance of other modalities	Open-mindedness toward other modalities	Embrace of multiple healing modalities

Table 1. Tenets of Technocratic, Humanistic, and Holistic Medicine (Davis-Floyd & St. John, 1998)

The tenets that comprise biomedicine and holistic medicine point to an assumption of this study – that there are major differences between these two healing systems. While the humanistic paradigm is an important model to consider, the scope of this study is limited to the two most obvious and opposing systems. I do acknowledge that a number of the humanistic tenets are practiced by both biomedical and non-biomedical practitioners, but humanistic models are rarely practiced in isolation. Largely due to what is accessible, the focus on this study rests exclusively on the comparison between biomedicine and holism. Furthermore, the tenets provided by Davis-Floyd & St. John serve as an outline to illustrate the philosophical differences across each healing system, and depict the paradigmatic tensions Coulter (2004) and others have identified. While their outline provides an excellent map, it is important to acknowledge that an entire body of literature exists exploring the various aspects of the tenets described above. A full review of these references would be another work in and of itself, and for this reason I am relying on the work of Davis-Floyd & St. John (1998) to highlight this extremely broad topic. Because the ultimate goal of this study is to explore the effects and processes related to integration from the perspective of the alternative practitioner, the intention to reference the tenets is only to show that there are distinctions between the two healing systems. Since the focus is on the alternative practitioner, the discussion now shifts to the description of how holistic medicine relates to CAM.

Holism Today

Complementary and Alternative Medicine (CAM), has been steadily growing in popularity (Eisenberg et al. 1993; Eisenberg, Davis, Ettner, Appel, Wilkey, Van Rompay et al.(1998); Kessler et al. 2001). We know from Chapter One, that there are a number of factors that explain the increase in CAM use. One important finding from this research reveals that the increased use CAM is in part due to dissatisfaction with the biomedical model and using CAM has been a way to address the shortcomings of that model.

The extensive evidence that CAM continues to grow in popularity suggests it is more than a trend. Some argue as to whether or not the groups of individuals using the term “holistic” can be considered a social movement since no consistent group of therapies exists and that the ideas espoused by one holistic group may deviate significantly from another holistic group (Vanderpool, 1984). It is important to address the relationship between CAM and holistic medicine. Holistic medicine reflects a healing philosophy that attends to the unity of mind, body and spirit. Put another way, holism is ultimately a paradigm or an orientation, and is not about individual therapies (Fulder, 2005). While there are many distinct CAM modalities, most tend to reflect a more holistic, rather than a biomedical orientation toward healing. Although there are many different ways to define holism (Jonas and Levin, 1999; Alster, 1989; Davis-Floyd & St. John, 1989; Berliner and Salmon, 1980; Guttmacher, 1979), I find Gordon’s definition provides the best synthesis. He says,

...holistic medicine has come to denote both an approach to the whole person in his or her total environment and a variety of healing and health promoting practices. This approach, which encompasses and is at times indistinguishable from humanistic, behavioral, and integral medicine, includes an appreciation of patients as mental and

emotional, social and spiritual, as well as physical beings. It respects their capacity for healing themselves and regards them as active partners in, rather than passive recipients of health care (Gordon, 1980: 3).

Although there is a wide range of practices and modalities that fall outside the realm of biomedicine, the underlying healing assumptions or philosophies represent a point of convergence. The term holistic medicine refers to a wide range of practices and therapeutics that share a common set of beliefs, behaviors and principles. In short, holistic medicine represents a collection of modalities centered round the notion of treating the whole person. To further complicate matters, the folding of holistic medicine into biomedicine has added another term to field, integrative medicine. Integrative medicine, as defined by National Center for Complementary and Alternative Medicine (NCCAM), combines mainstream medical therapies and CAM therapies for which there is some high-quality scientific evidence of safety and effectiveness¹.

For the purposes of this study, it is useful to look to the definition the National Center for Complementary and Alternative Medicine (NCCAM), a branch of the National Institute of Health (NIH), provides since most biomedical centers have embraced their classification. The NCCAM defines CAM as “a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine²”. The NCCAM acknowledges the diversity of practices and conceptualizes the various approaches to fall into five categories. These include: alternative medical systems, mind-body interventions, biologically based therapies, manipulative and body-based methods, and energy therapies. The creation of five categories represents a new way of thinking about the variety of holistic practices.

¹ <http://nccam.nih.gov/health/whatisacam/>

² <http://nccam.nih.gov/health/whatisacam/>

Because there are so many holistic modalities, it makes sense to label and condense them along some typology. Complementary medicine refers to practices that are used in conjunction with biomedicine while alternative medicine represents practices or modalities that are used instead of biomedicine. NCCAM's definition of CAM indeed views CAM through the biomedical lens with its emphasis on efficacy, clinical trials, and scientific rigor. These types of practices are called other names including, heterodox, unconventional, non-conventional, irregular, or unproven.

Typology	Definition
1. Alternative Medical Systems	Complete and separate systems of theory and practice. Examples include Traditional Chinese Medicine and Ayurvedic Medicine.
2. Mind-Body Interventions	Employs techniques to use the mind's ability to affect symptoms in the body. Examples include prayer, meditation, art, music and dance therapy.
3. Biologically Based Therapies	Use remedies found in nature, and include vitamins, herbs, and dietary supplements.
4. Manipulative Based Therapies	Treatment is based on manipulating the body. Examples include Cranio-Sacral, massage, and chiropractic.
5. Energy Therapies	These treatments incorporate the use of energy fields and are categorized as either Biofield therapies or as Bioelectromagnetic-based therapies. Biofield therapies represent those modalities that seek to affect the energy fields surrounding the human body and include practices like Qigong and Reiki. Bioelectromagnetic-based therapies include the use of electromagnetic fields

Table 2. Five Domains of CAM as Defined by NCCAM

As the table depicts, CAM could be seen an umbrella term that represents a wide variety of practices and modalities. It has been said that CAM is a residual category, meaning that it is defined by its exclusion from other categories of medicine (Wolpe, 2002). So, various modalities are assembled into one group mainly because they have been traditionally located outside the biomedical model. CAM practices have different histories, meanings and definitions, but at the core, share a set of philosophical assumptions regarding healing. Despite the commonality, it is rather difficult to provide one definition that is suitable for the variety of practices that fall under the domain of holistic medicine. The NCCAM typology therefore represents a good means to do so.

In general, most definitions of holistic medicine refer to health as a state of positive functioning and state of well-being (Goldstein, 2000; Goldstein, Jaffe, Sutherland & Wilson, 1987; Gordon, 1980; Guttmacher, 1979). This positive health orientation has two components: health as a value in and of itself and health as a praxis (Berliner and Salmon, 1980: 142). Health being as praxis as the authors assert, means that individuals are active participants in their health and well-being. This is remarkably different from biomedicine which sees health as the absence of disease and relies heavily on observations related to changes in physical and physiological functioning. While the biomedical model generally does not deviate from such functions, definitions of CAM typically include psychological or spiritual components. Furthermore, many of the definitions of holistic medicine include a spiritual component. The connection to spirituality signals the infusion of religiosity or metaphysics into healing, which is quite a contrast to biomedicine as it is largely understood by scientific and mechanical terms.

Despite the differences between biomedicine and holism as show in Table 1, there is now a movement underway known as integrative medicine, which attempts to merge these two systems into one. Although the central tenets or features for both healing systems have been adequately addressed, the question is not necessarily about clashing of cultures, but “what is made of these differences” (Kleppesto, 2005: 131). Specifically, in this study, we are interested in what is made of these differences from the perspective of the alternative practitioner. The next section will explore how these two systems can be thought of as occupational cultures and will also detail the characteristics of organizations or cultures that have merged successfully.

Occupational Cultures

What should be clear from the preceding section is that biomedicine and holistic medicine engage in different behaviors, rituals, beliefs and practices that are quite distinct from one another. While the tenets comprising each system are remarkably different, the occupational culture surrounding each system demonstrates differences as well. For the purposes of this study it is useful to think of each system as belonging to a unique culture. Framing each system in such a way enables us to later explore the literature on the best practices for cultural mergers and acquisitions.

The term culture has a variety of definitions across disciplines, but Trice (1993) argues that occupations themselves should be viewed as cultures. Occupations “are potent and shared belief systems held together by common emotional demands, or ideologies, and by common myths, sagas, stories, symbols, songs, argot, rituals and taboos, and unique rites and ceremonies, referred to as cultural forms” (p. 213). Based on

this definition, cultures are groups that are shaped by certain behaviors, and these behaviors Trice insists is what shapes group identity. A number of these behaviors and properties that enhance group identity are outlined by Trice and will be discussed in relation to this study to showcase the occupational cultures of both biomedicine and CAM. First, Trice proposes that identity is enhanced when members of a group feel they “*possess esoteric knowledge, skills, and abilities*” (p. 26). In this study, biomedical practitioners learn to possess expert knowledge in their field through an extensive period of socialization. Intense periods of socialization promote the idea that such knowledge is not easily acquired, meaning that only a special person is able to learn in such a manner (p.26).

Generally speaking, biomedical practitioners go through a rigorous academic program followed by several years of residency. This process sets them apart from others since the knowledge they eventually possess is not easily available to everyone. In contrast, there are a number of paths one can take to become a CAM practitioner. Depending on the modality, some CAM practitioners, like acupuncturists, massage therapists and chiropractors, attend institutions that are outside mainstream colleges and universities. The barriers or limitations placed on those who may enter these institutions are similar to the processes one goes through to be admitted to medical school. For these reasons, knowledge acquired through these institutions is also seen as esoteric or special since one must have the geographic proximity or the financial means to do so. Other routes to becoming a CAM practitioner exist and some practitioners are either apprenticed or self-taught. These methods are without a formal socialization process. Because these routes may be perceived as being ubiquitous, the knowledge these

practitioners come to possess may not be seen as special or unique since anyone who desires to do self-study could essentially become a CAM practitioner. However, given the credentialing movement in CAM, there is the tendency for most CAM practitioners to have met a certain set of standards prior to being able to practice their craft.

Another component defining occupational culture relates to the “*extreme or unusual demands*” under which a given occupation performs. This component has to do with the daily rhythm of an occupation, but it also points to the *emotional demands* placed on workers within a specific occupation (Trice, 1993: 29). In their discussion on the tenets biomedicine, Davis-Floyd & St. John (1998) point out that doctors are taught early on in medical school how to manage their emotions when dealing with patients. This act of emotionally distancing or disengaging is quite different from the manner in which CAM practitioners relate to their clients. CAM practitioners establish intimacy through physical contact, engage in collaborative discussions with their clients about health and wellness and sometimes may even share personal anecdotes about previous or existing health struggles.

Consciousness of kind represents the third component Trice describes for the creation of identity within occupational cultures. Consciousness of kind refers to “members” definitions of who is an insider or outsider, [and these definitions] delineate the boundaries of occupational communities” (p. 33). This means that occupational cultures tend to look differently depending on whether or not a person is identified as an insider or outsider. Put another way, “insiders know their culture immediately because they live within it, behaving in accordance with its beliefs and enacting the cultural forms associated with those beliefs” (p. 53). Outsiders, on the other hand, do not understand

occupational cultures since they are not engaged in the same processes as insiders. As a result, outsiders fail to understand the nuances of the mechanisms used to express or affirm ideologies, according to Trice. Cultural forms point to the myths, stories, symbols, language, rituals, taboos and rites used by various occupations to confer ideology (p.20). Occupations focus on rationalized myths, or the “elaborate rules and procedures [which] add to the accumulation of what an occupation or organization considers ‘proper, adequate, rational and necessary’ to incorporate into its structure in order ‘to avoid legitimacy’” (p. 83). Biomedicine is indeed a professional occupation since it relies on a *tested body of knowledge*, which uses evidence-based research to define its practices (p. 85). Since its inception, the American Medical Association (AMA) has created boundaries enabling physicians to identify insiders and outsiders. Professional organizations, such as the AMA, also function to limit who can practice within the field of medicine, or what Trice calls *occupational jurisdiction*. Professionalism is also exemplified by the ability of certain occupations to create relationships with institutes of higher education, which again reinforces the notion that the field possesses a specific body of knowledge (p. 86). Medicine has successfully been associated with colleges and universities since the early 1900s, and also enjoys a symbiotic relationship with the pharmaceutical industry.

Holistic medicine on the other hand, does not draw from one specific or distinct body of knowledge but instead represents multiple kinds of knowledge. These bodies of knowledge have only been explored scientifically in the last decade, so in this regard holistic medicine does not represent a tested body of knowledge despite the fact that some of these practices have been used for centuries. Compounding this, is the fact that

there is great variation in terms of the practices that are categorized as holistic, meaning that it is extremely difficult to identify a singular or common body of knowledge. In addition, holistic practitioners acquire their skills through several paths including apprenticeships, institutions outside colleges and universities, and also through folk channels. Baer (2001) explains that some holistic practitioners have been successful in efforts to professionalize, but professional efforts for other holistic modalities are just now gaining momentum. Holistic medicine does not therefore have the same degree of occupational jurisdiction as biomedicine since holistic medicine does employ the same kinds of practices restricting entry into the field

Both biomedicine and holism demonstrate differences in *cultural forms*, or the symbols, language, rituals, taboos and rites used that confirm occupational ideology. Uniforms are sometimes viewed as *symbols* in order for some occupational cultures use to set themselves apart from others. A uniform “is an ensemble of clothes that communicates instantly to most viewers of the tasks, ideologies, and mandates possessed by the person wearing them” (p. 97). Traditionally, doctors wear white coats and it has even been suggested that “whiteness of nurses’ uniforms stands for their work, performed under very clean and hygienic conditions” (p. 98). These same principles could also extend to doctors’ uniforms as well. In addition, instruments, such as stethoscopes and otoscopes, are also components of doctor’s uniform and some tools, such as digital thermometers, MRI and x-ray machines, emphasize biomedicine’s reliance on technology. Titles represent another type of symbol and are sometimes an extension of one’s occupational uniform (p. 99). Physicians are typically referred to as ‘doctor’ and they frequently place their credentials on their business cards and script pads. “Language

serves to maintain specific boundaries of an occupation” and the *language* doctors speak reflects their anatomical, chemical, and biological training (p. 101). Biomedical jargon is learned through an extensive socialization process which includes many years of schooling and residency. This language sets doctors apart from others, including their patients, who do not speak this same language. Additionally, doctors follow certain *rituals* like hand washing or donning gloves prior to seeing a patient, which again reinforces the hygienic principles of biomedicine. Finally, doctors engage in *rites of passage*, such as the medical residency, where young physicians are inducted into their profession after enduring long shifts for at least three years. Physicians engage in *rites of integration*, such as meetings of occupational associations, “which encourage and revive the common feelings that bind members of an occupation together and express commitment to a social system” (p. 110). Physicians also exchange and interface with pharmaceutical representatives which also serve this same purpose. Overall, it can be said the culture of biomedicine is seen as cohesive given the abundance of cultural forms that surround doctors on a daily basis, while holistic medicine is viewed as having less cohesive culture since it possesses few cultural forms that exclusively belong to them (p.39).

Holistic practitioners, in contrast, do not have a common uniform. In fact, CAM practitioners lack a specific uniform, which may support the notion that CAM practitioners do not demonstrate a cohesive identity. To compensate for the lack of uniform, Trice suggests that “members of occupations without explicit uniforms often dress in ways that approximate a uniform” (p. 98). There is scanty any literature that explores the symbols of CAM practitioners, but there is probably a wide degree of

variation in uniforms given the various types of modalities. It could be that CAM practitioners' attire is indeed more relaxed and less formal than their biomedical counterparts. Many CAM modalities require practitioners to engage in a large muscular activity or body manipulation, so it would make sense that practitioners would wear clothing conducive for these activities. In addition, there is also a wide degree of variation around the *titles* employed by CAM practitioners. For example, chiropractors, naturopaths and acupuncturists, are called doctors, but other practitioners are identified as educators or therapists. The variation in title is attributed to the fact that there are many routes for one to follow to become a CAM practitioner. There is also a great degree of variation around the types of *languages* used by CAM practitioners based on the modality. Acupuncturists, ayurvedic physicians and massage therapists all use different vocabularies that reflect the kind of work that they perform. Acupuncturists will rely on Chinese ideas or terminology, such as chi, when diagnosing their patients. Massage therapists may talk in anatomical terms, while Reiki practitioners may talk about energy. The point is that across all CAM modalities, a number of different languages are being spoken and each modality has its own set of symbols, rites, rituals and taboos. More studies are needed to understand the nuances across CAM modalities. Overall, it can be concluded however that holistic medicine is probably much less cohesive than biomedicine.

The remaining concepts pertaining to the formation of occupational cultures deal with social aspects and relationships with others. Trice proposes that occupational identities extend to other aspects of a people's lives and often influence their non-work activities. He suggests that occupational members find support and validation from other

members because they serve as a primary reference group. Since occupational members share common values, colleagues are truly the only ones capable of understanding problems and also the only ones qualified to evaluate performance (p. 38). Put another way, occupational members are poised to empathize with fellow workers since their experience and knowledge overlap. Medical residents are thrown into this process in medical school since they bond with fellow residents throughout their education and residency. A primary reference group naturally ensues for medical students since they spend many hours working together both inside and outside class. The medical school curriculum is devised in a way that facilitates the development of a primary reference group from within. Because medical education is a tedious endeavor, there is little time to find relationships outside of the profession. In fact, “the extent to which occupational roles restrict opportunities for making friends,” along with the status of an occupation, often determines how much “occupationally based activities affect members’ non-work lives” (p. 34). The relationships formed in medical school often continue through residency where students frequently call upon fellow residents for guidance but residents may also find support from teachers or mentors. When young doctors transition from student to colleague after residency, doctors learn to collaborate with other doctors and specialists regarding their patients’ conditions.

While there is much less written about the socialization process for CAM practitioners, the formation of reference groups also applies to CAM practitioners as well. CAM practitioners interact and troubleshoot with others who are in proximity and who share similar values and practices. Because CAM practitioners are more tolerant towards other modalities (Davis-Floyd & St. John, 1998), they are probably more likely than

physicians to enlist support from members outside their primary reference group.

Because occupational membership shapes non-work activities, it seems reasonable to suggest that occupational identity affects other behaviors as well. For example, a CAM practitioner and a physician would most likely treat their child suffering from a common cold using specific knowledge from their culture. A physician might bring a remedy home from the pharmacy or drug store to reduce a fever. A TCM doctor, on the other hand, might prepare herbal tea, brew vinegar in the home to diffuse the air, or rub a spoon on the base of their child's neck to reduce fever. While the intentions of both parents are to alleviate symptoms, the chosen activities relate to one's membership to a specific culture.

In addition to the group dimensions that define occupational cultures, Trice states that occupational cultures are comprised of structural features, known as the grid dimension. The grid dimension "consists of tangible structures through which members of an occupation attempt to order their relations with one another" and includes elements such as "hierarchal authority, formal rules, impersonal relations, differential rewards, and divisions of labor within the occupation" (Trice, 1993: 42). By using a combination of group and grid elements, we can see further distinctions between CAM and biomedicine.

Strong Group/Weak Grid	Strong Group/Strong Grid
Generate own structure to administer the organization	High sense of community
Weak grid elements	Prominent structural features
Strong group elements	Ranking system inside and outside occupations
Examples: Police departments and social welfare agencies	Accommodate definitions and practices in order to adapt to managerial subcultures
	Examples: corporate physicians
Weak Group/Strong Grid	Weak Group/Weak Grid
Have ideologies similar to management hierarchy	Reject both occupational expertise and administrative hierarchy
Occupation becomes assimilated over time and takes on management's ideologies	Prefer democratic consensus
Characterized by low cohesiveness and insider/outsider boundaries	Create new organization so that everyone has a voice in determining how work is organized and relationships structured
Examples: engineers, accountants, and social welfare agencies	Examples: producer co-operatives, alternative schools, and feminist health collectives

Table 3. Four Types of Occupational Subcultures (Trice, 1993)

Based on the points included in the table above, biomedicine seems to have strong group and strong grid components. Biomedicine practitioners enjoy a sense of community based on their professional associations, such as the AMA, and demonstrate high cohesiveness based on the abundance of cultural forms. Within the field of biomedicine, there is a clear division of labor within the profession, setting doctors apart from physician assistants, nurses, receptionists, etc. Conversely, CAM practitioners seem to have weak group and grid characteristics. Because many CAM practitioners work independently in their own clinics, by default there is a tendency to reject administrative authority since there is no such structure in place. When working with other CAM practitioners, the structure is most likely organized in such a way that all parties involved

have a voice in daily operations, given the collaborative relationships they engage in with their clients. In addition, CAM as an occupational culture does not have a strong group dimension give lack of cultural forms.

The above discussion demonstrates that CAM and biomedicine represent two very distinct occupational cultures. We also know from Davis-Floyd & St. John's characterization of the tenets comprising biomedicine and CAM that both systems employ different ideologies or frameworks for approaching health and wellness. Both CAM and biomedicine call upon different bodies of knowledge. They also engage in different rites of passage, speak different languages, wear different uniforms and have different emotional demands. The occupational cultures demonstrate differences both in group and grid characteristics. When two different cultures interact, it is typically expected that cultures will clash as a result of such differences. Specifically, it has been stated that cultural differences will produce feelings of ethnocentrism where "members...see themselves in terms of their occupational norms and beliefs...[Furthermore, it is believed that] ethnocentrism can make it difficult for groups of workers to understand and cooperate with one another" (p. 40). With that said, it is expected that the cultures of CAM and biomedicine will clash somewhat upon integration. In this study, two separate occupational cultures merge together in a new field called, Integrative medicine. Essentially, integration of two such systems is an experiment in creating a new culture and this study explores the effects of such a merger from the perspective of the CAM practitioner. While ethnocentric clashes based on

differences in occupational cultures will most likely ensue; this study is interested in the processes and behaviors that affect the practice of CAM modalities as a result of the formation of a new culture through integration.

Trice identifies three processes, chronic clashes, accommodation and assimilation, for which cultures adapt to one another. Biomedicine's relationship with CAM has largely been seen as a co-opting maneuver (Baer, 2001), so it would be easy to assume that the merger of these two cultures would be that of assimilation. We know that at least four models of CAM-biomedical integration – the market model, the regulated model, the assimilated model and the patient-centered model - are possible (Leckridge, 2004: 414). The market model is characterized by little state involvement and resembles a boutique model where patients may select some CAM practices and biomedical practices. The regulated model is similar to the market model in that patients determine what services are utilized, yet some safeguards are in place to regulate products and practices. The assimilated model also resembles the regulated model, but CAM products and services become an extension of biomedical services. According to Leckridge this model signals a shift from patient to physician choice of treatment, which undermines the CAM tenet of patient control and empowerment. The patient-centered model emphasizes patient control and empowerment and it emphasizes collaboration and teamwork. This model also represents a new paradigm for medicine since some of the characteristics of biomedicine are replaced or enhanced by some of the tenets central to CAM. Yet in this study, what model most closely resembles integration? I believe the tone or intention for integration is established by the manner in which an organization defines integrative

medicine. While researchers look for discrepancies between what people say and do, it is possible that the data might reveal a disconnect between the actual definition and practice of integrative medicine in this study.

Integrative Medicine

Integrative medicine represents a somewhat recent movement to blend CAM practices with biomedicine dating from the early 1990s to present (Winnick, 2005). In fact, using content analysis Winnick identifies three additional phases, condemnation, reassessment, and integration, to describe the relationship CAM has had with biomedicine. The condemnation phases, points to a period in the 1960s and 1970s where CAM modalities were often scrutinized and ridiculed in prestigious medical journals. A critical shift in thinking regarding CAM use occurred in the mid-1970s through early 1990s during the reassessment phase, which prompted biomedicine to consider whether or not there were issues within their profession that might have caused patients to seek other forms of health care. During the integration phase, biomedicine is currently seeking to control CAM modalities by using arguments about its efficacy.

The purpose of integrative medicine, according to the NCCAM website, is to “combine treatments from conventional medicine and CAM for which there is some high-quality evidence of safety and effectiveness.” There is a distinction between ‘integrative’ and ‘integrated’ medicine where integrative medicine refers to the synthesis of a new health paradigm incorporating both CAM and biomedical aspects, while integrated medicine refers to the process of adding CAM practices into biomedicine with physicians in charge (Hollenberg, 2006: 733). In this study, integrative medicine is

understood as incorporating the art and science of caring for the whole person -- body, mind and spirit – and treating and preventing disease, and to encourage patients to achieve a condition of optimal health. Integrative medicine is designed to combine traditional western medicine with complementary therapies for which there is high-quality scientific evidence of safety and effectiveness (Field document). This definition seems to be consistent with NCCAM's definition while it also suggests a more egalitarian merger of CAM and biomedical practices. Since biomedicine has been written about extensively in the literature, the experiences of CAM practitioners are highlighted exclusively in this study.

Best Practices for Mergers & Acquisitions

While merging CAM and biomedicine is a relatively new process, mergers and acquisitions have been written about extensively in business literature. Mergers are typically depicted as economic maneuvers for sustaining long-term growth, so there is a great deal of literature on the characteristics of successful mergers. There is a growing body of literature exploring mergers from cross-cultural perspectives, which we will explore given that CAM and biomedicine represent two different occupational cultures.

There are a number of reasons to explain why mergers often fail. The lack of effective communication about integration processes (Beckett-Hughes, 2005; Brahy, 2006; Papadakis, 2005) is often cited as one of the many reasons why mergers fail. Failures often occur as a result of organizations having no clear strategy in place for integration (Ryan, 2000). Because some organizations are inexperienced with the process of mergers, integration efforts are sometimes impulsive and organizations do not

achieve their desired goals as a result (Dolbeck, 2004). The lack of leadership (Beckett-Hughes, 2005; Ryan, 2000) and the loss of key talent (Beckett-Hughes, 2005; Papadakis, 2005) have also been associated with the failures of mergers. But the most common reason cited for explaining failures has to do with ignoring the importance of cultural differences when integrating (Beckett-Hughes, 2005; Brahy, 2006; Schein, 1996; Weber & Camerer, 2003). Moreover, Steffen (2001) points out that cultural due diligence has not been a standard component of integration efforts and Mitleton-Kelly (2006) adds that being attentive to the emergent culture in post-merger relationships mergers succeed.

Within the culture literature pertaining to mergers, a great deal has been written about the best practices for merging two organization or corporate cultures. Since CAM and biomedicine has been described as comprising two separate occupational cultures, the discussion will now focus on the characteristics employed for a successful merger between two cultures. Exploring the successful practices of cultural mergers helps to establish a skeletal framework for examining the processes of integration from the perspective of alternative practitioners. Overall, the best practices in cultural mergers generally emphasize: culture, leadership, human resources, and education.

Since merger failure has been in part associated with neglecting cultural issues, the literature highly recommends being attentive to cultural differences. Organizations have routinely engaged in strategic and financial due diligence when contemplating a merger, but cultural issues have only recently been explored. It has been noted that “culture clash...may de-motivate organizational members from learning about each other” (Greenberg, Lane & Bahde, 2005: 72). By attending to cultural differences, organizations can avoid the pitfalls associated with integrating. Attending to cultural

differences is commonly referred to as *cultural due diligence* (Brahy, 2006; Steffen, 2001) but others have recommended specific practices, such as taking cultural inventories to assess cultural fit (Hansen, 1995; Harper, 2002; Evans-Pucik, 2005; Wolf, 2003). Additional components of cultural due diligence may include looking at organizational structure, goals, management practices, technology needs, communication patterns, and turnover patterns (Brahy, 2006; Steffen 2001). It is believed that doing cultural due diligence “will help avoid costly cultural assumptions about the other organization and guarantee the impact of critical communication messages before and during integration” (Brahey, 2006). It is recommended that organizations *start early* not only to understand the culture of the other organization, but to also contemplate how that culture will react and fit into an existing culture (Brahy, 2006). Understanding one’s own cultural belief system by either doing cognitive or psychological mapping is another practice used to assess cultural fit (Hansen, 1995). It is believed that these practices will not only increase awareness of one’s own cultural system, but it also “increases an individual’s awareness of their not so visible belief systems and occupational biases” (Hansen, 1995: 64).

Engaging in cultural due diligence helps organizations assess the fit between the two cultures integrating. Specifically, cultural awareness can help “reduce unexpected post merger problems, help map out potential areas of conflict, and help avoid misunderstanding and confusion” (Bjorkman, Tienari & Vaara, 2005: 167). These authors also caution that placing too much emphasis on cultural distinctions could be counterproductive since highlighting differences might create barriers to integration. To avoid this pitfall it is recommended that organizations focus on developing the new culture.

Managing cultural differences is also associated with doing cultural due diligence (Beckett-Hughes, 2005; Brahy, 2006; Fiala, 2006; Wolf, 2003). Managing cultural differences refers to the process of nurturing the emerging culture, and one common strategy to achieve this is by making sure there are ample *opportunities for socialization*. It has also been recommended to attend to *informal integration* as well by creating ample opportunities for socialization (Beckett-Hughes, 2005; Fiala, 2006; Larsson & Lubatkin, 2001). While formal means such as cultural training are important, informal means, such as role-playing or team-building activities, are also advised (Fiala, 2006). Moreover, when Larsson & Lubatkin (2001) performed a meta-analysis in order to determine the best practices associated with acculturation, they found that socialization was the most important factor to consider.

Our results suggest that almost only one thing matters: involve the affected employees in such socialization activities as introduction programs, training, cross visits, joining retreats, celebrations and other such socialization rituals and they are likely to create a joint organizational culture on their own volition...(Larsson & Lubatkin, 2001: 1594).

It is equally relevant to note that developing culture takes time and needs to be thought of as a *long-term strategic goal* as opposed to a one time event (Brahy, 2006). Another strategy for attending to cultural differences is to create cultural awareness programs to facilitate an understanding of how cultural differences influence day to day operations (Brahy, 2006; Fiala, 2006). Beckett-Hughes (2005) recommends hiring an independent consultant to determine what cultural issues may be present before deciding on how to manage a new culture. Another strategy involves clarifying and *articulating*

what the new culture should look like before the two cultures actually merge (Krell, 2001). This sets the expectation and the parameters for the new culture so people clearly know what to expect.

Other research exploring what happens when similar cultures merge into one reveals that a resultant culture is likely to coalesce when opportunities to develop shared experiences are provided (Buono, Bowditch & Lewis; 1985). Meshing cultures takes time however, and such efforts can be hindered by various barriers. Language is one such barrier and differences in language can “create misunderstandings, confusion, and frustrations that can hinder learning and the development of a social community that supports learning (Schoenberg, 2001 as cited in Greenberg, Lane, & Bahde, 2005: 65). One strategy recommended to overcome this obstacle is simply to learn another language. In international mergers, Brahy (2006) recommends learning another language because it conveys a powerful token of respect but says that people need to go beyond learning about vocabulary and grammar to grasp other kinds of cultural knowledge.

Human resources departments can also facilitate integration efforts. Retaining key talent is another practice human resource departments can do to maintain morale and to avoid bad integration (Brahy, 2006). Organizations should focus on retaining and motivating key staff in addition to taking an internal talent inventory (Evans & Pucik, 2005). It is also recommended that a person (Becket-Hughes, 2005) or team is appointed to oversee integration efforts (Wolf, 2003). Cultural integration is a huge task, so it is important to have someone devoted to monitoring the integration effort. Wolf (2003)

goes a step further and recommends putting in place measures to determine the status of integration efforts. Again, this reflects the idea that *integration is an ongoing process* requiring adequate time, planning and evaluation.

Leadership also plays an essential role in integration. Long before a merger occurs, a great deal of planning should be done to examine the cultural, strategic, and financial aspects of a merger. Getting involved *early in the process* is highly recommended in order to have adequate time to assess cultural differences (Brahya, 2006). While anticipating cultural differences is indeed part of planning, organizations however need to develop concrete plans to attend not only to the physical aspects of a merger, but to the cultural aspects as well. Put another way, organizations need to *clarify and transmit the mission and vision* for the new organization (Breckett-Hughes, 2005; Krell, 2001; Mitleton-Kelly, 2006). Developing a shared vision with those involved in the merger has been found to be a significant learning experience (Bjorkman, Tienari & Vaara, 2005: 164). It is possible that this type of activity might signify how members of an organization interact or learn collectively. Developing a plan or roadmap is clearly essential in mergers. It is important to keep in mind however that the new *organizational structure should be somewhat emergent*, since “organizations cannot be designed in detail in advance” (Mitleton-Kelly, 2006: 36). An emergent design allows organizations to evolve naturally and to be adaptive and responsive to find new ways of working together (Mitleton-Kelly, 2006). One step in this process is to outline the structure and culture of the newly merged organization. Moreover, Beckett-Hughes (2005) says that organizations can follow one of three approaches: keeping distinctive cultures, adopting the culture of one of the organizations, or creating a new culture with elements from both.

While strategic planning is one aspect of effective leadership in mergers, *communication* is key to making cultural mergers work. In fact, one meta-analysis attempting to determine the best practices for successful mergers found that internal communication was the most influential factor for successful implementation of mergers and acquisitions (Papadakis, 2005). It has also been advised that communication should be *clear* in order to eliminate uncertainties or misunderstandings during a merger (Beckett-Hughes, 2005). Leaders also need to communicate *early, frequently and honestly* regarding the organization's new structure (Fiala, 2006). Open-minded leadership is the preferred leadership style in mergers (Krell, 2001; Schweiger, 2005; Wolf, 2003).

Mitleton-Kelly (2006) argues that successful mergers are realized through the process of *co-evolutionary integration*, or “the coming together of two or more separate companies to create a new organization, not through imposition, but through reciprocal influence...” (p. 39). Using complexity theory as a lens, Mitleton-Kelly states that an ideal merger would resemble the creation of a child, comprised of some characteristics from each organization, but would have an identity of its own. Distributing leadership and power facilitates this process since employees then actively work towards achieving a shared vision, and *leaders merely hold the space* for employees by permitting them to experiment with various ways to realize the strategic plan (p.39). Mitleton-Kelly suggests that other behaviors such as *effective communication*, allowing time for *reflection* and creating a *supportive environment* should also be adopted during a merger (p. 46).

Educational efforts can also promote successful mergers. We know from the discussion on the best practices for merging two cultures that some organizations offer cultural awareness trainings by developing programs that highlight elements from both cultures. Specifically, organizations attempt to educate employees about their own cultural orientation in addition to providing knowledge about the culture of the newly acquired entity. By recognizing that integration requires a comprehensive and *ongoing strategy*, organizations need to think about creating opportunities for *continuous learning and improvement* (Hansen, 1995). Some organizations find themselves incapable of learning, or what Schein (1996) refers to as *learning disabilities*, which means that new ideas fail to become entrenched in an organization due to a reliance on routines. To avoid this caveat, organizations in the midst of integrating need to place an emphasis on organizational learning.

Educational efforts are often described in the literature in one of two ways: either as the lessons learned from previous experience with mergers or how outcomes are affected through knowledge transfer (Greenberg, Lane & Bahde, 2005). Greenberg and colleagues take the idea of continuous learning a step further by stating that learning must also occur throughout the pre-combination, combination and post-combination phases of a merger. Specifically, they assert that bonds and/or barriers are created through language, space, organizational structure and motivation, and that managers must constantly evaluate how these in turn affect organization learning. They argue that by “increasing information flow and learning throughout the acquisition process, managers increase the likelihood of creating a new integrated organization that will support knowledge transfer and achieve its value creation proposition” (Greenberg, Lane &

Bahde, 2005: 73). The authors also propose that knowledge flow is facilitated by *developing social community* within a culture of *trust*. Furthermore, Wolf (2003) recommends adding both short and long-term continuous improvement models to the integration process. Short-term models assess whether or not integration expectations are being met, and long-term assessments allow an organization to develop integration practices for subsequent use. Willingness to adopt these models might reveal the degree to which organizational learning occurs. While educational efforts in mergers and acquisitions have largely been related to the processes around integrating, engaging in learning through all phases of a merger promotes the idea that learning is valued, and this in turn, could establish a culture of learning.

In the CAM specific literature pertaining to integration, a number of recommendations have been made for merging CAM services into biomedicine. Ananth (2003) provides a summary of recommendations exploring the best strategies utilized for integrating CAM into biomedical clinics around the country. These recommendations suggest that organizations should first focus on *building support* and should refrain from making large financial investments initially. Ananth (2003) also recommends finding unusual ways to fold CAM practices into existing services and suggests that a *continuum of services* should be offered in order to foster patient buy-in. That author states that CAM should also be *integrated into an existing core program* to ensure stability and organizations should *seek early support from physicians* since they are prone to resist integration. Lastly, Ananth (2003) supports *credentialing CAM providers* and recommends that clinics *analyze data* on CAM use and efficacy to guide integration efforts in their own communities.

Cohen (2004) provides a few additional strategies for integration related to *collaboration* between biomedical and CAM practitioners. He argues that collaboration will be enhanced if doctors continue being educated on CAM, and equally adds that CAM practitioners need to *increase their knowledge of biomedicine*. Collaboration, he points out, is contingent upon creating an *environment of shared respect and trust*, and it is believed this can be achieved by allowing time for relationships to develop.

Some of these strategies reflect the best practices for integrating around culture, human resource, leadership, and educational strategies as identified in the business literature. Cohen's (2004) recommendations demonstrate some attendance to cultural issues, since he argues for continued education for both CAM and biomedical practitioners. What is missing from this recommendation is the opportunity to discuss or process how these specific cultural differences may impede integration. The problem with this strategy is that it is expected that learning about another culture will simply resolve any cultural integration problems, but absent is a targeted strategy to accomplish this goal. With Cohen's education strategy, CAM and biomedicine interact solely within their occupational culture and miss opportunities for true integration.

Furthermore, there is little advice detailing how to create environments of respect and trust, and it may be useful for integrating organizations to create formal or informal opportunities, such as study groups, book clubs, or joint research, to initiate dialogue between the parties involved in the integration process. Most of the business recommendations provided by Ananth (2003) seem to reflect the financial or strategic due diligence practices adopted by most organizations acquiring another business. Ananth (2003) is correct to recommend that clinics and hospitals should get an early start

when integrating, but cultural due diligence is missing from these strategies. Additionally, it is unclear as to whether or not Cohen is suggesting a sustained educational commitment or a one-time effort. It is important to note that these educational efforts are largely modality specific, suggesting again that there is little opportunity for CAM and biomedical practitioners to exchange ideas. It might be useful for integrating organizations to explore how to best create professional learning communities in order to facilitate integration.

Finally, Russo (2000) provides the most comprehensive description for outlining the key factors associated with successful integrated medical services in the United Kingdom. Collectively, these factors represent a comprehensive model or strategy for integrating and attend to many of the shortcomings other the models proposed by Cohen (2004) and Ananth (2003). Many of these ideas overlap with the best practices identified in the business literature, but communication and teamwork comprise the core of this model.

	Successful characteristics of integrated services
1	Create a transition plan
2	Articulate a clear vision
3	Hire someone to coordinate the integration process
4	Rely on teamwork
5	Prepare and plan the detail and structure of services
6	Use clear and open communication
7	Foster a high level of cooperation between disciplines
8	Raise awareness for both patients and staff
9	Educate and train staff on how to work with specific groups of patients
10	Provide a location where complementary and orthodox practitioners could work together and share patient loads
11	Hire highly qualified complementary practitioners and/or orthodox providers who are train in complementary services
12	Receive top management support
13	Secure adequate funding
14	Develop feedback mechanisms from patients
15	Encourage providers to be flexible to change
16	Have patience for the integration process
17	Use an existing model for internal processes (scheduling, referrals, evaluations, etc.)
18	Create efficiency in appointment and referral systems
19	Use pilot projects to develop new services
20	Engage in evaluations and audits
21	Be committed to the process

Table 4. Successful Characteristics of Integrative Services (Russo, 2000)

Conclusion

CAM and biomedicine represent two distinct occupational cultures and each culture demonstrates differences in many areas. Practitioners of CAM and biomedicine have differences not only in knowledge and skill, but also in the emotional techniques utilized when working with clients. Differences also exist in terms of symbols, language, tools, dress, structure, rituals and rites of passage. As a result, it has been suggested that biomedicine has a more cohesive occupational cultural than CAM due to the preponderance of cultural forms. When different occupational cultures come together, ethnocentrism is likely to occur, which often causes two cultures to collide or clash. Even though it is expected that the cultures of CAM and biomedicine will clash when integrating, a number of strategies have been identified to reduce the effects of such a collision. These strategies serve as a starting place to consider the experiences of alternative practitioners involved in the integration of CAM and biomedicine. This study is not concerned with the success of any specific center, but rather the aim is to provide some understanding related to the mechanisms used for integrating from the experience of the alternative practitioner.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

Introduction

While there are many methods available for researchers today, the choice of design should not merely reflect the preference of the researcher, but should be decided by the types of knowledge a researcher hopes to acquire. Qualitative and quantitative studies both have their strengths and weaknesses, and the task for the researcher is to know when to use each method appropriately. An experienced researcher understands that there will be instances in which a qualitative design is needed to understand a phenomenon generally. The information gathered in a qualitative study can then inform a quantitative design in order to examine specific elements of a given phenomenon. Both methodologies have the ability to inform the other, and the decision to use either a qualitative or quantitative or to use a mixed methods design is largely shaped by the researcher's objectives.

In this study, a qualitative design was selected since I am interested in the *processes* and the *subjective* experiences of CAM practitioners working in an integrated environment. Survey research or other experimental designs are inappropriate to use since these methods tend to emphasize measurement of specific variables conducted

objectively. In contrast, qualitative research is generally an emergent process. Issues central to a study may “emerge, grow or die” meaning that questions, directions, and issues tend to shift when doing qualitative research (Stake, 1995:21). In this particular study, the choice to use qualitative methods was a natural progression from my initial exploration into the subject matter. Case study research is a process that evolves. “Case study researchers enter the scene expecting, even knowing, that certain events, problems, and relationships will be important, yet they discover that some of them this time will be of little consequence” (Stake, 2000). As Stake predicted, twists and turns emerged as I followed this case for roughly two years. When I initially conceived of this topic for study, the main goal was solely to understand the paradigmatic tensions between opposing healing systems. As the study progressed in tandem with the literature I read, I came to understand that the processes related to integration should also be explored.

While the choice to use a qualitative method was fairly evident given the fact that the study would focus on subjective rather than objective types of information, it was somewhat more of a challenge to determine what type of qualitative inquiry to use for this study. While there are numerous methods to use within qualitative research, the rationale for conducting a case study is explained below.

Purpose of Study

For many reasons identified in Chapter 1, patients have turned toward CAM to express their dissatisfaction with biomedicine. As a result, use of CAM modalities has grown steadily and biomedicine has reconsidered its previously standoffish position towards CAM. The in-depth description of the contrasting tenets of biomedicine and

holistic medicine (Davis-Floyd & St. John, 1998) highlights the fact that both systems approach healing quite differently. Although scholars have identified a paradigm clash of sorts between CAM and biomedicine, little research has been conducted to understand whether or not this proposed clash affects CAM practitioners working in an integrative environment. While such paradigmatic tensions provide an overarching theme to this research, this study has three main goals. First, this study attempts to understand how CAM therapies change as a result of being integrated with a different approach to healing (Coulter, 2004). Secondly, this study seeks to understand the processes related to integration from the perspective of the CAM practitioner. As described in Chapter 2, the *processes of integration* refer to practices related to culture, leadership, human resources and education as experienced by CAM practitioners working in an integrative environment. Lastly, this study will showcase CAM practitioners who have largely been marginalized in the academic literature. At times, the image of CAM has been depicted negatively by physicians in medical journals. By focusing on CAM providers this study hopes to alter this pattern by giving CAM practitioners an opportunity to highlight their experiences. With these goals in mind, it was determined that a case study would be the preferred method to explore the following questions.

Research Questions

“A case study, like research of all kinds, has conceptual structure. It is usually organized around a small number of research questions” (Stake, 2000: 440). The main

goal of this study is to understand the integration of CAM into biomedicine from the perspective of the holistic provider. Three main questions were raised to support this inquiry:

- 1) How do CAM practices change when aligned with a different healing orientation and context?
- 2) How might the experience of working in an integrated facility be described by CAM practitioners?
- 3) What do the processes of integration reveal about the relationship between CAM and biomedicine?

To gather information about the experience of CAM practitioners, it was necessary to become immersed in a setting actively integrating CAM and biomedicine. A new facility housing both biomedical and CAM providers was located and selected for study. The facility contained the structure to study individual practitioners who experienced various processes related to integration. CAM practitioners are the focal point of this study and interviews conducted with practitioners working in an integrated facility provided the majority of data for this investigation. Observations and documents were additional data sources and will be discussed shortly.

Rationale for Case Study Method

A case study was ultimately selected as the preferred method for researching these questions. “A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between the phenomenon and context are not clearly evident” (Yin, 2003b:13). Case studies are often described as explorations “of a ‘bounded system’ or case (or multiple cases) over time

through detailed, in-depth data collection involving multiple sources of information rich in context (Cresswell, 1988: 61). In Cresswell's interpretation, the boundaries of a system are shaped by time and space. While both definitions are pertinent to this study, the point Yin makes between phenomenon and context requires some attention. The experience of CAM practitioners and processes involved with working in an integrative environment are indeed blended and fused with its context. There is a fine line between the context for this case, the integrative environment which shapes and informs the experiences, and the phenomena, the experience and processes related to integration. Clearly, the integrative environment is both part of the context and the phenomena.

Case studies purposefully focus on context, unlike experimental designs which attempt to isolate or control both variables and context (Yin, 2003b: 13). In this study, the goal is to learn about the experience of CAM practitioners working in an integrated facility, and the context is something to be understood rather than controlled or manipulated. Case studies are often the preferred method for studying processes, which can be nebulous at times. Since processes related to integration are of interest, a case study method is appropriate. The case-study method is also suitable since the goal is to understand, rather than to generalize or predict outcomes, which happens to be the goal for most quantitative designs.

It is commonly known that two principal uses of the case study are to obtain descriptions and interpretations of others (Stake, 1995: 64). This investigation fulfills these criteria since I am interested in exploring the perceptions of CAM practitioners working in the *same* integrative environment over a period of two years. The rationale for focusing on a group of individuals in the same facility was determined for two

reasons. First, because integration of CAM and biomedicine is a relatively new phenomenon, there simply are only a few clinics in the area in which to study. The advantage of remaining in the same facility will hopefully provide some consistency given that the respondents are exposed to the same processes related to integration. Second, while other cases do exist in a number of cities in the US the purpose of this research is part exploratory and part theory building. While a cross-case analysis might be helpful to shed light on theoretical elements once this exploratory research has been presented.

Yin (2003a) identifies three types of case studies: exploratory, descriptive, and explanatory. Exploratory case studies are sometimes utilized to serve as a prelude or a pilot to a study. The goal of exploratory case studies is to obtain information for the purposes of generating research questions and hypotheses (p. 5). *Descriptive case studies* “present a complete description of a phenomenon within its context” while *explanatory case studies* “present data bearing on cause-effect relationships [to] explain how events happened” (p. 5). This case study is both exploratory and descriptive. The exploratory segment of this study aims at understanding the experience of CAM practitioners working in an integrative environment since theoretical components have yet to be identified in the literature. The descriptive segment of the case study relates to the processes related to integration since some concepts have been identified that shape the direction of this inquiry.

Although there are a number of case study configurations, this study is a single case and was selected because of its uniqueness (Yin, 2003b). A case is deemed *unique* when a given phenomenon is “so rare that any single case is worth documenting and

analyzing” (p. 41). Using this perspective, the integration of CAM into mainstream medicine is still a relatively new phenomenon. While CAM certainly has grown in popularity, the marriage of CAM with biomedicine is still a relatively new phenomenon occurring predominately in biomedical facilities found in medium to large cities. In this sense, it is a rare and unique subject worthy of investigation.

Description of the Study

“A case study is both a process of inquiry about the case and the product of that inquiry” (Stake, 2000: 436). Four procedures were used to address the research questions and include: selecting a site; collecting data; performing analysis; and crafting a report. The first three components will be discussed in this chapter, and the analysis will be presented in Chapter 4.

In order to understand the processes associated with integration from the perspective of the CAM practitioner, a site was needed to explore this research agenda. For the case, I naturally sought a facility where CAM practitioners functioned in tandem with biomedical personnel. A site was located that housed two physicians, two chiropractors and a variety of alternative practitioners. The mission of the selected facility is to “treat every facet of a patient’s health needs” and to “help guide patients and make sure that they’re looking at themselves as the whole picture” (field document). The facility is a relatively young enterprise, so it is understood that a great deal of shifting occurs in the first few years of any new endeavor. With that said, it is important to point

out that the facility is not the focus of the study, but learning about the experiences of the CAM practitioners within this environment will inevitably bring some attention to the practices incorporated within the facility.

For the purposes of collecting data, it became necessary to become fully immersed in this facility where CAM practitioners worked in conjunction with biomedical practitioners. When doing case study research the units of analysis should be related to the research questions (Yin, 2003b:24). The unit of analysis for this study consists of the experiences of a small group of CAM practitioners working in the same integrative facility. It is believed that experiences of CAM practitioners working in an integrative environment will expose some of the barriers or problems related to integration. Including the voice of the CAM practitioner within the analysis will also bring into focus the processes involved with integration.

For the case study, I elected to interview six individuals representing different modalities. In-depth interviews were conducted with informants on multiple occasions to explore the questions outlined in the research agenda. Bi-monthly meetings were mandatory for practitioners, and they served as a way to routinely check in with practitioners about their experiences at the facility. Documents and field notes are the main source of information describing these events. In the interest of full disclosure, my role in this study went beyond the status of a researcher. At the time the study was conducted I was affiliated with this facility as a practitioner. The issues related to this role will be discussed in an upcoming section.

Sampling

While there are no clear cut guidelines dictating how many respondents to interview in qualitative research, sampling decisions were shaped largely by the number of CAM practitioners working on site. There were roughly nine CAM practitioners working at the facility that did not hold a traditional medical degree. There were a handful of doctors who worked at the facility due to their experience in holistic medicine or because they possessed some other type of esoteric knowledge that enabled them to practice a different modality. For the most part, the medical doctors were not considered eligible for sample unless they believed their job was more aligned with the other non-biomedical modality they performed.

In this study, I elected to interview a total of 6 CAM practitioners who worked in the integrative medical facility. Respondents were selected to participate in the study using the maximum variation sampling technique (Patton, 1990 in Glesne, 1999), which refers to the method of selecting participants based on cases that represent variation of some kind. Because the site of study proudly represented all five aspects of the NCCAM's domains, informants were selected to represent diversity across each of these fields. Doing so would provide insight into issues that span across modalities and would reveal patterns related to the processes involved with integration.

The lack of diversity in sample selection is one limitation of this study's design. The field of CAM research is largely dominated by female practitioners, and the majority of those interviewed for this study were female. Similarly, there was also a lack of ethnic diversity since most participants were of Caucasian descent. In general, I found these characteristics to parallel those of the CAM workforce described in the CAM use

literature, and for this reason it did not seem necessary to seek other informants with different gender and ethnic backgrounds. That is not to say that issues pertaining to gender, race or other identities are not important, they were merely outside the scope of the research and would have added additional complications for site selection. Because interviews with informants were openly structured, participants were given sufficient opportunities to voice and articulate any issues pertaining to race, identity or gender.

It is important to note that employee turnover was at times a problem for this facility, and several of those individuals who resigned their position were selected to interview. The rationale behind this decision was to explore the possibility that resignations could have been attributed to barriers related to integration and it would be beneficial to capture and understand the reasons for departing the organization.

Methods and Forms of Data Collection

The case study method traditionally insists upon using multiple sources of evidence. Multiple sources of evidence are important features of case study research since they “provide a detailed in-depth picture” of the phenomenon being studied (Cresswell, 1998:37). Yin (2003b) identifies six ways of collecting evidence to support a case and include: documents, archival records, interviews, direct observation, participant-observation, and physical artifacts. Multiple sources of evidence become important as Jorgensen (1989) points out since “the more information you have about something from multiple standpoints and sources, the less likely you are to misconstrue it” (p. 53). For these reasons, three main sources were used in this study including: interviews, documents and observations.

Interviews

“Qualitative researchers take pride in discovering and portraying multiple views of the case. The interview is the main road to multiple realities” (Stake, 1995: 65). As Stake stated, the main vehicle for collecting data for this study was open-ended, formal interviews with informants. My interview style tends to be more conversational, since I tend to see informants as co-creators of the case study. When conducting formal interviews, informants are asked the same questions time after time to provide consistency in data (Jorgensen, 1989). Although the interviews followed the case-study protocol, they were flexible enough to allow for the discovery of emergent topics. Through the use of interviews I was able to explore each informant’s experiences related to working in an integrative environment. Interviews help reveal an informant’s experience within a context, and when questions are constructed based on known behavior witnessed through participant observation informants’ responses can be better interpreted (Glesne, 1999: 43). Interviews proved to be a safe environment to probe about the issues and challenges related to this kind of work and enabled me to ask about interpretation of events and exchanges I witnessed during meetings.

After informants were identified as possible interview candidates, they were contacted via email, which served as an invitation for the interview. While the initial email functioned as an invitation to participate, it also created an opportunity to provide background information regarding the study and its intentions. Overwhelmingly, there was much support and enthusiasm from the informants and every informant who was contacted consented to an interview.

Once an interview was accepted, a date, time and location were established. Generally, I attempted to schedule interviews so they were at a convenient location for each informant. Interviews took place in restaurants, coffee shops, homes, and in offices and interviews lasted between one to two hours. Before each interview commenced, informants were again told about the purpose of the investigation, were provided a consent form and were given an opportunity to ask questions. Informants were also told that they would never be identified by name in the text and would be assigned a pseudonym to conceal their identity. The consent forms were obtained to acknowledge that informants gave their permission to be involved in the study and were doing so voluntarily. A copy of this consent form can be seen in Appendix A.

After the administrative tasks were completed, informants were asked a series of questions developed with the research agenda in mind. Interviews were taped on a digital recorder with informant consent and were later transcribed by a third-party contractor. A complete list of these questions is provided in Appendix B.

At the end of the interview, the transcription process was described to informants and they were asked if they could be contacted if follow-up interviews were necessary. Informants were told to anticipate a copy of the transcript to review as a means of ensuring the quality and authenticity of the interview and transcription process. Details of this procedure will be explored in an upcoming section of this chapter.

After the first round of interviews was transcribed, it was determined that follow-up interviews were needed as a means to delve deeper into some of the processual issues related to integration. Given the interest of time it was determined that these interviews would be conducted over the phone. Because rapport had been well established with

informants over a two year period, I felt confident that this arrangement would still provide insightful information. Informants were again contacted via email and were asked for a preferred time to schedule a phone interview. Before the second interview commenced, informants were asked permission to record the conversation using a digital recorder. Detailed notes were taken on a computer during the interview. The second round of interview questions can be found in Appendix C. Every informant participated in the second round of interviews.

Observations

Observations are sometimes analogous to a funnel and have been identified as descriptive, focused or selective (Spradley, 1980). *Descriptive observations* generally occur in early stages of research when a researcher is unfamiliar with a culture. Because researchers at this phase have not honed in on specific phenomenon, there is a tendency to over-document the more mundane aspects of a site. *Focused observations* are of a somewhat narrower focus and researchers intentionally seek to observe specific events. *Selective observations* “represent the smallest focus through which you will make observations. They involve going to your social situation and looking for differences among specific cultural categories” (p. 128). The majority of observations included in this study were either focused or selective since I was looking to observe specific characteristics. Because I was not new to the setting, my observations were certainly more focused on the literature I had read, the interviews conducted with practitioners, and my experience as an insider.

To gain an in-depth understanding of CAM practitioners' experiences in an integrative environment, I spent time observing practitioners in multiple settings in addition to interviewing informants individually. "Observational evidence is often useful in providing additional information about the topic being studied," and often reveals insightful information regarding the context or the phenomenon being studied (Yin, 2003b: 93). Bi-monthly meetings served as the main portion of these observations and were beneficial since each modality was given frequent opportunities to ask questions, identify problems and discuss the nature of such work in general. These meetings were initiated by senior leadership and were co-facilitated by the coordinator of the facility. Observed meetings clearly lead to greater understanding of the case and were of particular interest since it was the main forum in which all practitioners, both CAM and biomedical, interacted. As a practitioner, daily interactions are structured to occur between provider and client, so time limits the amount of interactions that occur between practitioners. With the exception of a brief exchange in a hallway or a scheduled lunch appointment, interaction between providers is difficult to capture. For this reason, meetings were pertinent to the research questions and provided opportunities to explore the issues raised during interviews. But other events, classes and presentations were observed as well.

Glesne (1999) states that, "the main aim outcome of participant observation is to understand the research setting, its participants, and their behaviors" (p. 45). In accord with my research questions, I was looking for situations or examples that would help explain the experience of CAM providers. Throughout the course of making observations, I was looking for issues or tensions between CAM and biomedical

practitioners that arose during meetings. More importantly, I also sought to understand whether or not these issues were resolved since resolution is often a window revealing how CAM practitioners are valued, received and treated by others. I sought to observe instances in which practices were modified or enhanced as a result of working alongside biomedical practitioners. Observations also provided the opportunity to understand how CAM practitioners related to leadership and how leadership responded to CAM practitioners. Patterns of collegiality and communication were revealed during focused observations in addition to how practitioners engaged in integration with others. Field notes were created to capture such observations and were frequently explored through the interview process as a way to understand and verify the exchange.

The main drawback to the observation method included in this study was that not all respondents were present and available for observation. The delivery of patient care was another barrier to observation since much of these activities are regulated by patients' rights to privacy. Observations practitioners had with clients were largely off-limits and were in part outside the scope of this study. While integration did not commonly occur in the examination room, it was more likely to find practitioners talking about integration informally. For this reason, I positioned myself in what Glesne (1999) calls *safe places*, or spaces that are not controlled by anyone. Frequently, these safe spaces facilitated impromptu conversations with others and created opportunities to observe informal exchange between practitioners.

Documents

Documents “enrich what you see and hear by supporting, expanding, and challenging your portrayals and perceptions” (Glesne, 1999: 59). Documents also reveal “a communication among other parties attempting to achieve some other objective,” and a good researcher will try to understand such objectives as a way of being misguided by other forms of evidence (Yin, 2003b: 86). For this reason, documents were collected throughout this case study from a number of sources and represent the third form of data collected for this investigation.

Yin (2003b) explains that documents should be used to “corroborate and augment evidence from other sources,” and serve three main purposes (p. 87). First, documents are useful to collect because they clarify and reveal points of interest mentioned during an interview. Secondly, documents can provide insight and corroborate information gleaned from other data sources. Thirdly, documents are frequently used in case studies to make inferences about certain aspects of the case, but researchers are cautioned to treat such “inferences as clues worthy of further investigation” (p. 87). In this study, documents were obtained a number of ways and were used initially to provide background information about the site. The primary means of collecting documents occurred during routine visits to the site. Frequently, agendas were dispersed at meetings and reflected the weekly items of agenda. Other materials, such as schedules, presentations, workshops and financial information were also collected for the case when available and appropriate.

Electronically, email interactions with key information were also archived for the case study. Web searches were conducted to locate articles, newsletters, blogs, mission

statements, and additional forms of data as a means of providing background or contextual information about the case. It has been noted that documents can provide a researcher with “historical, demographic, and sometimes personal information that is unavailable from other sources” (Glesne, 1999: 58). Many of the documents obtained electronically provided means to chronicle events as they occurred retrospectively.

Informants were asked to share any documents they felt might be helpful to this study. Overwhelmingly, most informants were extremely generous in this regard. It is interesting to note, however, that one key informant was hesitant to share documents despite several requests. Whatever the reason, the reluctance to share data partially limits my ability to triangulate. Some of the documents requested were sent in an abridged fashion. It is unclear as to why this informant was reluctant to share materials and this behavior could be interpreted in a number of ways. Reluctance to share materials could be related to a trust issue, meaning that the informant may be leery about how the researcher will interpret the documents. Secondly, the informant may not want to expose materials that would portray any one or anything negatively. Thirdly, there could be repercussions in the workplace for releasing and disseminating such information.

Data Analysis

Unlike quantitative designs that typically rely on computers to aggregate data, the researcher is typically the instrument for conducting analysis. Much of this process begins in the early phase of data collection, since researchers constantly reflect and

evaluate what they see and hear in the field. But at the end of a qualitative study, most researchers have amassed enormous amounts of documents and interview data, so the task then becomes reducing the data into a useful form.

Although there are various techniques for reducing data, the process typically begins with reading and reviewing the materials. In this study, transcripts and documents were read through multiple times to become acclimated and oriented to the data corpus. To attend to emergent issues pertinent to the case, transcripts were first coded using an open coding process where “the investigator identifies potential themes by pulling together real examples from the text” (Ryan and Bernard, 2000: 783). First, I read through the documents and labeled passages with codes representing the essence of the text in the margins of the document. Second, I copied and pasted passages expressing similar ideas and then systematically reviewed the passages to see if specific patterns or themes emerged. While coding, “sometimes we will find significant meanings in a single instance, but usually the important meanings will come from reappearance over and over (Stake, 1995: 78). The majority of quotes used in this case study, unless noted otherwise, are indicative of multiple instances of a particular pattern found throughout the data corpus.

Based on the characteristics of successful mergers, transcripts and documents were coded a second time using an a priori schema. The a priori process involved reading through the data with a set of pre-existing codes, which was informed by the conceptual framework devised in Chapter 2. After coding was completed, a code book was created, which became an essential tool for interpretation facilitating additional data

reduction. A case study was prepared to describe the major findings of this effort and include: the experience of CAM practitioner, strategies for integration, and barriers to integration.

Role of the researcher

Participant observation helps a researcher “learn firsthand how the actions of research participants correspond to their words, see patterns of behavior, experience the unexpected, as well as the expected, and develop a quality of trust with others that motivates them to tell you what otherwise they might not” (Glesne, 1999: 43).

In Glesne’s (1999) description of the participant-observation continuum, the status of researcher can range from “mostly observation to mostly participation”. Using this continuum as a framework, my status in this study would best be described as full participant. The term *full participant* refers to a person who “is simultaneously functioning as a member of the community undergoing investigation and an investigator” (p. 44). In the setting for the study, I was employed as a CAM practitioner while the investigation was being conducted. Each position, researcher and employee, brought its own set of strengths and weaknesses to the research design and these will be described below.

Prior to the study, I was involved with the planning and initial implementation of this facility. Eventually, I was offered a position as a practitioner and months after the facility opened, the site was selected for study. My employee status enabled me to access the site quite easily. Because I was subjectively immersed in the subject matter, and my position was also the same as those I was hoping to study, I was exposed to many

of the same experiences and procedures as my informants. One of the benefits of being an insider is that it affords one “the possibility of experiencing the world of daily life as an insider” (Jorgensen, 1989: 63). My placement situated me in such a way to have a very personal, yet subjective experience in which to draw upon. As a result, I was able to understand and identify issues salient to the practitioners working at this site. My status as an insider showed other practitioners that I understood their position, or to use Trice’s (1993) language, we were part of the same occupational culture. Sharing a culture also meant that we also shared issues. The shared experience facilitated in building rapport with other practitioners and enabled me to craft interview questions from an insider’s perspective. Trust and rapport were established quite easily, again due to the fact that I belonged to the same occupational culture as my informants. During interviews most practitioners shared extremely intimate details, anecdotes and stories with me, which revealed to me as a researcher that I was a trusted individual.

While there are a number of benefits to sharing membership with a group being studied, it is nonetheless a precarious position. Along with my membership role comes a certain degree of biasness based on my experience at the site. Awareness is the best strategy in dealing with researcher bias, and reflexivity was the strategy I employed to bring my biases to light. Strategies for addressing researcher bias will be discussed in the trustworthiness section of this chapter.

As indicated above, my status went well beyond that of causal observer. As a practitioner, I taught a number of courses, participated in meetings, conducted research and led presentations on behalf of the facility. My interest in doing these activities did not stem from my research agenda, but rather was a genuine effort to help advance and

support the facility. At some point into the research, this arrangement did shift the more I experienced as a practitioner. During these moments I was drawn more toward the observer aspect of Glesne's continuum, and the focus was on witnessing the experience of participants. I found myself trying to shy away from drama and politics and felt conflicted about assuming more responsibilities at the facility. This was often not easy to do, however, as I experienced conflict between wanting to advance the center and wanting to just be a witness to the process. On one hand, I wanted to participate in a number of activities because I was interested in helping the facility. Another part of me wanted to drop back into observer mode in order to witness events as they unfolded. I strove to exist at times in the margin, which "offers the vantage of seeing without being the focus of attention, of being present without being fully participant, so that [I] was free to...fully attend to what occur[ed] before [me]" (Glesne, 1999: 63). Assuming a marginal position was at times determined by the needs of the center. Midway through the research project, another practitioner was hired within my specialty area, which temporarily relieved me of some responsibilities so I could experience the margin.

During my work and my exchanges with others at the facility, I strove to be a non-judgmental observer, attempting to witness events as they occurred without preconceived notions or expectations. My employment status at times challenged this desire. Because of my membership role, for example, I was sometimes called upon to make distinctions or recommendations about matters pertaining to my discipline. Being a non-judgmental observer was probably the most challenging aspect of field work. Because I had a history with colleagues and central leadership, these exchanges inevitably became part of my consciousness and undoubtedly influenced my perception

of events that transpired in ways I cannot even see or identify. In qualitative research, the researcher becomes the research instrument (Janesick, 2000: 386) and I am therefore a product my dual roles. The problem with membership roles as Glesne (1999) points out, is “the more you function as a member of the everyday world of the researched, the more you risk losing the eye of the uninvolved outsider; yet, the more you participate, the greater your opportunity to learn” (p.44). My subjective involvement with the site was more of an asset since my membership enabled me to understand the experiences of CAM practitioners more clearly. Subjective involvement can help provide a more accurate description of a phenomenon than would have been possible by any other strategy (Jorgensen, 1989). My position as an insider inevitably contributed to my perspective on what I was experiencing as a researcher, and in the end, I am doubtful if any other position would have been able to provide me such in-depth knowledge.

My status as researcher within the facility was initially revealed to only a select few. As mentioned in a previous section, I sought and obtained permission from central leadership to conduct my study within the site. Other practitioners became aware of my status as a researcher only as they were contacted for interviews. Key personnel took a somewhat distant, yet supportive role in my research. Initially, my research was not promoted internally, but towards the end of my project administrators were more vocal about my research in meetings and in relations with others. I did nothing to actively conceal or identify my role as researcher, instead I simply allowed my status to evolve naturally and informed other participants at the facility when opportunities to do so were presented.

While being a full-participant certainly provides a number of benefits including easy access to a desired site and enhanced rapport with informants, there are a few problems that emerged with this role. Yin (2003b) identifies three main problems related to membership roles (p. 96). First, time spent observing could be limited or reduced as a result of having other responsibilities to tend to at the site of study. In this study, teaching did limit my time to observe, but it did provide other opportunities to interact with clients and administrators. For the most part, responsibilities at the facility did not interfere with my observations.

Secondly, participant-observers tend to become supporters of the group being studied, implying that the researcher may easily lose the ability to witness from multiple perspectives. In this study, I clearly identified with the population being studied since I belonged to the same occupational culture as my informants. Specifically, the research agenda sought to focus on the role of the CAM practitioner since it largely has not been addressed in research. The research agenda is designed to support the group being studied.

Thirdly, “if the organization...being studied is physically dispersed, the participant-observer may find it difficult to be at the right place at the right time...” (p. 96). In this study, there were a number of challenges working with a population of individuals who work behind closed doors with clients. Due to privacy laws, watching practitioners interact with clients in the traditional sense was not an option, but I experienced what it was like to be a client as I scheduled services with a number of practitioners to get a sense of their work. Some organized meetings scheduled in

locations outside the building were also inaccessible since I did not receive an invitation to participate. At times, I wondered if such meetings were restricted due to my role as a researcher or due to some other unforeseen explanation.

Ethics

The role of ethics in research permeates all aspects of a study and in this investigation traditional ethical procedures were implemented. Four main components addressing ethical concerns will be discussed and include: informed consent, deception, privacy and confidentiality, reciprocity (Christians, 2000; Glesne, 1999). A proposal of this study was reviewed and approved by Ohio State University's Institutional Review Board (IRB). The proposal included a description of the study, research and interview questions and a copy of the consent form. Because of my status as an insider, I was poised in such a way to easily access staff, meetings, and documents. Although I had been involved in the planning of the facility for a number of years, the study did not formally begin until permission was officially obtained by the appropriate channels. After I received permission from the facility officials, I launched the study, which involved interviewing selected candidates making observations, and collecting documents. Prior to each interview, informants were given an overview of the study, the consent form and an opportunity to ask questions. The purpose of the consent form is to ensure that those participating in the study are made aware of the possible benefits of the investigation as well as the procedures that will be followed throughout its course. Informants participated voluntarily in this study and were told that they were free to

withdraw consent and discontinue participation at any time. All six informants participated fully and none withdrew consent. A copy of the consent form is included in Appendix A.

Ethical codes exist to protect the identity and privacy of those who choose to participate. As researchers, “we have a positive responsibility to safeguard [informants’] rights...interests...and even their sensibilities” (Spradley, 1980: 21). To protect the anonymity of those interviewed, informants were told before the interview began that they would be identified by pseudonym in the text. Telling informants about the use of pseudonyms at the onset of the interview gave some informants a certain degree of comfort to express themselves fully. While each interview represents a specific modality, informants are identified as practitioner 1, practitioner 2 and so on in order to protect respondents’ interests. For additional protection, descriptive characteristics may or may not be modified since the number of these facilities in the US is still a relatively small number. Given the fact there was significant turnover at this site, it was difficult to follow any one person longitudinally. There were of course some exceptions, but these distinctions will not be identified in the text in order to conceal respondents’ identities. In the end, both current and former employees contributed to this study. Data collected in conjunction with this study was also kept confidential and was stored appropriately.

In some social science experiments, deceptive tactics are employed in order to elicit specific kinds of information needed for a study. This study was crafted to be “free of active deception” and deceptive elements were not purposefully invoked (Christians, 2000: 139). However, it is possible that some practitioners who were not interviewed for

this study could have felt as though my research was covert, since my role as researcher was not immediately evident to all parties involved at the facility.

The notion of reciprocity, or giving back to informants in some capacity (Glesne, 1999), framed the implementation of this study. Through the course of a study, relationships are developed as researchers interact with informants while collecting data. Historically, my own research with others has always resulted in the desire to give back to informants in some way and has been shaped by common sense etiquette. If, for example, an informant suggested we meet at a coffee shop or restaurant, I routinely paid for such items as a way to thank informants for their time. Other examples of reciprocity I engaged in was providing research materials on an informant's topic of interest and offering to share copies of the final product of this research. I also came to see the interview process as a way of giving back to those I interviewed. Glesne (1999) points out that "although researchers do not unwittingly assume the role of therapist, they nonetheless fashion an interview process that can be strikingly therapeutic" (p. 127). In several instances, informants told me explicitly that they were appreciative I took the time to listen to their problems and to tell their story.

A few additional ethical considerations pertaining to matters of knowledge deserve some attention. Glesne (1999) points out some ethical and political issues can emerge when doing research in a familiar setting, or what she calls *backyard research*. Here, "political consequences are often more challenging in backyard research in that you may have to negotiate with colleagues and superiors not only what data can be collected but also what gets reported" (p. 26). In this study, to my surprise, I experienced a few instances where colleagues were reluctant to share any documents beyond what was

outlined on the facility's website. While it is unclear why certain informants refused to share, hesitancy could be indicative of something else such as fear or mistrust. It could be that as a result of one's position he or she might not be able to share documents without internal repercussions.

In addition, the study also generated some forms of *dangerous knowledge*, or "information that is politically risky to hold on to" (Glesne, 1999: 27). Instinctively, there is the desire or impulse to conceal such information, but given that my research philosophy is shaped by a greater desire to help make situations better, the information will be presented honestly and tactfully.

Limitations

One limitation to this research design pertains to the use of single rather than multiple case studies. Multi-case designs are preferred over single case designs since they tend to increase the possibility of replicating what is found from case to case. Single case studies, on the other hand, can be "vulnerable" because a researcher focuses exclusively on that one case (Yin, 2003b: 53). Problems can sometimes emerge within a case where the case has to be abandoned for some reason, and without having an additional case in which to compare, a researcher can find herself without data. While I did not have to abandon this site for any reason, having another case in which to contrast findings would have been useful. Without another case it can be difficult to discern if some of the themes or issues that emerge are unique to all cases or are just exclusive to the one being studied.

As mentioned above, there were a number of problems related to *backyard research* and acquiring *dangerous knowledge* (Glesne, 1999). The main limitation points to problems accessing appropriate data forms, specifically documents. While attempts were made to collect sufficient documents in order to generate robust findings, I suspect that this was somewhat limited since a few key informants were reluctant to share. This will undoubtedly inhibit some aspects of triangulation.

The intent to focus primarily on CAM practitioners could have produced a few blind spots in the data as well. Because of my involvement as a practitioner, coupled with the fact that the investigation focuses exclusively on CAM practitioners, there might have been some tendency to overcompensate for the lack of data on CAM practitioners. If the design would have included biomedical practitioners, it might have provided greater insight as to how these issues were perceived by leadership and administration, and if they were perceived to be issues at all. In order to compensate somewhat for this shortcoming, two interviews were conducted with staff that had overlapping roles, who served in some capacity as practitioners and administrators.

Lastly, when doing any kind of qualitative research, the notion of generalizability is commonly thought of as a design limitation. Generalizability is possible in qualitative designs, but is quite different in quantitative studies. Statistical generalizations are typically employed with survey research and provide the ability to make inferences about a population using a sample of that population. In case study research on the other hand, analytical generalization is the typical result. With this approach the researcher “striv[es] to generalize a particular set of results to some broader theory” (Yin, 2003b: 37). While

the experiences of CAM practitioners in the field is considered exploratory research, the processes related to integration are sought to understand how these components relate to the best practices utilized for successful mergers.

Trustworthiness

“Ensuring that data are accurate is a cardinal principle in social science codes as well” (Christians, 2000: 140). A certain number of safeguards were employed in order to ensure the accuracy of data and will be discussed below. Trustworthiness is the qualitative term for research validity and represents a number of procedures that can be utilized when conducting research to ensure the accuracy of data. Cresswell (1998) outlines eight procedures satisfying the requirement of trustworthiness and include: prolonged engagement and persistent observation; triangulation; peer review or debriefing; negative case analysis; clarifying researcher bias; member checks; rich, thick description, and external audits (p. 201-203). Four of these procedures were built into this study’s design and are discussed below.

Prolonged engagement and persistent observation facilitates a greater understanding of the culture being studied and solidifies rapport and trust between researcher and informants. Prolonged engagement shapes the direction and the outcome of a study since questions are constantly assessed and analyzed based on observations and interactions in the field. In this study, I was able to remain in the field for roughly two years, which afforded me the opportunity to steadily compare and delve deeper into what I was observing and hearing from my informants.

The decision to use *Triangulation*, or “the process of using multiple perceptions to clarify meaning [by] verifying the repeatability of an observation or interpretation,” was a natural consequence of obtaining multiple types of data (Stake, 2000: 443). This process involves exploring data from various sources in order to elucidate research findings (Cresswell, 1998). Using this technique, interviews, documents, and observations were used to explore patterns and search for consistency throughout this investigation. For example, exchanges I observed with practitioners were frequently clarified in interviews or with follow-up conversations in order to corroborate what I had witnessed. This pattern of noticing, observing and verifying was applied across all forms of data collected in the field. Although it is acknowledged through the notion of crystallization there are more than three ways of knowing and that “what we see depends upon our angle of repose” (Richardson, 2000: 934). Given the fact that this is a traditional case study and not a mixed-genre text, the decision to use three forms of data to triangulate is appropriate. For applications or documents outside of the traditional sort, the idea of crystallization will undoubtedly beckon me to examine this data again with adequate time and reflection. It has been my experience that while there are fixed end points or deadlines guiding research projects, additional stories and lessons learned from working in the field invariably surface, but only with sufficient time and reflection. I am certain that through the formal process of writing a dissertation, other possibilities or stories will emerge with perspective. For me, working with the data in a traditional sense, is merely part of the process to shape and inform other data stories.

Because I see the process of research as being co-constructed throughout the course of the investigation, *member checks* were another obvious choice for this study.

Member checks refer to the process of sharing data with informants for the purpose of ensuring quality and accuracy (Glesne, 1999; Stake, 1995). After interviews were transcribed and the analysis was completed, informants received copies for review. Informants were asked if the transcript represented the interview accurately and fairly and whether or not they felt their story was portrayed accurately in the analysis. Informants were invited to modify anything they disagreed with and were instructed to use the Track Change function in Word as a means of recording any changes. Overwhelmingly, most informants agreed with the content of the interviews and analysis, and made few amendments to the documents.

Lastly, being an insider in this case I frequently dialogued with other colleagues throughout this research process as a way to explore my own subjectivity. My predisposition to favor CAM practitioners was brought to my attention through conversations with colleagues. Informal dialogue helped me process and identify some of the issues I brought to the study given my background and experiences. As a result of such conversations, I realized I had the tendency to see the facility as not being integrative. I also realized my tendency to align with practitioners since I was one of them. Once I became aware of such tendencies, I was able to acknowledge the small, progressive steps the facility was making towards integration. Additionally, I was able to see more clearly the obstacles facing the facility as a whole. Engaging in conversations with others served as an on-going tool by helping me identify my own biases and enabled me to formulate a more balanced and accurate case study. In the past, I have engaged in journaling as a means of reflexivity, but I found the conversational interactions invaluable since I was able to receive immediate feedback. While journaling at times has

been an asset, I find it can perpetuate the researcher's biases and agendas. Processing with an outsider who is not engaged in the case study process pushed and challenged my assumptions as a researcher.

Appendices

Consent form

Interview Protocol 1

Interview Protocol 2

CHAPTER 4

DATA ANALYSIS

Introduction

The focus of this chapter is to describe participants' general experiences and attitudes about working in an integrative environment. The case study begins with a brief overview of the history and context of the integrative environment and proceeds to show how practitioners' expectations regarding integration went unfulfilled. Due to a clash in vision, practitioners describe how they became disconnected from the integration process.

The second section, Strategies for Integration, uses the best practices for integration as a lens to understand what processes were used to lessen the impact of a cultural collision between CAM and biomedical practitioners. While there are a number of strategies used to promote a successful integration, they are used inconsistently to merge the cultures of CAM and biomedicine. Across all strategies for integration, structural changes and leadership issues strongly influence the integration process.

The last section, Barriers to Integration, identifies some of the issues and challenges practitioners experience working in an integrative environment. Most of these obstacles are related to structure or direction or a combination of the two.

Historical Context: Organizational Structure and Leadership

*The really exciting thing about this is that no one's ever done this before.
(Ruby, CAM practitioner)*

The facility for integrative medicine originally began as one graduate student's quest to combine traditional with alternative medical care. Frustrated with having her patients fail to comply with her biomedical requests, such as getting blood work done, she sought a solution, which was to open a center that combines both biomedical and non-traditional practices. The result was a cozy facility housing a handful of CAM practitioners who shared patients and collaborated collectively about their patients' care. The initial goal of the center was to bring together health care providers representing all health and wellness modalities. Essentially, the center provided singular services but specialized in helping patients put together team based approaches for addressing health concerns. Within this framework, patients received attention from experts in all traditions and forms of health care, and the experts, in turn, received a deeper understanding of their colleagues' unique practices. The center fostered the idea that no solitary practitioner can claim to be an expert in wellness, and acknowledged that each tradition underlying each modality is comprised of its field own experts. For this reason, the center advocated for responsible interaction between all levels of traditions and modes of wellness.

Although it was still a relatively young enterprise, the concept nonetheless caught the attention of a nearby university, which had recently sent some of its medical students to visit the center as part of their medical training. Since 2000, the university had been contemplating the prospect of opening an integrative facility, and even formed a

committee to explore this possibility. The initiative was composed of a “multidisciplinary group of faculty and staff as well as a range of service providers in the nearby area, including the graduate student mentioned above. The mission of this group was to develop a proposal for the creation of a facility for Integrative Health and Wellness, which hoped to bring together an interdisciplinary team to provide access to responsible information on integrative care” (document). The proposed facility sought to provide education, research and clinical practices focusing on the concept of wellness.

The university launched an exploration phase that involved researching existing ideas and facilities, including the aforementioned center in town. A visit to the graduate student’s facility sparked the university’s interest, and ultimately initiated a dialogue with the owner about the possibility of bringing her center to the university. This meeting was essentially a conversation to clarify the graduate student’s vision and objectives for incorporating her center into the university system. After many rounds of communication with the graduate student, the university formally made a deal to acquire the fledgling center in the fall of 2004.

Part of this newly forged agreement stipulated that the graduate student would remain part of the facility as it relocated to the university. She retained her positions as director since her doctoral work was consistent with the position and was responsible for five main duties including: clinical activities, management of the Integrative Medicine Model and practitioner relations, marketing and program promotions, human resource management, and financial management. Additionally, the director was responsible for conducting intake procedures with patients and providing a synopsis of each case to distribute to the integrative team of practitioners for review and recommendations. The

director would then prepare a plan of treatment options based on team recommendations and then worked with the patient to meet his or her wellness goals. The university brought in a medical director, who was mainly responsible for patient care, but also tended to a host of administrative duties, such as supervising physicians, making recommendations regarding the hiring of medical staff and developing of programs.

The structure of the original center was influenced by the framework of the five NIH domains, so practitioners were hired in each of these areas. The business model was conceptualized as a wheel and all practitioners were represented as spokes on the wheel, including the medical director. The center itself was the hub, linking all of the practitioners together through a strong core of administrative support. This model symbolized the idea that all practitioners were equally important to the success of the center and also reflected the essence of holism.

...if you really want to unify healthcare providers... you need to put them together in a way that nobody runs the show. The yoga teacher is as equally the person that's going blow the top off that somebody needs as is the physician, as is the psychologist, as is the personal trainer and in order to do that it was this pancake horizontal... that's like wheel to me you know, and at the very middle of that wheel is a really solid administrative process (Ruby)

Because of the symbology the wheel model, practitioners understood that everyone's position was equal in terms of power. Although both a director and medical director had been appointed, in the eyes of the practitioners these positions were non-hierarchical and just other spokes on the wheel. In fact, the medical director at times referred to himself as, "just one of the thirty-eight."

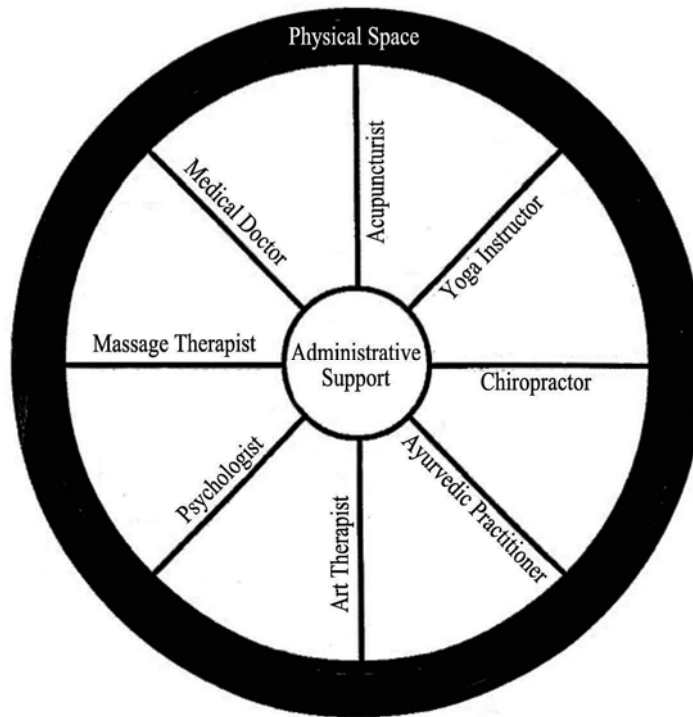


Figure 1. Visual representation of the wheel model

At the core of the wheel model was a strong administrative support team whose goal was to assist practitioners in many ways. The administrative team was intended to help practitioners network, to link patients with providers, and to facilitate scheduling and billing so practitioners could spend more time focusing on patient care. Prior to being offered services, patients would engage in an intake process with the director where they would talk about their health issues as well as their expectations for treatment. After such a consult, the director would share patient information with all practitioners, and practitioners were expected to respond with the various ways they could help that patient. The patient would receive a synopsis of all the different assessments which would enable them to make informed decisions about their health care. Once treatments commenced, a record was made using a special filing system where each patient file had five

compartments to allow for patient notes to be included and organized by domain. The filing system had a learning component built in, so practitioners sharing patients could easily learn about the other modalities their patient was using. This system not only organized patient information across all five domains, but it allowed other practitioners who were sharing patients to learn more about the other modalities at the center.

New Beginnings

The prospect of a new facility at the university level generated much excitement in the surrounding community.

I think that we were all incredibly excited for not only what we were a part of, but what the community was going to have offered to them...you know, we would sit and have tea together and we would just be so excited for what was going to take place (Greta)

CAM practitioners in town were especially joyful, and the director received dozens of applications from practitioners hoping to join the center as a result of this flurry of excitement. The excitement was not exclusively reserved for CAM practitioners, but physicians involved in this process were also “giddy” and “enthusiastic.” Fueling the anticipation leading up to the grand opening, the new facility was endorsed by high ranking university officials in newspaper and magazine articles. After a lengthy search, a space was eventually found to be the new home for the facility, but needed extensive renovation. The facility was temporarily housed in another location until reconstruction was completed. The new building was decorated applying feng shui principles and was arranged by one of the incoming practitioners.

The facility was slated to house two physicians, three chiropractors and a variety of alternative practitioners. A total of thirty-three alternative practitioners brought a

range of practices to the facility including: psychotherapy, hypnotherapy, traditional dietetics, treatment for eating disorders, personal training, shiatsu, massage therapy, medical massage, integrative body work, herbal counseling, women's health, feng shui, life coaching, licensed social work, electrodermal screening, art therapy, transformational breathing, Ayurvedic medicine, sports massage, energy medicine, Trager, reflexology, acupuncture, yoga, treatments to improve cognitive abilities and Pilates. Being in a university setting, the facility naturally intended to be involved in education and health related outreach programs for the community.

Shortly after the facility opened at its temporary space, tensions between the director and medical director began to erupt over who was in charge. Several weeks before the facility was scheduled to open, the director made an announcement towards the end of a provider meeting that she was resigning. The announcement itself was an act of protest directed towards the providers to demonstrate that what was "initially important in the facility...wasn't going to be there anymore" (field document). Practitioners unable to attend the meeting were later sent an email from the director explaining that the medical director had assumed most of her responsibilities, and because of this she would be stepping down from her position.

Many practitioners, obviously, were extremely confused about the sudden change in leadership and immediately sought clarification. Most of the practitioners I spoke with who were there during this period of transition indicated that there was neither adequate closure nor sufficient explanation regarding this change in leadership. For example, one practitioner told me that the director's departure, "...was done sort of in a mysterious way that I couldn't quite figure out. And then all of a sudden two practitioners in the

same modality were leaving...” (Ladini). Other practitioners slowly resigned, and the administration later dispersed an email identifying twenty-one CAM practitioners who were no longer affiliated with the facility. The medical director contacted all practitioners via email in an attempt to provide some clarity regarding the facility’s vision and direction. One piece of correspondence stated that the leadership was now in the hands of the medical director and maintained that the vision was still...

...to have the highest trained licensed and/or certified professionals in each of the five domains of the NCCAM as are available in a modern primary care network facility for easy access to our patients and clients while being available to teach medical students, residents, and other providers as we practice in an integrative manner with the highest degree of professionalism.” (Medical director)

As a result of the change in leadership, things began to shift as the facility struggled to find its identity amidst the change. The CAM practitioners who remained still believed in the concept of integration and were hopeful that they could still be a part of this exciting new model. The change in leadership, however, signaled a structural break from the wheel model. The new direction brought a new structure bearing strong resemblance to the medical model, and many practitioners began to struggle with unfulfilled expectations.

FINDINGS

CAM Practitioners and the Experience of Integration

Unmet Expectations and the Clash of Visions

As stated above, CAM practitioners were excited, enthusiastic, and overjoyed about being in an integrative environment. The excitement initially expressed by the most of the practitioners eventually faded. In explaining her hopes for integration, one practitioner stated,

And I thought if this center has [the director's] kind of energy, and you have all these people coming from all these different perspectives, Ayurveda, acupuncture, traditional Chinese medicine, yoga, psychologists, all these things...And I thought, gosh, that's just a dream come true...And I felt like, well, this is it. This is where I could be the rest of my life. I think I'd fit in perfectly here...then all of a sudden all these changes were happening right around the time that I got there.

The changes practitioners experienced were related to a sudden change of leadership, and subsequent change in direction. Practitioners originally assumed that they would be part of a multidisciplinary team collaborating on patient care. The center's wheel model was explicitly shared with prospective practitioners who were excited about the idea of teaching to and learning from their biomedical and alternative counterparts. CAM practitioners, who were introduced to the wheel model, were accustomed to learning from one another as they had already created informal opportunities for education and collaboration.

We did just basic things, like with the practitioners, where we had lots of pot lucks and that kind of thing...And at each pot luck we'd randomly pick a couple of practitioners that would talk about what they did... And kind of be able to speak to you for 5 minutes or whatever about their modality and get questions from

practitioners...And those were just more social things, but it made the group really close knit and I think if people consider people friends they're much more likely to send their patient's into those people's care. (Ruby)

Opportunities for education went beyond informal exchanges since collegiality, communication, and collaboration were the foundation of this model. Practitioners, in fact, were expected to have sessions with colleagues in order to experientially understand different modalities.

...you had to experience a session with all of the other practitioners and so we had an open trade policy that was mandatory where practitioners needed to be receiving sessions from other practitioners to learn first hand about the work that they did. (Ruby)

With the change in direction, a number of structural changes occurred and most practitioners indicated that their expectations regarding direction were largely unfulfilled. “As the facility opened and the directorship changed then the whole outlook of it changed...the whole way it was going to run,” explained one therapist. Another practitioner mentioned that the university led initiative was hoping to receive a large grant to launch a facility around clinical, research and educational components, which contributed to some of the confusion about direction.

When the grant fell through, the medical department still, for some reason, was interested in setting up a clinical presence and kind off took over the process... and it was made clear that this is now a medical department project, but I guess I didn't understand all that that entailed. (Elliot)

It soon became clear to the practitioners that something was indeed shifting, but the new agenda was not overtly expressed or articulated. According to one practitioner, “At that point [after the director had left] the direction of the center wasn't clearly established. Everything was in chaos...and I don't know right now if the direction of the facility was foreseen by [the university administration].” While the facility was

struggling to find its footing, its mission remained nebulous for many of the CAM practitioners involved in the process. Practitioners who once had a clear idea about the mission of the facility were suddenly in the dark about its future direction.

I guess this is where it was a little frustrating because they knew I had been talking with [the director] and that she had explained to me what her thoughts were...And [central leadership] certainly didn't do anything to change that idea...And I expressed to them what I thought the center should be and it was along those same lines of the practitioners working together, and they certainly didn't do anything to correct me. (Ladini)

Faced with a high degree of employee turnover, the facility sought to replace some of the practitioners who had left. When asked how these new practitioners were introduced to the facility, one practitioner told me that,

My impression was that they were bringing people in who had no idea that the center even had a mission...They were just given jobs and told that they would be given patients and that there wasn't an overriding philosophy explained to them. (Elliot)

Without a doubt, CAM practitioners went from having an extremely clear understanding of the facility's mission and agenda to having a very hazy understanding of the new direction and day-to-day operations. One practitioner mentioned that, "...as time went on, I just saw a real shift in the focus. You know, you go to the meetings and everything was about the director's model...And trying to shoe horn integrative care into a medical model" (Ladini). The impetus to revert back to a medical model was due to the fact that the medical director realized that he was responsible and accountable for the actions of all practitioners at the facility. At this time, the facility operated with more of a parallel model where all practitioners were operating side by side but were not integrating. As one practitioner related, "When [the director] left and Larry became the director, I don't know that at that point that he was going to be the director or responsible

for it, so I know it changed quite a bit in that his medical license was covering everybody for liability and everything.” As a result, CAM practitioners experienced a huge disconnect between their initial expectations and the reality of the new agenda, which resembled more of a traditional medical rather than integrative model. This disconnect was experienced in four areas including: status, collaboration, research and the role of the physician.

Unequal Status

A number of practitioners articulated their frustration with the cavalier manner in which their comments, opinions and ideas went largely unnoticed by leadership. CAM practitioners, as spokes in the wheel, entered the facility expecting to be vocal and collaborative colleagues. Those who were initially hired were told they were selected due to the mastery level of skill they possessed in their particular modality. The assumption was that all practitioners would be consulted for their unique skills and knowledge. The reality, however, was quite different and practitioners indicated that they were not treated as equals and that their opinions were not valued. One practitioner commented, “...at first I was gung ho and tried to contribute, but you get tired to listening to yourself and nobody else listening.” Another added, “I have never felt validated. I have never felt appreciated for the skills I bring...And I think it is down right arrogant for them to ask for mastery level people to come in and not validate...or at least contemplate what we have to say.”

Another CAM practitioner, who had been doing CAM related consulting for a university for over a decade, shared with me that he had found a way for massage therapists to promote their modality within the university community.

I presented [my idea] at a staff meeting and was told, "That's none of your business, you shouldn't be talking to massage therapists about things they have no control over. If you have anything like that you come to the medical director first." And, I did talk to him first, and still nothing was done and all of those massage therapists left the facility because they were starving. (Elliot)

One practitioner, however, explains why equality might not be realistic, suggesting that CAM practitioners only want the benefits of equality without its limitations.

Are they looking at modern medicine and traditional medicine and saying, I deserve all of those things...But along with all of those things comes malpractice, bureaucracy, universal standards and training and certifications. And all of a sudden they don't want to come with it. They want the vision of the doctor as the top of the heap, but they don't want everything that comes with it. (Sally)

Collaboration

CAM practitioners also had unmet expectations regarding collaboration. In addition to being treated on a level playing field with physicians, CAM practitioners believed they would be communicating and interacting with medical doctors and other practitioners on patient care. As the model deviated from its original intent, components once held to be central to the model, such as collaboration and the role of the physician, took on new meanings or were significantly altered.

...so we went from collaborative health care where the individuals coming in to the clinic would have the benefit of all these people looking at them and making suggestions to everything channeled through one particular person with on particular philosophy and one particular knowledge base. (Elliot)

Collaboration with colleagues was clearly desired and expected, but did not occur for the majority of those who were interviewed. In fact, when asked if there were opportunities for collaboration, one practitioner responded by saying, “Absolutely not. None. Not a single one...And I feel like in some situations [collaboration was] almost discouraged...” While practitioners experienced a disconnect with expectations regarding collaboration, the lack of collaboration as it contributes to integration will be discussed in more detail in the section titled, Strategies for Integration.

Lack of research

The university initiative focused on three major areas they had planned to include in the development of an integrative facility: education, clinical practice, and research. For those who were familiar or involved with the university initiative, they carried the expectation that they should be engaging in research projects. Major colleges and universities typically engage in research related activities, so practitioners joining the facility after leadership changed could have assumed that they too, would be engaged in research for this reason. Whatever route brought practitioners to the facility, most had the distinct impression that research would be conducted.

While the facility now has plans to conduct research in the field of integrative medicine, these activities have not yet officially started. The change in leadership and direction temporarily delayed these efforts as the facility regrouped to focus on clinical and educational activities, but it appears that practitioners were not made aware of this change. In explaining her attempt to ask a fellow colleague to engage in research, one practitioner related,

I went to her [a colleague] and asked her to help me to develop a research process. And she was really stumped. And she said, I don't know if I can, but there's a person that I can talk to. And then every thing started to fray, so that process didn't take place. We were told coming in before the center ever opened that we were to engage, that was part of what we were deemed necessary. (Greta)

Other practitioners understood that research was temporarily suspended until the facility became more stable. “We were actually told recently that there's not going to be any research at the center for quite a while. They discourage it. I think they're focused on making it survive financially right now and they don't see research as being an income source” (Elliot). In listening to administration talk during meetings, it seemed as though that they did not perceive research to be an immediate priority. Based on previous experience with research, the facility's financial consultant conveyed the impression to the collective that research typically generates more financial loss than gain.

Role of Physician

The role of the physician also changed significantly as time progressed. Physicians went from being one of the many spokes on the wheel to being the center of the model. Apparently, even the media displays that were once used to explain the wheel model were enhanced to reflect the change. According to one practitioner, when the university committee was first conceptualizing the facility, they used a Da Vinci man to represent the patient in the center of the model and surrounding him were the five domains of healing working together for the optimal health of the patient. “When [the

medical director] started presenting that picture, he put it in a slide presentation...and started lecturing, he interpreted that the figure in the middle of the diagram as the MD, not the patient.”

This shift signaled a new hierarchy that was not apparent before. With the doctor in the center of the model, a vertical hierarchy replaced the wheel model which sought to promote equality and collaboration among practitioners.

...if you have somebody in the center -- And I think you can just sit there and see everything in a balanced way. And see, that the integrative center is supposed to be a balance of everything. And, you know with a big circle all with everybody all around it and pull in who we need, when and where and then go from there. But you know you got a medical director, a doctor, everything is going to skewed from that direction and he's going to control the way he wants...(Ladini)

This change ultimately skewed the purposeful distribution of power from the CAM practitioners' point of view. With the physician poised at the center, all patients were first expected to be channeled through the medical director before finding their way to the various CAM practitioners. While this appears to be somewhat similar to the intake process as the wheel model describes, the problem was that practitioners were removed from the collaborative process with the physician in the center or top of the model. A “one-stop-shop” mentality was instilled when the facility was first being conceptualized, which implied that patients would be able to come in and choose from a variety of practitioners. Instead, practitioners saw the new model as restricting patient choice and reifying the medical model since the doctor now develops and decides upon treatment protocol. One practitioner explained, “Now they are treated like any patient at a medical clinic, they make an appointment, see a doctor, and the doctor decides what needs to be done for you.” CAM practitioners now felt as though they had to obtain

permission from the medical director regarding most matters. According to Greta, “We were always told that we had to go through his [medical director’s] approval -- from changing the sheets on the table, for talking to anybody that shared the room, and to whether a person was going to have a specific treatment” (Greta).

The Return of the Medical Model

I think a lot of the early providers were looking for something very different than what they found. (Sally)

With any new business or enterprise, direction tends to naturally shift and change from its original intent before it settles into a more permanent state. The facility was very much a work in progress during my time in the field, but these natural undulations were complicated by a sudden change in leadership and direction. A new structure was created with this change in leadership, and was experienced by those practitioners who chose to remain and also by the ones replacing the ones who had left.

I think we're in an early prototype kind of a model where most people are classically trained in their particular modality without being trained to become integrative or even know what that means. I think the next generation will be a little closer to that and probably the one after that will be a lot closer. (Sally)

During the time I interviewed practitioners, a new structure or direction was formulated that mimicked the medical model. In general, practitioners thought the new direction resembled the medical model and found it to be lacking communication, collaboration and integration. Part of the problem, from the perspective of the CAM practitioners, is that they perceived the new model to be without holistic influence. One practitioner indicated, “The whole foundation of that center goes against...what a holistic

center would be to me.” The foundation of the facility was not about sharing patients and dialoguing with others regarding patient care, but instead focused on the traditional medical model. As one practitioner explained,

...the agenda seems to be to develop a model which keeps the MD at the center of health care and keeps everyone else subservient to them. So, when they say integrative care, what they are meaning is they are going to try to integrate medicine into the same formula, the same formula that they have now, where at a hospital the respiratory therapist just gets a prescription for whatever the doctor thinks needs to be done. (Elliot)

CAM practitioners felt as though there were merely tools to be used at the doctor’s disposal. The structure was perceived to limit and restrict their vision and how integrative medicine was implemented. “...You go to the meetings and everything was about the [medical] director’s model...and trying to shoe horn integrative care into a medical model,” explained one practitioner. The new model introduced many barriers to integration, which will be discussed in an upcoming section. These barriers included issues around time, billing, and sharing patients among others.

One of the significant features of the new model is that it places the initial intake procedure back in the hands of the physician. Originally, the hour long intake originally was supposed to occur with the director, who would then relay the patient’s story to the team of CAM practitioners. After the practitioners provided their assessments, a summary would be provided to the patient to aid in the decision making processes related to treatment options. In the new model, the physician visits with the patient for roughly thirty minutes to review their history and to observe their systems. The session concludes with the physician introducing a small change, such as a dietary modification, and requests a follow-up visit with the patient to monitor progress. At subsequent follow-up

appointments the medical doctor may slowly prescribe other treatments or may refer to another practitioner. The main difference in this model is that the hour long intake is replaced by ongoing visits with the physician. One benefit of this model is that the physician cultivates a relationship with patients over time, but from the CAM practitioners' perspective, it perpetuates dependence on the physician and takes away power from the patient. Another benefit is that the physician is able to develop a treatment plan over an extended period of time to see how patients respond to various treatments. Some integrative medical facilities tend to overwhelm their patients by introducing too many changes at once without providing time to observe what is and working. In describing her main criticism of this model, one practitioner stated,

And, so once again you're just putting out fires and I just don't think you can truly get an understanding of where this person is coming from in those interrupted sessions. You can become more familiar with them as they come in, but I think to have the first underlying understanding where you can sort of try to put the puzzle together and see who can help them. And I think you really need that chunk of time up front to work through that, and just to kind of come up with a game plan because maybe it's going to be that their next visit is not supposed to be with the doctor.

Appearances

Due to the incongruity between the implemented model and the vision most CAM practitioners held regarding integration, many expressed that the facility was maintaining a phony appearance. As one CAM practitioner stated, "I believe that what they are stating on their sign is not what they are practicing" (Greta). Another added, "I don't like to be a harsh person but it just seems like to me it was almost a front to try to appeal to a

new niche of people who would be interested in integrative medicine -- almost a new marketing tactic” (Ladini). While the goal of the facility was to attract diverse patients, one practitioner remarked that,

...it's kind of like an upscale doctor's office. That's what tends to happen when they try to institute holistic healthcare -- and then it's like an elitist thing, which is part of the building notion that I came to not like. You know, here are these people and come see these people, which then separate these people from those people. (Ruby)

The main reason practitioners felt as though the facility was maintaining appearances was mostly due to differences in the definition of integrative care. From the interviews I conducted, most CAM practitioners shared Elliot's sentiments below.

They were defining integration simply as having people in the building together whether or not they were sharing ideas or communicating or collaborating on patient care, which that didn't happen. My definition of integration would be that it's a team of practitioners working for a common goal and communicating freely with no restrictions between them so that the patient's are getting the best possible care. And that was not at all discussed or encouraged, in fact it was discouraged. (Elliot)

The facility brochures and materials, on the other hand, define integrative medicine quite differently.

Integrative medicine incorporates the art and science of caring for the whole person: body, mind and spirit, to treat and prevent disease, empowering patients to create a condition of optimal health. The integrative approach enhances traditional medicine with additional resources including: alternative medical systems, mind-body interventions, biologically based therapies, manipulative and body-based therapies, and energy therapies. (document)

The point of contention most practitioners had was that the facility was not performing integrative medicine, but rather was engaging in an enhanced version of traditional medicine. These different approaches regarding integrative medicine created

ripples of discord and tension throughout all aspects of the case, and contributed to the belief that integration was not happening due to the disconnect between initial expectations and the reality of the new structure.

Lack of Integration

The impression most practitioners had was that integration was simply not occurring. In fact, many expressed dismay and frustration with the lack of integration and lack of voice in patient care and in daily operations. The influence of the medical model, the shoe horned version of integrative care, and the doctor poised at the top in hierarchical fashion all contributed to the belief that there was a lack of integration. One practitioner summarized all of this by saying,

...from most every aspect that you would think of integrative medicine to be, it did not happen in my viewpoint. I did not work with the medical practitioners, with them telling me what their assessment was of the patient and then now would you do this from your end in your expertise for this patient for their higher health on this particular condition. That did not take place. (Greta)

Patients also seemed to be confused about integrative care, too. In a meeting I observed, one of the CAM practitioners asked the medical director how to respond to a patient who wanted to know when her integrative experience would occur. Apparently, her patient had expected a more integrated or group exchange including other practitioners and other modalities. The medical director informed the practitioner to tell patients in the future that integration is a service the facility performs only if it is requested, but it is not something that occurs without such a request.

Disservice to Patients

Many practitioners indicated they felt they were actively deceiving and misleading the community when practicing integration in a manner inconsistent with their belief. The lack of overt strategies to integrate, coupled with a lack of collaboration and communication among practitioners, fueled the belief that practitioners were doing a disservice to patients. One practitioner shared, “But if in a center that is open to the public and claims to be able to do [integration], and then they bring in people who aren’t skilled and don’t have the knowledge and the caring behind it, then that public sees a perception that’s false.” Furthermore, practitioners explained that patients were confused and disappointed because they came to the facility expecting integration to represent a certain kind of care, but received something else. In describing how her conscience continued to bother her regarding the work she was doing at the facility, one practitioner stated,

And I just got to the point where I felt like I really couldn’t do there what I intended to do. And I felt like it was a disservice to the patients. And so, I was starting to feel guilty about saying we’re an integrative center when people are coming in and not getting what I think they should get and what I should be able to give them. It got to the point where it felt like it was almost a joke. (Ladini)

CAM practitioners believed that their patients were disappointed and confused about the kind of integrative care they received at the facility. The confusion is attributed to differences in how integration is defined explained one practitioner, “...how integrative medicine is define nationally even is very, very different from center to center. And I think that’s caused a lot of confusion when patients come in the door expecting one thing and receiving something very different.” Another added,

...people are starting to have a good idea about what integrative care is. There are things on TV, you know, there’s a lot more in the paper. So, their expectation is such.

And when they come in and they're force-fed supplements and rice and water diet or whatever, I think that they're disappointed. And then we're all disappointed too that it's not a blend. (Ladini)

Practitioners noted that as the facility became more focused on productivity with the medical director regulating patient flow, there was a perception that the facility was moving away from putting the patient first as originally intended. In explaining the lack of focus on patient care, one practitioner commented, "...just by the very structure and the way the center is set up and how the patient flow is, the patients have been taken out of the loop, they are not now part of the decision making process". (Elliot) Another added, "And so I think that there is just no plan in place to try to understand where the patient was coming from, and what their real needs were."

Group Healing Sessions

While most practitioners stated that integration did not occur on a daily basis, there was a monthly event that served as the main vehicle for integration. During these sessions, a patient's case was presented in front of a group of practitioners representing all modalities, including physicians, for consideration. After the patient's issues were described, each practitioner had a short amount of time to explain to the group how he or she would treat the patient. Most practitioners felt that this concept for integrating was an effective way to begin a dialogue with practitioners across various modalities.

[These] sessions in particular become a very good forum for taking one specific patient case with the patient there, and getting each practitioner to communicate how they would approach that person. I think that gives you a lot of insight into some of the differences, I guess between different practitioners, how they think, what their medical model is, and their belief system because some of them address things at a mind/body/spirit level, but from a different cultural perspective whether it's Chinese culture, whether it's acupuncture culture, whether it's chiropractic culture, you start to hear that. (Sally)

Part of the problem with using this approach is that modalities are not consistently represented because not all practitioners regularly attend these sessions. As one practitioner commented,

We have opportunities to do that [communicate across modality], but not everybody shows up, and part of it is because people are maintaining outside practices and things and so their hours when they are not at the center are booked elsewhere. So, communication would vastly improve if we could do that more often and if everyone was committed to be able to be there.

Another practitioner provided some insight as to why some practitioners might need to maintain private practices. She said,

I didn't make it to any of the other ones [sessions] because. I didn't give up my personal practice and that was an evening that I have always worked. And so I didn't switch my personal practice times around for more than I needed to accommodate the center because I was losing a lot of personal money. (Greta)

While most practitioners thought the concept behind these sessions was correct, many had doubts as to whether or not integration was occurring and implied that the sessions only promoted the appearance of integration. “I think the [group healing event], even though it might have been a bit staged I think that was sort of the right concept. The [medical director] made a big deal of making sure we all came in to see it, and now I feel like it was a big show,” explained one practitioner. Others expressed that the structure of the session was not what was described to them because the medical director would bring in a patient he had already treated.

[The medical director] will bring in a patient who he has seen and I've been to maybe a dozen of theses on call things. Every single one of these patients has seen [him] for a couple of months and these are patients who have responded to his dietary changes and things like that. So most people by the time they get there say that they felt 90% better than I was when I first came in. So it's not bringing patients in who truly need it, it's he's parading patients past all of us that he's already cured. (Elliot)

Elliot's comment again reflects the notion that the doctor is situated at the top of all decisions regarding patient care. In very few instances did practitioners report having an exchange of ideas about care with other practitioners. In fact, one practitioner added, "...other peoples' viewpoints weren't brought into the circle like it was expected." Because of the inability to share their opinions and expertise, CAM practitioners felt as though their voices were not included in the collaborative care of patients.

Lack of Voice

The lack of voice was a profound issue for many CAM practitioners. Several of the CAM practitioners interviewed had established successful patterns of communication with biomedical practitioners in their previously held positions, and had clearly expected to continue this pattern at this facility. CAM practitioners felt frustrated, disappointed and dismayed that their opinions regarding operations and patient care were not considered.

[I] think [senior leadership] maybe listened, but I don't know that anything was really taken into consideration that I said, because I talked a lot about different things that I saw like at [other centers]. Or different ways that I thought the center should be operated, and you know it's just pretty much yeah, okay whatever. So, I feel like I had absolutely no voice in anything that went on there as far as the director or anybody.
(Ladini)

In addition to feeling as though their suggestions went unheard in day-to-day operations, CAM practitioners stated that their knowledge and expertise went unrecognized. For example, in explaining her attempt to communicate with leadership regarding patient care, one practitioner explained, "When you would sit at a meeting for a

specific patient and say, that I really think that the anti-inflammatory, or the pain killer, the muscle relaxer, is inhibiting them or you know...then you were told, 'Why would you know anything about that?'"

In describing his expectations for having a voice, one practitioner related his experience at the facility to a book he was reading about successful businesses practices.

In it [the author] says that he spent his lifetime studying successful companies and he came up with seven habits of those who are really successful. But when he looks at the top echelon, you know the top 1% of the top 1%, there's something else that they all do. And that's the eighth habit, and the eighth habit is listening to everybody in the organization. Even the janitor's opinion is just as important as the guy on the 16th floor because everyone sees the business or organization from a different viewpoint, and every viewpoint is valid. That was the complete antithesis of what I experienced there. What I was told there was that my opinion didn't matter and wasn't wanted. (Elliot)

The sentiments expressed above suggest that some practitioners held holistic expectations for patterns of communication. The wheel model fostered the belief that practitioners should not only have equal roles in the process of integration, but should equal voice as well. Other practitioners stated that leadership directly impacted their ability to have a voice. One practitioner explained,

...and it was just about let's bring experts from all over these things so we can be shoulder to shoulder with everything. And I think that really got lost. As soon as you have one person, saying that they [leadership] know how to do things it makes everybody else shut up. If you know, then why am I here, you know? Why should I continue to grow and try to work harder and try to be authentic if that's not what this environment wants? (Ruby)

Inconsistent Status

Although CAM practitioners had hoped to be treated as equals, the manner in which they were brought into the facility produced some inconsistencies in terms of status. Due to the wide variety of practitioners employed by the facility, there is a great

deal of variation regarding employment status and classification. For example, some practitioners, such as chiropractors and acupuncturists, are similar to physicians in terms of status and pay since they receive a base salary and productivity bonuses. Massage therapists were initially brought in as contractors, but were later upgraded to hold salaried positions. In pointing out the problem hiring practitioners with differences in terms of status and pay, one practitioner commented,

...massage therapists who are hourly, are considered professional technical but they clock in and they clock out. And for them that looks a lot more like a medical assistant or a business assistant which is a staff position. And it feels I think a bit demeaning in comparison to having a base salary and all that. (Sally)

Other types of practitioners, such as yoga teachers for example, do not receive a salary and are paid by the number of classes they teach or by the number of students who enroll in their classes. When yoga teachers are not teaching they almost have volunteer status since they are expected to attend meetings, participate in the planning of materials and presentations, and promote the facility all on personal time.

The way a practitioner is classified in a system could determine whether or not a practitioner receives compensation for a patient who does not pay. Contract employees are different than salaried employees because contract employees will not receive any compensation if the patient refuses to pay for services. Salaried practitioners, on the other hand, still receive their wages. In explaining this discrepancy, one practitioner shared,

...Currently we have a contract massage therapist and an employed massage therapist. And a patient calls in and needs to be booked. Who, as a business person, are we more likely to book that patient with? We're already paying one for the time they're there. And the other one isn't paid if they don't see a patient. Because in trying to care for the business of things, it makes sense to make sure that the one that we're paying for is fully busy. (Sally)

Differences also exist in terms of the various titles practitioners hold at the facility based on their experience and level of education at the time of hire. When practitioners were hired at the university, they were assigned a faculty position based on their credentials. Most CAM practitioners, as explained by one practitioner, "...have never had a faculty appointment [and] are just very excited to say that they are faculty..." Other practitioners, who previously held more prestigious titles, were slightly disappointed with their newly assigned title.

Some of the practitioners...[were] at a very high level academic appointment [in other positions]. Coming to the United States because of his licensure differences didn't hit near the [same] status. And a lot of his colleagues came over from [abroad] and decided to go back through residency and get their M.D.'s are at a higher status in terms of their faculty appointment. I think for him it's a sense of shame that his faculty appointment is so much lower than what everybody else is. (Sally)

Although integrative facilities are starting to have more of a presence in the United States, they are still somewhat rare. Because CAM modalities are slowly starting to enter institutions, such as the university, human resource departments struggle with how to classify practitioners. Most university systems typically do not have titles or classifications appropriate for CAM practitioners. When massage therapists were initially hired, the university had very few in the system, and classified those entering the facility as a professional technical position. Some massage therapists, according to one practitioner, "had a real issue with this. The word 'technical' really stood out. For one, they already had a pay scale established for them that couldn't be adjusted."

CAM practitioners also experienced differences in terms of visibility. During a meeting, one practitioner commented that her modality was not represented the same way on the front page of the facility's website along with other practitioners. A quick visit to

the website confirmed this, and it was also observed that some practitioners could easily be contacted by persons navigating the website by immediately initiating an email. This was not consistent across all modalities. For example, if a visitor wanted to communicate with a certain practitioner who did not have an email link, the visitor first had to go through the facility's coordinator or medical director. There also appears to be inconsistencies in terms of the providers' online profiles. Some practitioners representing modalities such as acupuncture and chiropractic have their photos, work experience and contact information included on the site, while practitioners representing other modalities, such as yoga and massage, only have their names and titles referenced.

Inconsistencies such as these also contributed to practitioners' perception of inequality. Across the board, CAM practitioners saw differences in salary, status and benefits. In addition, some practitioners had access and means to engage in professional development, while others were not afforded these same opportunities. This issue will be explored in an upcoming section.

STRATEGIES FOR MERGING CULTURES

Using the best strategies for integration, as discussed in Chapter 2, as a lens to understand the experience of CAM practitioners, it is evident that the facility had no comprehensive strategy in place for integration, but did engage in some of these practices inconsistently. While the facility used many of the same strategies businesses use for merging cultures, the implementation of such strategies varied in terms of use and frequency. There were more strategies utilized in the first phase of operations when the wheel model was in place. As the facility adapted to its environment and reverted back

to the biomedical model, inconsistent strategies were used to promote the merging of two separate cultures. Overall, there is some evidence suggesting that the facility at times engaged in the four frames for successful integration -- culture, human resource, leadership, and education -- as described in the literature review.

Cultural Frame & Due Diligence

There were many instances demonstrating that the facility engaged in strategies to manage cultural differences between CAM and biomedical practitioners. Mainly, these strategies involved engaging in cultural due diligence, providing opportunities for socialization, and also articulating a vision for the new culture.

One of the best examples of cultural due diligence I witnessed before the facility opened in its permanent space was an anthropologically framed presentation given by a member of the university initiative. The topic of the presentation was how to deal with academia and was directed toward CAM educators and practitioners. The goal was to empower and to inspire CAM practitioners to be the bridge between the two cultures. The material in the presentation clearly acknowledged cultural differences between the incoming CAM staff and the existing biomedicine staff operating in an academic environment. Specifically, the presentation highlighted differences in terms of territory and space, language, environment, accoutrements and ethnocentric ideas and beliefs. The culture of CAM was characterized as having little oversight or accountability since most CAM practitioners typically worked in independent practices. The biomedical culture was described as an academic environment defined by formal training, licensure and

credentials. Additionally, biomedical culture at the university is shaped by bureaucracy, accountability, and research, and has the presence of students abound, which contributes to the feel of being in a learning environment.

Numerous strategies to adopt and to ensure successful integration were then outlined and described. Some of these strategies reminded CAM practitioners to be aware of their own ethnocentrism and fears, to avoid playing into stereotypes, and to find commonalities with biomedicine, such as high quality patient care. CAM practitioners were encouraged to fit into the biomedical and academic environment by dressing professionally, by preparing research bibliographies specific to their modality, and by learning to use the languages of the university and of medicine. Offering to mentor, teach and collaborate were recommended to CAM practitioners as a way to facilitate integration, and practitioners were also reminded to be open to the possibility of being mentored and taught by their biomedical counterparts. Lastly, practitioners were invited to participate and engage in educational and university events for networking purposes.

The intent of the presentation closely resembles the notion of cultural due diligence, where different cultures learn about their own biases in addition to learning some background information pertaining to the culture they are entering. While this presentation occurred right before the facility opened, it was never repeated as time progressed nor was there any mechanism put in place to facilitate these recommendations. It is also unknown as to whether or not biomedical staff received a similar presentation on the culture of CAM. Furthermore, after the facility experienced a

significant degree of practitioner turnover, incoming practitioners were not, to my knowledge, given the same presentation or any sort of formalized cultural awareness training. As one practitioner commented,

I don't know that there was ever a formal process for that. My understanding was before I got there they did some of those things with large provider groups. I don't know what that looked like. I haven't seen a formal process of that done short of different practitioners doing presentation about their or where they are coming from with certain patient cases...(Sally)

In the absence of awareness training, the facility made frequent attempts to educate practitioners regarding the various modalities used in house. One practitioner mentioned, "...one of the things that we've tried to do in some of the provider meetings is to have a little bit of a presentation on some of the different practitioners' modalities specifically." Informal presentations were used inconsistently to teach practitioners about the work their colleagues performed.

Articulating the new Culture

One of the best strategies identified for successful integration involves anticipating, articulating and expressing the essence of the new culture. As noted above, many practitioners mentioned that they had unmet expectations regarding integration, which maybe a consequence only for those who were brought in under the graduate student director. These practitioners not only had a clear understanding of their job duties and responsibilities, but they also held very specific ideas about working conditions. One possible explanation could be that this group of practitioners received more communication regarding the new culture. As leadership and direction changed, the mission appeared to be somewhat hidden, but towards the end of my time in the field,

it seemed as though a clearer vision was beginning to emerge. Practitioners implied that the new leadership was not expressly communicating his agenda, and this idea will be discussed in more detail in an upcoming section on leadership.

One practitioner, somewhat savvy to the integration process, knew of the importance of articulating the culture of the facility. In discussing the role leadership plays in the timing and setting the tone of the culture, she said, "...you do it [articulating vision] from the very beginning as best you can, but it has to have significant buy in from the top in order to make it happen. It has to also have some measurable way of knowing when it's not working for certain people." Throughout its early stages of conception and development, the facility attempted to clearly articulate the vision and culture, but the change in leadership contributed somewhat to this strategy being ineffective since there were inconsistent attempts made to express the new vision to practitioners.

Socialization

Formal and informal opportunities for socialization are other techniques used to promote successful integration, and there is some variability in terms of how this was experienced by practitioners across the case.

Most of the practitioners interviewed indicated that they regularly interacted with fellow practitioners both inside and outside of work. One practitioner related, "I met pretty frequently with people outside and just, or even if we had time while we were in the center" (Greta). Another provided, "...actually Avery [fellow colleague] and I are

going to meet for lunch in a couple of weeks. And Zubin and I, we've met for dinner with my husband and he's offered to help us pack when we move" (Ladini). Clearly, practitioners interact and socialize with fellow colleagues.

Another felt that more opportunities were needed for socialization.

...but in terms of team building it would be nice to do some things that were, like ice breaker kinds of things where you got to know the practitioner, not just from a clinical standpoint, but it's who they are, you know what kind of life they had outside of work and things like that. (Sally)

Other practitioners commented that attempts to create opportunities for socialization were modified by leadership to include an emphasis on marketing. One practitioner described an instance where practitioners had planned an event purely for the sake of bonding, but leadership orchestrated a significant change in the agenda. She said,

...there were a couple of others that thought, you know, all we do is hear one another complain all the time. We really need to try to get together on just a fun day. So, we had talked to them [leadership] in a meeting, about us having a picnic. And we were told that that couldn't happen, but if we wanted to come to the big [university] picnic thing that they would really like for us to be there, but that they wanted us in a capacity of being, selling the center to the other people who were there. (Greta)

Another practitioner related a similar experience when describing the possibility of hosting an in-house retreat for the practitioners to understand where they saw themselves fitting into the center.

I think it [retreat] was first scheduled for May and then [the medical director] decided to cancel it. He said it would be more useful if we could open it up to the public and we charge for it all. Or have his financial people, he has people who give him money for his cause or whatever, invite some of those people to it. He was sort of thinking along those lines, and Avery and I said, no, that's not what we wanted. It's something for us to bond...and not just be a show. (Ladini)

A retreat was eventually held some time later, but not all practitioners were invited to this event. While this also demonstrates inconsistencies in terms of status and benefits amongst practitioners, again the event seemed more professional rather than personal as most practitioners had hoped. One practitioner explained,

...so each person got about 15 minutes to do a power point presentation, this is what I do with patients, this the kind of patients I see, this is the kind of patient you should refer to me and that's how it was. So it wasn't a touchy feeling you know, I have three brothers and four sisters and I was born in such and such, none of the getting to know you kind of things that I think of in a retreat. (Sally)

Human Resource Frame

As mentioned previously in Chapter 2, human resource departments can facilitate integration in two main ways: by retaining key talent and by assigning a person to oversee integration efforts. In this case, a high degree of turnover occurred as leadership changed, and even after the medical director was in charge there was some ongoing fluctuation in terms of CAM and internal support staff. In reviewing my notes from various meetings, it appears the facility had on several occasions discussed their plans to hire additional practitioners. The facility explained that the practitioners who chose to leave were not fitting in as hoped and had unrealistic expectations for integration. CAM practitioners, on the other hand, felt that turnover was largely due to problems with leadership. Whatever its cause, the bottom line is that the facility did experience some initial turnover and it is unclear if they made any efforts to retain key personnel.

There was some variability related to leadership styles and whether or not there was a person assigned to oversee integration efforts. In the original wheel model, an administrative person was initially hired to coordinate and facilitate relations among

practitioners, but not to oversee integration efforts. Initially the director seems to have been the one responsible for supervising the integration efforts since part of her job duties were “...to develop and manage the integrative medicine model...and to facilitate and maintain collaboration among practitioners” (document). It is unclear as to how successful she was in this effort since she was not there for an extended period of time, she left right before the facility officially opened. We do know, however, that she was quite diligent in conveying and expressing the facility’s agenda since many practitioners later expressed that their expectations for integration were not met. After the change in leadership, the medical director attended to integration efforts for a while in addition to seeing patients. Three months later, a center coordinator was hired to assume administrative, management and marketing duties, but there is not strong evidence to suggest that the coordinator oversaw integration efforts. Since practitioners experienced a lack of integration, it could mean that there was no one assigned to monitor the progress of integration.

Leadership Frame

Leadership can facilitate the manner in which integration occurs and clear communication is a requirement for effective leadership. Practitioners consistently explained that communication was lacking and ineffective, and that the personality of the medical director interfered or hampered efforts to integrate. Many practitioners felt that the medical director was not open to learning from other modalities and that senior leadership lacked a strong presence at the facility.

Unclear Mission

One of the biggest obstacles practitioners repeatedly encountered was that leadership did not clearly convey the facility's mission, vision, agenda or how integration was to be implemented. As discussed in the introduction to this chapter, practitioners reported that they were unclear about the mission of the facility. One practitioner expressed that the mission was not immediately apparent to him, but as time progressed he managed to glean more about the direction of the facility.

Actually in the beginning I did not know much about it [the facility]. I'm thinking I understood it some, you know about the mission over there, but not, at the beginning. Actually I did not really think about it much. I just started working there. I saw my patients and went to the meetings and then I understood more, knew more. (Zubin)

When I inquired about how incoming practitioners were made aware of the mission and agenda of the facility, the responses I received gave the impression that there was no clear strategy in place for conveying expectations.

My impression was that they were bringing people in who had no idea that the center even had a mission, that they were just given jobs and told that they would be given patients and that there wasn't an overriding philosophy explained to them, as far as I know. (Elliot)

In addition, when prospective practitioners become employees, it appears that there is no formal orientation process in place to explain how integration occurs.

Then the first day, I'd never really met with Dr. Smith at all for any kind of orientation. I showed up my first day and Katrina was there and said, "Oh good, you're here! Your first patient is in room 1." So I didn't have any kind of guidance or orientation and I said, "So, I'm just going to see patients just like...? And she goes, "Well, didn't they go over that with you?" I said, "No." So I just went in and kind of stumbled around the first day and talked to him [medical director] a little bit more and he goes, "Well, come in the room with me and I'll show you how I do it." Then I said, "Well, when do we get together with the other providers or when do they come in?" He goes, "Well, if they need to be referred to somebody then we can refer them." (Ladini)

The facility eventually became aware of this disconnect with practitioners and their expectations. The center coordinator told me that when they now interview prospective employees they make a concerted effort to describe the mission and agenda to make sure the candidate is a good fit for the facility. Because the facility is also part of a university system, if a person is eventually hired he or she goes through a mandatory orientation process, which familiarizes candidates with the university system. Practitioners also reported that they learn about the agenda and mission through monthly meetings and informal discussion. As one practitioner explained, “We had meetings...so during the meetings and during presentations we learned about it [mission]. And of course at the facility the medical director and the facility coordinator talked about this again and again, so we learned this from them, too” (Zubin).

Leadership Style

A strong leader, according to one practitioner, should embody and model the characteristics they hope to see in their employees.

Honestly I think the leadership piece is important in that you have to have someone to look to, somebody that's protecting the push towards integration. To a larger extent, the mark of the leader who is going get that to happen is for that person to help the team become a team and work together as a team. Because ultimately integration has to be integrating with all the practitioners if that's how they want to practice (Sally)

Unfortunately, most practitioners did not share Sally’s sentiments about their leader. Quite often, practitioners described him as “misogynistic,” “maniacal,” “controlling” and “sociopathic”. Many expressed that the medical director was by and large disinterested in learning from his CAM counterparts and felt that he did not practice what they perceive to be integration. “I guess going back with Larry being our so-called

leader, I don't think he was a leader of integrative medicine, I think he was the Medical Director. I think he was very interested in productivity and making money and making a name for himself,” according to one practitioner (Ladini). Practitioners routinely stated that they believed the medical director was more focused on productivity than integration. Another practitioner added, “I think the strategy of the leadership was divide and conquer. If he could frighten everyone and badger them into not talking to each other and make all the communication go through him and then he could pick each one apart and kind of exert his power over the individuals” (Elliot).

Many practitioners at the facility did not recognize or could not identify the role that senior leadership played in the integrative initiative. Furthermore, most practitioners experienced very little contact and involvement with senior leadership. One practitioner commented, “The one piece that seems to be creating a barrier in that still is there are at times...Dr. Smith isn't around real often. She's coming to these month lunches and that's been of some benefit I think” (Sally).

Personality

From the perspective of the practitioners interviewed, the personality of the medical director clearly seemed to interfere with integration efforts. The general consensus was that the medical director was more interested in being in a position of power than in devising strategies for integration. One practitioner explained, “I don't think he really cares for there to be integration, if he wants to be top dog he doesn't want there to be integration because there can't be a top dog if everybody is really truly integrated. I think that would scare the pants off of him” (Ruby). Another added, “The

majority of the physicians who want to do this, get it. It's just that for some reason the [medical] director that they chose wants all of his feathers outward like a peacock, and that's all he wants to be seen. I think it's self-serving" (Greta).

Others were unhappy with leadership's style of interaction since they often described him as being "controlling" or "intimidating." "The only thing, knowing his personality and having worked with him for three years, he could not stand not being in a position where he did not have people to manipulate. This is fun for him. This is where he gets his kicks," commented one practitioner. Others mentioned that they felt as though he "played the part" of being holistic and team oriented. "He presents himself initially, to be the warm and fuzzy, and I really want to help the world mentality, but we both have experienced that this isn't necessarily," according to one practitioner. Another added, "This guy is about the most opposite from holistic that I have ever met in my life. It's just blows my mind that he's the [medical] director of this place." Because practitioners expected and had hoped to have voice in integration efforts, it seems that practitioners were also disappointed that leadership was not more holistically oriented. In fact, practitioners noticed that the medical director was largely uninterested in learning about other modalities, which contradicts one of the central tenets of holistic medicine.

Closed to Other Modalities

Because the medical director was poised in the center of the model, practitioners had the impression that he was self-sufficient and capable of attending to every patient's needs all by himself. Several noted that he rarely beckoned for the expertise of the CAM staff.

And, then I found the [medical] director never really talked about any of the other things other than his agenda. Of prescribing his regimen of supplements, and that was pretty much it. And if they weren't doing any better, well, you got to increase their fish oil or something. It was never a focus of well, maybe we need to have them see somebody else here. (Ladini)

Others felt that the director wanted to incorporate other practitioners, but only to use them to parrot his medical advice. The inability for practitioners to contribute to patient care fueled the belief in practitioners' minds that their skills and expertise were not valued.

We had two very qualified Ph.D. dieticians and they were told by the medical director that they were not supposed to tell the patients anything other than what the medical director had written down on his forms that he handed to patients. He had his own little nutritional instruction forms that he handed every patient repeating the same thing...and what the dieticians were told was that they're job was to explain his ideas to the patients, not theirs. (Elliot)

Some whole heartedly believed that the medical director should experience the various modalities the facility offered by scheduling sessions with various practitioners. Practitioners explained that it was important for the medical director to sample such services to increase his familiarity with treatment offerings to inform and shape his decisions regarding referrals.

...but they [massage therapists] always thought it was curious how he never even came back for a massage, even when they were interviewed. Anything, just to experience the massage that they were giving so that he could understand each of their techniques. Because it comes to a point where it's better to try to match the patient up with the massage therapist because you know that some people are not going to go for a real rigorous massage. They're going to need something more soothing, maybe along the line of Oriana...more energy kind of massage type things. And, so you know I tried to figure that out with each of the practitioners, they'd say he has no clue about any of our techniques. He's never been back for a massage. He's never asked anything along these lines. Just here to do massages. (Ladini)

Another practitioner commented that the medical director's lack of interest in other practitioners at the facility suggested that he questioned their skills and abilities.

And on more than one occasion we brought out [to the medical director], well, "Have you had a treatment by one of us? And, we were always told, "No." We were always told that he had a person that would come, even to his apartment and work on him, for a lot less money than what we were suggesting and that he would just fall asleep. So, what was he saying to us? So, what was he saying to us? We're not good enough for you to be worked on in here. (Greta)

Others observed the medical director's lack of interest in other ways. With the doctor at the top, practitioners felt the medical director also ignored them in meetings and presentations as well. One practitioner explained,

I don't think he [medical director] was very interested in having recognition for anybody else or really any kind of integrative medicine. He firmly believed that his supplement program is all that people really needed and I think that he brought in all the other practitioners just so that he could say that he was at an integrative center (Ladini).

Another added,

...that the first week we were open I came in on Monday and he had been in there over the weekend and in the waiting room, on all four walls of the waiting room, was some sort of plaque or award that he had received and nothing about the other 22 practitioners in the clinic, and that's the way it still is, there is nothing out there to let anybody know who's sitting in that waiting room that there is anybody practicing here except him. He's decided that any new patients have to flow through him, although he is giving some new patients now to the other MD's (Elliot).

Open to Other Modalities

While the medical director was perceived to be generally disinterested in practitioners and the modalities they represented, practitioners on the other hand, are extremely open to learning about and experiencing other modalities. Overall, most practitioners shared a strong desire to learn from others, had a history or pattern of learning from others, and engaged in experiential sessions with their colleagues.

Practitioners had the expectation, hope, and desire that they would be learning from other practitioners. “And so I felt like this was going to be the perfect opportunity for me to be who I am -- Practice medicine in a holistic setting, Integrative setting, where I could learn more from everybody,” shared one practitioner. This comment suggests that practitioners had expected to embrace and integrate their holistic ideals and ethics into the work that they did at the facility. The holistic concept expressing the notion that everyone is connected is embedded in the idea that everyone had something valuable to teach. Another offered, “I think everybody has something to contribute and that's why I think the nursing staff for me, was so valuable because they, they get different stories from the patient than what I get.”

Learning from others, as one practitioners explained, occurs only when practitioners are open to having their belief system challenged, and if openness is not present then practitioners are likely to resist learning something new. One therapist commented,

And so in order for people I think to get on the boat of change...And start sailing into some of those waters they're going to have to be completely open and honest and willing to accept...that what they have thought and know and hung their hat on their whole lives may not be real and may not be true, may not be the best. And until that happens...they're going to be staying in what they've known all along...(Sally)

Some practitioners revealed that they had already established patterns of learning from both CAM and biomedical practitioners in their previously held positions. Some worked directly on or with physicians in private practice. Others were consultants for biomedical agencies or created monthly round table discussion groups with practitioners spanning across various modalities.

The model I was coming in with is one that 12-13 years ago, a group of friends and I established a group... and we weren't quite sure how to make it work and we wanted

to set up some integrative clinics. We had several osteopaths, massage therapist, chiropractors, acupuncturists, all in this group of people. And to get to know each other we met one Friday night a month for a couple of years and we'd each bring cases with us that, you know, this is a patient that I've seen for a while and I can't quite get them right, this is the case, what do you think about it? And we'd have a round table discussion. It was very productive for me and I still refer to those people and they still refer to me even though we are not meeting anymore, we're still good friends after 12 years. That was the kind of environment I was expecting to find when I came down here, that we would be having meetings and sharing ideas. (Elliot)

Other practitioners demonstrated their willingness to learn about other modalities by scheduling sessions with other practitioners. One practitioner explained,

I actually have gone to chiropractic services at the center. I requested a treatment, because I like to experience other modalities even though I don't have any conditions warranting a treatment. And also they come to me like Dr. Ringo, Dr. Frieda, Dr. Gonzalez, they have come to me for treatment. (Zubin)

Self-directed learning

While practitioners were extremely open to learning from others, they frequently engaged in self-directed learning behaviors focusing on integration. In general, practitioners seem to be rather inquisitive and highly motivated to learn about integration on their own accord. It is hard to say whether or not these behaviors were encouraged as part of their formal training or was something that evolved by itself, since the practitioners I interviewed followed different routes when becoming CAM practitioners. Most practitioners engaged in self-directed learning to grow professionally or to prepare for sessions with patients.

One practitioner explained that learning in an ongoing fashion was her responsibility, "And so it was my charge, working on an integrative level to understand their [biomedical] lingo...To understand their dialect, so that then I could help them to help me integrate what I do with what they do." Others discussed shadowing fellow

practitioners and asking questions about their practices so they would be better informed to make referrals. Keeping abreast of current trends in the literature was another way practitioners engaged in learning. As one practitioner commented,

But I will say that in the last year especially, I do this medscape auto email as evidence studies come out that are new information. As they come out I get all the emails on all this stuff. And I'll have to say the percentage of information that's coming out on diet, yoga, chiropractors, acupuncture, supplements, all this stuff, the percentage of that stuff coming out is increasing. Just in the last month I've seen two articles on yoga. One of them talked about how it was as effective as physical therapy for back pain and then another one for headaches... (Ladini)

Researching patient conditions prior to an appointment is another learning strategy practitioners pursued. As explained by one therapist,

Now in terms of what I'm doing with patients when I'm referred patients and go and learn a little bit more about what they're dealing with, I'll do some research on it before the patient comes to me so I make sure I have a greater understanding of what their experience has been. I do that on my own. I don't know that that's encouraged, although if I had a patient referred to me and I went into the session completely unprepared I think that would impact my ability to get future referrals. (Sally)

Although practitioners clearly expressed the desire to learn from others, many felt this sort of behavior was not rewarded and sought to ways to engage with others that would not draw attention. This kind of *under the radar* collegiality will be discussed in an upcoming section describing the culture and conditions for those working at the facility.

Lack of Communication

Patterns of communication proved to be a disappointment since most practitioners had hoped to cultivate working relationships with colleagues and patients. In addition to the shattered perception that would influence daily operations and mechanisms for

integration, practitioners expressed that communication was one-way, from the top down. Communication was described as being difficult and inconsistent, which undoubtedly clouded the facility's shifting mission and agenda.

In terms of the direction of communication, most practitioners indicated that the medical director was not reluctant to develop initiatives from the top down. One practitioner provided, "...in the staff meetings it was pretty much all one direction. Everything was from the top down." Another added the communication is "one way. I mean here's a dictatorship. So I don't think as far as with the [medical] director and all of us -- it was one way -- nobody else really had any kind of say. If we tried to it was pretty much discounted or ignored." Another added,

...but I had fairly limited contact with them [colleagues] because by that time we had actually been told that the practitioners weren't allowed to talk to one another. We weren't supposed to be discussing clinic policy or anything about why we were there or what the role of the clinic was, that was considered treason. I wasn't supposed to talk to massage therapist and massage therapist weren't supposed to talk to the doctors. It was pretty weird. (Elliot)

At times, communication was described as being stressful, difficult, unclear, and inconsistent. As one practitioner explained, "I just feel like it was all kind of doomed from the start because communication wasn't there... but I don't think I was there at any particular time that they would give me any details about how it [integration] was done." Still other practitioners felt they did not properly understand the direction of the center or the how to get things done at the university, which in turn, made daily operations somewhat problematic. For example one practitioner discussed,

The communication was not an easy open forum from my perspective, so I to this day still don't understand, and I don't know if it was because they didn't know, or that they had censorship that they needed to do from the higher ups [at the university]. I really don't know what all the dynamics of it was, I just know that you just felt like there was unanswered questions and there was a hole in the system. (Greta)

Others hinted that the personality of the leadership sabotaged efforts to communicate.

I would say the real collapse in integration happened way before patient care was even an issue. I mean it happened administratively where, you know, Sara, as the office manager, the person she reported to was the [medical director] and he refused to even speak to her and so we weren't even able to communicate as the administration of the center. (Ruby)

Some discussed their attempts to communicate and interact with leadership about patient care. For example, one practitioner had hoped to dialogue with the medical director regarding a patient they shared who was placed on a special diet. She explained,

I'm not quite sure where that particular diet came from but from other diets that I have seen with that heading on it or with that purpose in mind, umm it didn't, it wasn't consistent. But that's probably with a lot of things, too so...And then what I also said was, "Well, could we sit down and talk so that you have a better of idea of what I can do for this condition?" Then that time there just wasn't the time to do it...but it didn't happen, time after time after time. (Greta)

Another talked about her attempt to use communication to quickly solve a problem, but felt frustrated that process became somewhat formalized. Issues like these might indicate that practitioners also had holistic expectations for structure and communication. Accustomed to working in small, informal organizations, practitioners generally serve as the receptionist, billing agent, etc., in addition to performing their services. The bureaucratic model changes this and makes simple procedures more complex and formal.

He has to put in a formal complaint to administrative people and this and that, it's like you couldn't just go to the front desk people and say something's not happening right today, we're not getting the billing form, you can't do simple communication with things like that. That was a serious problem if you communicated with anybody about a concern that you had with them or the way the office if operating. (Ladini)

For the most part, practitioners were informed of center developments in two major ways: email and routine meetings. One practitioner discussed the problem of using email and meetings to communicate with other practitioners,

...a lot of the communication, I try to keep everybody informed of what's going on, but because a lot of them aren't there at the same time that may be by email and for me that doesn't feel very personal. We also have some providers who don't like computers who really don't check their email very often. And they aren't part of the loop and they feel like they're not kept up, so we've got several layers of that, too. (Sally)

For those who do check their email regularly, some indicated that they did not receive important updates about the facility, and subsequently miss opportunities to participate, network and engage in other events or meetings.

Lack of Collaboration

Related to a lack of communication, CAM practitioners expressed that they did not exchange or share ideas as often as they had hoped, and for this reason there seemed to be a lack of collaboration occurring at the facility. One practitioner commented, “We don’t share our experiences too much. No, so... we probably need to emphasize this. You know, like after discussion of the case [at group healing sessions] we need to share everyone’s experience before they ask you questions. That would be good, but so far here we haven’t had this” (Zubin). Another explained how she had made attempts to collaborate with others but ceased doing so,

Initially we were told that, we all had to spend time with one another in practice. So, what I took that to mean was I was supposed to go talk to the chiropractors and the acupuncturists and the general practitioners and understand how they wanted to work. And the nutritionists, the yoga people and I tried to make an effort to do that with everyone and from the little group meetings that we had, I think that I was one of the only people that was able to accomplish the most amount. Then I started hearing that we weren't supposed to do that with anybody, you know, that we weren't supposed to do that. So, I didn't make the extra effort that I had been doing it. I

followed through with some of the times that I had already set aside that we were supposed to do that on personal time not on the center time. (Greta)

Others noted that the lack of communication and collaboration ultimately affected their patients' experience. This will be discussed more thoroughly in an upcoming section, but generally most practitioners felt as though patients were not benefiting from the diverse modalities the facility had to offer. One practitioner commented,

...and so the patients coming in didn't get a very broad exposure to different ideas and so within 6 or 9 months another 20 or different professionals kind of gave up and left because nothing was getting past the medical director. He was just handling things himself and not referring people. (Elliot)

Collegiality

Because practitioners did not feel they were allowed to communicate and collaborate, it would seem logical to assume that practitioners also suffered a lack of collegiality. Largely due to a top-down and intimidating approach to leadership, practitioners did not openly share that they enjoyed a high degree of collegiality. One practitioner stated, "...practitioners have been so isolated from one another except in very selective controlled venues." Another added, "Some people are very defensive in the group at times, some people are likely not to speak up, and some people won't speak up if certain people are in the meeting." Another talked about how there is animosity amongst the practitioners because some have retained their private practices while holding a position at the facility. She said,

There's also a bitter resentment. Some of the practitioners again have private practices, have seen some of the center's patients in their practices or have seen patients that they've got because of their relationship with the center in the practices. So, you've got a few people who are fully committed at the center and they don't see patients anywhere else. Looking across the table and if I refer these patients to so

and so, is it going to benefit the center? And there's a lack of trust there that everyone's in it for the benefit of the center and the patients, and not just in it to gain something for themselves outside of the center. (Sally)

Despite the efforts of leadership to quell practitioners' attempts to communicate and collaborate, practitioners found covert ways to interact with colleagues. As one practitioner pointed out, "We...despite his orders to the contrary, because we worked in proximity, have managed to develop relations. And there is some collaboration going on, just because it's going to happen, but it's not supported by the structure, so there is no collegiality." Another commented,

...I felt like anything that I had to do to try to bring any of the other practitioners into it, was completely done on my own. I felt like he didn't do anything to help us understand how it can be integrated...Or when we could have the other practitioners be involved or what not. I felt like he did absolutely nothing to promote it or encourage it or to educate any of us on it. (Ladini)

Even though most practitioners had issues with leadership, the group bonded as a result and they appeared to be a cohesive group that respected and supported one another. Since practitioners perceived there to be a lack of support for collaboration, many felt as though they had to engage in clandestine efforts to work with other colleagues.

...the communication was unfortunately how do we work around the administration and leadership and get the things done that we needed to do rather than discussing the issues we should have been discussing, which was how to improve patient care and stuff like that. Pretty much the discussions were venting about the state of affairs and we tried to figure out how to get things done despite the leadership. (Elliot)

The issues practitioners had with leadership forged a bond between them, which enabled them to be a cohesive group despite leadership's efforts to restrict communication. In general, most CAM practitioners highly respected and supported their colleagues.

Lack of support

Creating a supportive environment is yet another way leadership can cultivate the successful integration of two cultures. Practitioners stated that they received little support in terms of hiring support staff and mentioned that senior leadership was unsupportive resolving conflicts with the medical director. There also appeared to be inconsistencies related to the distribution and allocation of funds for professional development activities.

When joining the university many practitioners had the perception that they would be well supported in terms of supplies, resources and personnel. One practitioner commented, “Now, if you are in a setting like at [our university] you just assume, what I figured out is a lot of the practitioners who originally came on with the center assumed a tremendous amount of resource and money would just come their way and they could practice as the wanted.” With the medical director poised at the top, several said that supplies and resources were inequitably distributed between CAM and biomedical staff. As one practitioner shared,

Also, when we originally set this up there was money in the budget for a support staff for the chiropractors and the acupuncturist who would help us with therapies, do ultrasounds, paperwork, just support staff, like a medical assistant is to a medical center on the medical side. When we came to hiring those people, [the medical director] hired three medical assistants and nobody for our side. So we have three chiropractors and an acupuncturist functioning without an assistant and [he] had three assistants. (Elliot)

Additionally, there appeared to be some variation around amount of resources given to practitioners for professional development, which was by and large related to a practitioner’s title and position. For example, employed practitioners receive financial support for continuing education classes. One practitioner explained, “Yes, actually each

year I have \$1,200 hundred dollars to use for continuing education. So actually I can go outside and take whatever continuing education classes.” Contract workers and volunteers, on the other hand, are still required to attend professional development courses needed to maintain their licenses, but they are expected to with their own time and resources. Another added,

I'm a contract person. If I were employed I would have dollars set aside for continuing education, CEU's and encouragement to do that. I have to do that to maintain my licensure but it's on my own, so encouragement to me would be helping to support it by giving me time to do it and funding to do it. So as a contract person I don't have that. (Sally)

The practice of distributing resources for professional development to some but not all practitioners within the facility nonetheless establishes a hierarchy among CAM practitioners. For those who were brought in under the wheel model, this practice clearly undermines the ability to maintain equality among practitioners.

Some practitioners mentioned that senior leadership routinely did not follow through with issues practitioners raised. Related to a lack of voice practitioners experienced as mentioned earlier, one practitioner described an instance where he had complained to senior leadership about the medical director’s reputation and inappropriate behavior. He explained, “I’ve been very open with all this stuff. Her response was to me, ‘Well, you can go to assertiveness classes to better learn how to deal with him because we can’t change him.’” Clearly, this practitioner experienced a lack of support since he was essentially told to deal with the problem, and in the end had no resolution to the issue he raised. Situations such as these left CAM practitioners with the impression that senior leadership was inattentive and apathetic about their issues.

Education Frame

Educational efforts have been known to promote successful mergers and integration. Education, in this case, not only refers to cultural due diligence presentations and the integration sessions the facility engaged in as mentioned above, but it also refers to whether or not an organization has learned through its experience integrating. While there was not much evidence to suggest that the facility engaged in additional educational efforts other than what has already been described, it has been noted that the facility did learn to be more assertive with its vision and mission during interviews with prospective employees. Because the facility was also in a period of growth and transition during the time I conducted my field work, it seemed as though they took a significant period of time to regroup and reflect after changes in leadership occurred. During this period, the facility created a new business plan, which undoubtedly contains the blueprint for its future. The facility learned how to network more within the university and also how to use a productivity model to motivate practitioners.

Working Conditions

The topic of working conditions experienced by CAM practitioners arose quite frequently during interviews. Given that the facility strives for optimal health and care for its patients, it is surprising that so many practitioners communicated that there was an unhealthy culture permeating the facility. It appeared that many expected a more balanced and relaxed working environment on par with holistic values. The culture of the facility was influenced by fear related to management styles and interactions with the medical director.

Practitioners working at an integrative facility expected a peaceful environment shaped by the holistic values they embrace. As one practitioner related,

...it wasn't a healing environment. That was I think maybe the most striking thing to me was that I was expecting a high level of integrity, intelligence, healing and compassion and what I experienced was exactly the opposite. It was no compassion, no healing... (Elliot)

Ironically, practitioners observed that they did not experience optimal health while working at the integrative facility. One practitioner commented, "I really became physically ill and I became emotionally confused in the time that I was there." Others noticed that they had experienced extreme weight gain or loss. For example, one practitioner explained,

It's an oppressive kind of system. I wasn't very healthy when I was in that system and I've been telling people lately that I gained 20 pounds and I've found my boundary, just sort of because there was such a disconnect between what I believed and then what was actually going on. (Ruby)

Many expressed that leadership was modeling an unhealthy approach to work. Practitioners shared that they often received emails around the clock from the medical director, who often reminded practitioners that he had three full time jobs. Some practitioners followed the medical director's lead and worked incessantly, and the effects of such behaviors were obvious to fellow practitioners. In describing a colleague who worked long hours, one therapist observed that she was functioning,

...Like a chicken with her head cut off, not taking good health. Maybe that's her life style, but I constantly saw her become more and more, and so, she was just this perky sweet little thing. [When I saw her last]...I just see her looking tired. I hate to used haggard because that's such a strong term...But the times that I saw her she was a hugging a Starbucks. She over and over exclaimed how she hadn't eaten and she was on a liquid diet basically. (Greta)

Others described an uncaring environment, which was related to how leadership managed and addressed practitioners. In explaining this culture of fear one practitioner shared,

...you could feel his presence in the building I think before you even saw him and everybody felt restricted I think. Everybody's personal energy would be off, just you know, auras were off, and I think that people didn't interact nearly as well. They were afraid to be seen talking with each other because they didn't want him to think that you were in cahoots about something when actually, you know, you were just talking about a patient. (Ladini)

Patterns of verbal and psychological abuse were experienced by many practitioners. Some explained that leadership frequently engaged in demeaning exchanges with colleagues and staff members. In relating this pattern of abuse one practitioner said,

If anyone made a suggestion, very frequently the director would single them out and belittle them in front of everyone else, make fun of them and later in private would approach them and tell them don't ever say anything like that again. And so, the communication was, we were supposed to only take what we were told and do it. And we were really discouraged to communicate between the practitioners. They did not want anything like that going on at all and then we were told outright not to do it. (Elliot)

Additionally, management decisions were consistent with patterns of inappropriate behavior. One practitioner who maintained a relatively busy practice told me about her resignation experience. Being courteous, she gave the facility two weeks notice. When she returned the following day after making the announcement, fellow practitioners informed her that she had been removed from the website and that her schedule had been cleared.

Then I walked up to the front and I said, "Could you tell me what my schedule is for the next time I'm supposed to be here?" Without any hesitation, the gal said, "I'm pretty sure you don't have anybody." That was a huge red flag, and she said, "But let me look." She looked and then she goes, "Nope, you don't have anybody." I went, well; let's play this game this way. "I'll clean my room out now,"...And I'd

been there maybe an hour and a half... “I’ll clean my room out now, and if there are any patients that need to see me, I will fulfill my obligation. But we’ll just pretend that I’m not here and you can make sure that if there is anybody next week -- but I’m kind of guessing there isn’t” -- and I said, “ Actually why don’t you just look that up for me.” She did and there was no one. Now, I had been booked out, so that was a real...passive aggressive management decision. And it was a horrible, horrible thing to do to the patients because you could see progress being made (Greta)

The excitement practitioners originally had for the center was gradually replaced by sadness. As one practitioner explained,

I think we began to recognize after a few months that this just wasn't going to be what we had hoped it would be and people started bailing, actually the day the clinic opened people started quitting, even before that. I think it was just, I don't know, just very sad; it was the ending of a dream. (Elliot)

The dream of working in a harmonious, integrative environment was replaced by the reality of working in a culture shaped largely by fear and intimidation. Although practitioners established their own methods of communicating clandestinely, these practices were not enough to sustain them. As a result many resigned, some became complacent, and others chose to remain in order to act as an advocate on behalf of their modality. For those who have remained, there are a number of emerging issues that affect how integration is implemented and these will now be discussed below.

BARRIERS TO INTEGRATION

In conversations with CAM practitioners, it became apparent that there were a number of barriers restricting the integration process. This section identifies and describes the challenges and barriers practitioners frequently encountered and will be useful for future organizations contemplating the integration of CAM and biomedicine.

Access to patients

Uniformly, practitioners commented that the structure of the facility restricted their access to patient flow. For a period of time, practitioners were told that all patients first needed to schedule an appointment with a physician at the center prior to seeing any other practitioner. In explaining the rationale for this decision one practitioner said, “...the other thing is the way it was structured where they really wanted a doctor to get in there first so they could get the billing into the insurance company going. Instead of having some kind of group encounter because they didn’t know how to bill it out.”

As a result, both patients and practitioners were disconnected from the integrative experience as a greater reliance on physicians was building. Patients had a difficult time scheduling with direct access providers. One therapist commented,

I’ll tell you when I really started really, really drawing back to watch it was brought to me by more than one of my patients asking me why it took them so much effort to get to me...they were told they had to do this diet for X amount of weeks before they were going to get a referral. I only saw that coming out of one of the physicians. (Greta)

Financial Focus

The emphasis on financial matters instead of patient care was another obstacle for integration. While focusing on financial viability is certainly necessary for the overall success of any business, many practitioners expressed that money matters were accentuated more than patient care. One practitioner shared, “What they wanted me to do was basically just shut-up, we don’t want to hear what you have to say, just make money for the clinic, that’s really what we want you to do.” Echoing similar sentiments another added, “I think all he [medical director] wanted was get them in for that massage and get

them out. I think that I saw that and I don't know that I recall that he's ever said that...but I think that he's implied that...And he just wants people to just do your job, do the massage and get them out."

When prompted to explain why they thought biomedicine wanted to integrate with CAM, one explained, "Because they see the money. They're following their tail."

In elaborating this idea another practitioner articulated,

And he [medical director] just really wants business and business to be business and he doesn't want any of the fluff, or whatever...He's just wants to be a money maker...A good title -- integrative care -- get people in there and just make some money...And just get people in there, do their massages...do this and that and get them out the door so you can get the next person in. I think that because of the people that [the director] had talked with they did have a different expectation and he just wants to bring people in and set their expectations right the way he wants them to be. (Ladini)

The above quote affirms the disconnect between values and expectations. It also suggests that there may be another disconnect with the practitioners' and director's motivation for joining the facility. Many CAM practitioners expressed that they believed the integrative process would be a way to advance their particular modality and while they were not uninterested in making money, their priority was to advance their modality in an academic sense. In explaining why two of her colleagues remained at the facility despite their frustration with direction, one practitioner commented,

Really, they are there really because of their craft...Because they want to bring light to it, and they feel like by being involved with the University it's bringing it to light more, more people are seeing it. So, I think it's more of a mission for their practice other than it's something that they enjoy doing, being there.

University Setting

It has already been noted that inconsistencies in terms of status, titles and benefits arise when CAM practitioners enter a university setting, but the setting itself was also found to create both barriers and opportunities for integration.

Being in an academic environment creates one distinct benefit – educational opportunities for the university and its' student. The facility does provide education and training to the nearby medical school and it has graciously opened its doors to a number of volunteers. One practitioner elaborated this idea by stating,

...the students who are benefiting from us being there are med students, traditional medical students. The medical students are benefiting and we're starting to bring in, and we have CAM students, like Dr. Richardson right now has an exercise physiology student who is interested in CAM who is following her... (Sally)

From the facility's perspective, the university environment has been criticized for being generally unsupportive. Others noted that the university was unaware of the services offered at the facility. Practitioners also honed in on the fact that the facility did not have the interdisciplinary approach as was described by the university initiative. One practitioner commented,

And I don't think the University has supported this center one bit...I mean was talking with a high ranking official at the hospital -- somebody very, very, very high up, about as high as you can get. And, so I ran into this person, but they didn't ever know the center existed. And because of their status they should have known about the facility. And they're like, you know, is that place still over there? I heard you say you started over there and I haven't heard a single thing, So, the medical community at the University is basically unaware of us over there...And I think that there's been no effort to try to work with any of the departments in the University so that they can better understand how we can fit in with the University. (Ladini)

Augmenting this idea, another explained that competition, resentment and redundancy exist between various agencies within the university. She explained that another medical facility had frivolously spent money on chocolates to share with its employees for a holiday. She commented,

Do you know how much money they spent on that? That money didn't bring many more patients at all. That kind of money at a little center like [ours]... could have done a world of good in terms of growth. You look at that kind of thing, and you see the resentment, and then we have to struggle and say why we're not breaking even. Part of it, you end up getting in fighting even amongst university centers. You get silos, which is a big, big barrier in the [university setting].

This same practitioner describes the effects of bureaucracy and redundancy at the university level. Apparently, another university agency offers the some of the identical services as the facility, and, as a result does not refer patients for these services because they can offer them in-house. Competition, then, naturally occurs within the university setting, and those who are more holistically oriented are frustrated by this lack of cooperation.

[Another university agency]... is offering some of their massage therapy now. They're not making referrals to us for massage therapy, even though it would make sense in a whole system. If you we're looking at the overall health of [the university system] you would say it would make sense to utilize the resources that are already there rather than develop your own and have neither do particularly well... There's no way they can be making money doing that, yet they're offering it because as a comprehensive...center it makes them look more comprehensive and more holistic...[instead of] making the referral to us and saying we're all part of the same team. This is still making them more comprehensive, more holistic, and you know what, it's making them more of a team player because all of sudden they are utilizing other departments at [the university] and everyone is doing better... They don't look at it that way. They look at from a silo mentality. (Sally)

The university setting is also seen as a restrictive environment with many layers of rules and regulations that ultimately effects integration.

...I don't see everybody stepping forward and making the same commitment to the model becoming more integrative. I think the other piece of that is, even the

leadership from Dr. Smith on down, live in the same restrictive kind of environment in the University that says well we have to live within these parameters because we're are in the University and there is no way we can get around it so people get the sense of apathy out of that from the leadership on down. (Sally)

One practitioner was so overwhelmed by the bureaucracy she hired her own billing specialist to help her understand the billing process. In explaining why she hired the consultant, she stated that,

...I don't have the time to go through the stacks of papers that they sent on how to bill. I don't have that time and even if I did have that time -- I don't care. All I asked for was a quick reference sheet. Give me a sample form so that I can go, Oh well, slot one needs to have this in it. Slot two...Make me a trained monkey because this isn't what I do. (Greta)

Insurance & Managed Care

CAM treatments are generally out-of-pocket expenses for patients, but insurance agencies are starting to cover more CAM services. While practitioners are excited about the change, they remarked that their unfamiliarity with insurance and managed care is an obstacle for getting reimbursement for services. Because many patients typically have paid their provider out-of-pocket in the past, practitioners often do not know how to work the complicated system of managed care.

It can be a barrier to those who don't know how to work the system. Managed care is interesting. There are different companies; they all have different policies and different ways of being. And if you are a CAM practitioner and you are unfamiliar with how to deal with insurance, the in and outs then can be a huge barrier because you don't know how to put the thing in a chart that is needed in order to get it covered. (Sally)

Practitioners are initially excited about the prospect of insurance picking up some of the cost of their treatment, but are clearly not as adept at working the system as their biomedical counterparts. In elaborating this idea one practitioner stated,

Yet, when they get down to it...they then have to do a pre-cert which they didn't have to do before and they have to document to a degree that they've never done before. Then all of sudden if there's a denial, then they have to appeal it and they don't know how to do that. And they don't understand why they can't just go by the diagnosis that's not covered. Or when they got someone in for massage they can't do a 1/2 hour of energy work and a 1/2 hours of massage and have the whole thing covered as a massage because that's fraudulent. So, ultimately it changes the way you practice. So, it's a barrier for a CAM practitioner...

Another noted how insurance altered the way practitioners performed their duties.

She said,

People come in they'd be complaining of three different things that Lou [practitioner] really wanted to treat simultaneously... but he wasn't allowed to because some peoples insurance has barriers where you can only treat one problem per visit. I think the business of healthcare is one of the hugest problems, but I don't have any idea how you go about changing the bureaucracy of pharmaceutical companies and medical corporations. (Ruby)

Productivity

In order to be financially viable, the facility became highly focused on provider productivity. A strategy was devised to generate revenue for the facility, which centered on making providers even more productive. The productivity model nonetheless affected the manner in which patient visits, and ultimately integration, were implemented.

Because there was now pressure to see more and more patients, providers had less and less time to practice their modality in an integrative fashion. One practitioner commented,

They, last summer, came out with this productivity model where you had to reach a certain percentage of this and that...And if you were not getting it you were going to suffer severe, severe pay cuts...I mean unreasonable pay cuts. There is no way you can do the intake that I was originally wanting to do. And even though I was doing it in a 1/2 hour...There is just no way you can do that with that model. (Ladini)

Managed care and the productivity model provided the justification for reshaping how patients were seen at the facility. Ongoing visits with physicians are the backbone of the model, which replaced the lengthy intake process as described earlier. The focus on productivity contributed to the perception that there was too much of an emphasis placed on profit and not enough attention directed towards patient care. Since practitioners have limits to the amount of time they can spend with their patients, the productivity model makes the business of treating patients somewhat mechanical, which takes away some practitioners' ability to be in the present. Practitioners, then, move to the rhythm of the clockwork established by managed care, not the needs of the patient. The model is therefore more profit driven than healing oriented.

Another problem with the productivity model is that it perpetuates patient dependency on the physician or provider. The foundations of holistic care emphasize patient empowerment, wellness and education, and return visits to the physician undermine these values.

The way a practitioner is paid can affect how a patient receives treatment. One practitioner explained,

So, it goes down to who is paying the provider, not just who is paying for the service, but how that provider is funded. If they work for a company and they get a salary, and it's not depending on productivity, they may treat the patient very differently than if they are funding themselves and if they don't see X number of patients a day. Their business fails. They may treat the patient differently. So, when you bring in, when you are looking for a lot of productivity out of a provider to bring them in at a flat salary -- It doesn't make any sense -- Because there is no incentive to be more productive, to add on that extra patient at the end of the day to work an extra hour. (Sally)

Productivity then, became the lens to understand other activities. For example, one practitioner explained how time set aside for educational purposes could be considered unproductive.

...part of the reasons they [practitioners] were wanting to be a part of the center is because they want to participate in these things [educational outreach]. If they were being paid for that time it would be different, than if it's on their own time. Or on their clinic time, in which case their productivity hits a loss and they lose money because they can't make their bonus -- because of the way their paid. So, the way they are paid makes a difference in how they view their time doing these other things. (Sally)

Lack of knowledge about CAM

Many practitioners expressed frustration that a physician was in charge of overseeing daily operations largely because they have the perception that medical doctors have limited knowledge about CAM modalities. In fact, for those familiar with the wheel model, practitioners were explicitly told that no solitary provider can be an expert in wellness. As one stated, “No one person, I don’t care if they’re an M.D., chiropractor or a psychic, no one knows everything about everybody else’s field.” Because there are philosophical, cultural, scientific differences across modalities, it is difficult, or close to impossible for one person to have a detailed understanding not only how such practices work, but how they interface. Some expressed that physicians receive too little information about CAM, and others commented that the medical schools do not adequately prepare physicians about CAM.

Practitioners noted that some physicians use their credentials to become practitioners of CAM. One practitioner took this idea a step further and implied physicians use their credentials to control CAM modalities even though they lack

sufficient training. He stated, "...they are trying to find a way even though they're MD's to make themselves look like the experts of alternative medicine. They go to a two week course and now they're certified in alternative medicine."

Another practitioner familiar with the curriculum at medical schools remarked that professors are generally still unfamiliar with how to respond to CAM related questions, even though medical schools now offer survey courses on CAM. Apparently, when students ask detailed questions about CAM, instructors typically respond by stating that there is insufficient evidence to recommend such practices, according to one practitioner. Medical training, she suggests, teaches students to be closed to other modalities. She stated,

Whenever it came to anything as far as supplements or herbs if that question comes up you just say, "Well, there's not even information out there about that to really give you a good answer. I would just avoid it." So, that's pretty much the can answer that I think most traditional people are given...That's, I think, a real problem. I think that's where a lot of the problem stems because you've never been challenged to possibly look into it. It's always there's just not enough information -- just don't bother with it because you just don't know. (Ladini)

Yet another practitioner explained that physicians are reluctant to ask patients questions about what kind of CAM treatments they receive because most doctors do not know what to do with such information. In explaining this idea one practitioner commented,

They're [patients] saying, "Oh yeah, I'm taking horse chestnut and this, that and the other and I'm taking black cohosh". And the physician is like, "Well, I don't know what this is." They don't want to ask a question that makes them look ignorant...So they don't ask the question which makes them ignorant. They don't want to look ignorant, but they want to stay ignorant.

This practitioner explained that this is also a problem for CAM practitioners. From time to time, CAM practitioners receive information from patients regarding

specific medicines they are taking. Typically, most CAM practitioners do not study pharmaceuticals as part of their training, so they lack knowledge about medication and similarly, they too lack an understanding how such medications could interfere with the treatments they recommend.

A number of programs have been developed to train physicians how to become practitioners in certain fields, such as acupuncture for example. CAM practitioners perceive such programs to be easy routes into disciplines that traditionally require many years of training. Acupuncture programs in China for example are usually eight years long and the curriculum generally requires students to take many courses in Western medicine. So, practitioners coming out of such programs have an excellent understanding of both eastern and western approaches to healing. The training programs for the physicians in the U.S. are very brief in comparison and only teach the application, not the theory behind acupuncture. There is a sense among CAM practitioners that programs such as these can dilute or create misunderstandings about their modality. One practitioner raised questions regarding the quality and intent behind learning a modality quickly. She stated,

When someone is absolutely devoted to Reiki and has gone through extensive amount of experience, versus somebody who is licensed to do a medical modality and learns Reiki in a weekend. Is there a difference in quality? Is there a difference in intent? Is there a difference in the ability of that person to, you know, in their day to day nursing, stop, do a Reiki session, oops, go back to your nursing. Or somebody who's living it.

Practitioners both praise and condemn such programs. In explaining why programs dilute the practice of acupuncture, one practitioner commented,

Like the UCLA program, most of the time they just listen to tapes and watch movies. And that's it. Then have one week or two weeks -- I don't know exactly, for practice and for direct contact -- it's too short. Yeah, that's not enough at all. So, they don't know really how to use the theory to guide a clinic practice...

Passive learning is not preferred for a discipline that requires a high degree of interaction between practitioner and client. Such programs, in addition, tend to gloss over Eastern theories and conceptions of the body, which influence the type of treatment a patient receives. The same practitioner continued, "They just use the acupuncture points, like medication, you have a headache? Oh, this point is good for treating headache."

While some practitioners feel bittersweet about such programs, they understand the programs serve another purpose: to make progress towards gaining acceptance into the culture of medicine. Training programs give medical doctors exposure to modalities like acupuncture, which increases the likelihood that physicians might start recommending acupuncture as a treatment option for patients. But for all of the reasons described above, practitioners feel that such trainings are too superficial. One practitioner explained that such steps are a natural part of medical evolution.

...are we naturally combining things that will eventually emerge a more effective medical system that easily navigates between all of these different things...Ties them together in a whole new way that will become more effective than traditional medicine alone...It will, this will not be unusual anymore. They won't call it integrative medicine. (Sally)

Fear

While practitioners described a palpable sense of fear when talking about their working conditions, fear was also identified as something that restricts integration. Fear

was thought to affect integration in four ways. First, some simply feared the changes integration would bring to their modality. Second, some practitioners worried that the medical board might scrutinize their practice once they became associated with the integrative medical facility. Third, practitioners were reluctant to share and refer patients for fear that they might not return. Fourth, other practitioners were afraid they could lose their job if they were not being productive in the eyes of management.

The prospect of integrating represents a fear towards change for some practitioners, and inhibits the amount of learning that occurs across modalities. In explaining how integration challenges practitioner identity one therapist stated,

What people are afraid of, I think on both sides is probably going to differ pretty significantly. I mean, is it a fear of new things? No, not necessarily. Is it fear of being told that you've been wrong all of these years? Or, that what you've been believing in, people have a hard time letting go of the things that have sustained them or the things that have given them a sense of self, the things that have built somewhat of an ego. Not in a bad way, but an ego sense of that's the sense of who you are. So, if all of a sudden after you've been practicing after 30 years you look back and you say you what, how many lives I could have done better with and how people. My god! I was prescribing this medication and it killed people... (Sally)

In addition to the fear of change, some practitioners were also afraid that their credentials and the way they chose to practice would somehow be challenged by the medical board. One practitioner commented,

Everybody had to just a really strong fear based impulse to a lot of things, you know practitioners worried that they were going to get hit by the medical board...I got so many phone calls of people asking me, "Am I going to get slammed by the medical board for doing Reike and for not being a massage therapist?" (Ruby)

Others, attuned to the tension and discord between CAM and biomedicine, commented that some practitioners were reluctant to interact with CAM practitioners for fear of damaging their reputation. One practitioner mentioned, there's "...also a fear of

what their other professionals would think about them that if they started accepting referrals from alternative practitioners. They would be diminished in the eyes of their peers and lose business.”

Another practitioner discussed how fear impacts biomedical practitioners’ ability to share patients. She explained,

...their fear is one, they’re going to send you a patient and the patient will never go back to them because you are going to give them all this weird stuff. Or I think down deep the fear might be you get the patient better when they couldn’t. Or the fear is that they will be implicated if they send them to you and you do something to screw up the patient and they’re the ones that referred them to you. (Sally)

Related to the fear of referrals, practitioners are sometimes afraid to refer patients to other modalities since reimbursement coverage varies. Practitioners are afraid to refer patients to other CAM practitioners because they could somehow be competing for insurance reimbursement. One therapist explains below,

...[a practitioner] at one point had mentioned a health plan that covers chiropractic for [the university] and the same benefit pool that also covers acupuncture -- so a total of 30 visits of either or, or a combination of both. And when that rolled out a year and a half ago, she had made the comment that she was never going to refer any of her [university] health plan patients to acupuncture because she didn't want to lose visits that she could use...People are afraid to refer their patients to the integrative center because they are afraid that they won't get the patient back. (Sally)

Lastly, some practitioners feared they would lose their job if they were not meeting the expectations set forth by the productivity model. For this reason, the productivity model most likely contributes to the culture of fear described in a previous section. One practitioner mentioned,

When [the accountant] would come into those meetings and do the financials, we could feel the anxiety level go up. Some people are busy and some people aren't as busy as they'd like to be, and the way people are paid...There's a sense of fear, if the patient base doesn't increase in certain areas then people are going to lose jobs. So

they saw [the accountant] as being the enforcer and the one whose just looking at the dollars, and people get scared that if they don't get enough patients they are going to be gone...(Sally)

Time with patients

When CAM practitioners perform services in their home or private practice, they have the luxury and the flexibility to spend as much time as they desire with their patients. When working in an integrative environment, however, due to managed care and the productivity model, practitioners have less time to spend with patients. In describing this problem one practitioner said,

...they kept cutting my time shorter and shorter and shorter to see patients and kept trying to shoehorn me into this productivity model...And it was just going to get worse and worse. I had less time to deal with the other things because I had to get my billing in and if I didn't have the billing that I needed for my encounter, then I'd get in trouble for it. (Ladini)

Another practitioner explains how she treats patients differently when there are no time restrictions. She revealed,

...then I think that actual hands-on work that I do, I realized how much I enjoy that because I really wasn't doing a lot of that at [the university]. I was, but it was like 45 minutes sessions, you know, get them out in an hour. And my mindset was a lot more towards, okay what can I do in the next 45 minutes as opposed to okay here's this person in front of me, I don't have anybody coming in until this time. Lets see how I can help them...(Ruby)

While CAM practitioners clearly desire the flexibility to have sufficient time with patients, the harsh reality of working in an integrative facility is that practitioners are now accountable for their time. There have been a number of CAM centers that have opened their doors only to shut them shortly thereafter because they had not found a sustainable method to support integrative care. The facility in this study saw security and stability in the productivity model as a method for ensuring its long-term survival. In explaining the

time issue, one practitioner mentioned that both CAM and biomedical practitioners both need to sacrifice some part of their practice or ideals for the sake of integration.

She stated,

...traditional physicians will tell you, I would love to spend an hour with a patient. My god, I get five-ten minutes and I have to run boom, boom, boom -- I never feel like I get to know my patients. And CAM practitioners can't even imagine trying to see patients that quickly. Yet in order to be financially viable.... in that setting...unless you can pick up the pace or raise your prices to the point where you won't have any patients because no one can afford it. There has to be middle...There has to be a give on both sides. I haven't seen too many examples of that. (Sally)

Referrals

One of the biggest obstacles CAM practitioners identified was the referral process. Patients could directly call and request certain services, like massage or chiropractic care for example, but state law requires that patients obtain a referral from a physician before visiting an acupuncturist. Even though some modalities do not require referrals, practitioners expected referrals from physicians as a result of being in an integrative environment. Many practitioners reported they were dissatisfied and frustrated with the infrequent referrals they received from their biomedical counterparts.

One therapist explained that the lack of referrals created different work loads for practitioners within the same modality.

...in just my area alone it shifted because there were certain people who were getting appointments set, and there were other people who weren't. So, some of us would be working and others of us would be sitting around with our hands in our lap. And day after day, week after week, you're wondering why aren't I getting any of the clientele? Or patient loads, whatever you want to name them. Or, why hasn't this physician ever referred somebody back here if that's how they have to get to us? Or, what is it that they're wanting that the physicians think the patients need that they're wanting

that I can't give them and so there became personally intended or not, there become tension between some of us in the ranks. (Greta)

Because referrals are the responsibility of the physician, both practitioners and patients were frustrated by the barriers and restrictions this process created. Practitioners were frustrated not only because they became somewhat dependent on physicians for referrals, and depending on whether or not practitioners were a contractor or employee, the lack of referrals had the potential to seriously impact one's ability to earn a decent salary. Practitioners also felt that physicians were unfairly put in a position of power to make recommendations based on their limited knowledge of CAM. One practitioner explained the frustration of needing a referral by stating,

This is the pressure...because why do I need a referral? It's kind of like, you know, even though I don't have a medical license here, but really I have this [same] knowledge [as an MD]...So why do I need a referral? Why do I need to have someone who doesn't know [my modality] guiding me to do what ever...So, this is the pressure.

The need for referrals can sometimes restrict how a practitioner can treat a patient, depending on the modality practiced. During a meeting, one practitioner asked the medical director as to whether or not he could treat additional symptoms when a patient with a referral came to see him. The practitioner was told that another referral would be required to treat any other conditions that arose after the initial referral was written, meaning that the doctor needs to be kept in the loop. As one practitioner explained,

It does affect my work, yeah. In Chinese medicine, you know, we see the body as a whole...Each part is related so each symptom...So the clinical manifestation could be anywhere...the whole body. I have a headache and have low back pain...in Chinese medicine it could be the same thing...So if we treat it...We just treat a symptom not directly to treat the headache or the lower back pain. From Western medicine, oh you think, oh, just treat the symptoms...if you have a headache, treat headache...you have lower back pain, this separate. You need to get referral to treat it. It's not practical. (Zubin)

Practitioners also noted that patients were frustrated by the referral process. Some patients who regularly consume CAM know precisely what kind of treatment and provider they want to experience. Because patients must consult with a physician prior to using some services, they feel are being ushered about by physicians. For those being introduced to CAM care, the mandatory visit to the physician may not be an issue, but it can present a problem for those who have a history using non-traditional modalities. As one practitioner commented,

I've had people come in and they would say, "Well, I really just want acupuncture and I don't understand why I'm here." It's just really awkward, and so I would just go through and say, "Well, this is what I do. I just try to go through your history and...if I see anything that can help you as far as diet or anything else, here. So, if you want to talk about it fine, if not I'm not going to bill it. You know so; I did do that because I found it very awkward, and trying to control things a little too much. Trying to control patients a little too much, they don't appreciate it (Ladini).

There are some barriers that exist that restrict practitioners' ability to share patients. The manner in which patients pay for services can impede practitioners' abilities to integrate.

So, you have to understand that the type of clientele and their funding sources are very different based on modality. So, by nature they [practitioners] can't always share patients...You may have a large number of Medicaid patients on your case load as a physician, and not be able to send them to a massage therapist...not because you don't believe in massage therapy. It's because you have very few patients that meet the criteria of needing that who can afford it as well. (Sally)

Other CAM practitioners may be reluctant to share patients due to perceived differences in treatment styles. Unwillingness to share case loads can create problems for patients. In describing this problem one practitioner said,

...when one of the other [practitioners] who was part of the early group that came on, was still there, if one of his cohorts was on vacation and her patient's needed to be seen...she told the front desk to never, ever, ever let her patients see that particular

[practitioner] because she didn't like the way he practiced. So, that was a barrier. If, you've got that, and out of access reasons you need to get that patient in, there is a real conflict as to what to do with that patient because there was no one else to refer that patient to. (Sally)

Physicians may be reluctant to refer patients because it undermines their authority. In a meeting I observed, some acupuncturists asked senior leadership if they could somehow expedite the referrals they obtain from physicians. Physicians are reluctant to do this for a couple of reasons. First, if physicians are motivated by a productivity model, then they have incentive to see as many patients as possible as opposed to passing them off to an acupuncturist. Second, physicians perceive the act of writing referrals to somehow undermine the knowledge they possess since the patient is requesting a treatment that the physician might not prescribe. The doctor may decide instead that another type of treatment is best for that patient. The physician, then, becomes slightly offended that the patient is circumventing their expertise by suggesting their own treatment. In explaining this problem, one practitioner commented,

...When you got a physician at a certain salary level, the last thing you want to do is have them do what Dr. Smith was concerned about happening, which is just become a feeder source for the primary reason of signing off on something to get a patient to a modality where the physician isn't an active participant to actually work with the patient too. (Sally)

With the physician as the gatekeeper for access to CAM modalities, practitioners clearly expected referrals to flow based on the structure of the facility. Practitioners indeed seemed dependent on physicians for referrals. One practitioner pointed out however, that act of granting referrals goes both ways. She stated,

So when you put them in the same center together and...if by nature the way the center is set up...the CAM practitioner is somewhat dependent on the traditional physicians to send them patients because otherwise they don't have visibility. Then they get upset when they're not getting enough patients sent to them...Versus when somebody comes into the CAM practitioner...they're not necessarily expected to send

them to the traditional physicians. So it's kind of one sided. I think there's a level of frustration and tension between the two...Partly because one's still feeling their being repressed and the other one is feeling like... who are these people...they don't trust me. They want to be integrative, yet they're not integrating. (Sally)

The problem with this argument is that CAM practitioners do not have the same access to patients as physicians. The structure of the facility provides more immediate access to patients for physicians since they do not need referrals. Physicians are also likely to be the first point of contact a patient has with the facility due to the rules stipulated by the medical director.

Practices Change as they are integrated

Practitioners have noted that the way they perform their modality changes slightly when added to an integrative facility. As discussed in the section above, state laws dictate that patients must have a referral prior to scheduling an appointment with an acupuncturist. Additionally, those practicing acupuncture in an integrative environment are unable prescribe herbs to their patients. In explaining her reasons for referring patients to a colleague's private practice one practitioner said, "Dr. Jones... can't use his herbs....he's doing half work. And, so if I ever refer to him I always refer his private practice so that he can do his herbs." As this practitioner pointed out, TCM relies on several methods including needles, herbs, pressure and moxibustion to treat patients. Like pharmaceuticals are to physicians, herbs are an essential component needed to craft individualized treatment plans. Other practitioners have likened this problem to "a surgeon practicing with one arm tied behind her back."

Another added that there are cultural differences affecting what one can practice in an integrative environment. One practitioner said,

...we know acupuncture in China is known to treat over 300 different conditions. The World Health organization cited 43 conditions treated for acupuncture...So Acupuncture actually can be used for lots and lots of conditions. But here, in our center, the main conditions I have seen are neuromuscular skeletal conditions. These are the majority of my patients. (Zubin)

Conclusion

Although the facility for integrative medicine had a turbulent beginning, there is evidence to suggest that it is slowly moving out of its transition phase. Several months ago, the facility unveiled a new plan showcasing its business model and future plans for research and education. It states, “the [facility] now has clear direction, medical center administrative support, responsibility, and the challenge to further develop the unique clinical/business model of Integrative Medicine...to meet the needs of the patients, their families, the community and healthcare community locally and nationally” (field document). The facility appears to be actively addressing a number of the issues identified in this case study, but the continued emphasis on the business model suggests that productivity will only become more pronounced over time. This may further exacerbate the clash in values experienced by CAM practitioners who are working in this facility. Because the holistic model highlights the values, beliefs and ideas of CAM practitioners, the findings described above are believed to challenge the assumptions of holism in three distinct ways.

The structure of the integrative facility signaled a departure from the more diffuse, web-like structures familiar to CAM practitioners. CAM practitioners,

accustomed to operating in solo practices and to having a high degree of collaboration with colleagues, expected open lines of communication with their fellow practitioners. By and large their expectations were unfulfilled since they experienced a rigid bureaucracy instead of a holistic model promoting equality for all. With the medical director in charge, the leadership introduced a new layer of accountability, and gave physicians more power and control. As a result, practitioners were removed from the intake process, which hampered their ability to interact or network with patients. Holism assumes that the patient is ultimately responsible for his or her own health, but the structure of the facility placed this responsibility back in the hands of the physician. Because many practitioners at times needed referrals to work with patients, their work with patients became directed rather than negotiated.

Relationships among holistic practitioners are based on mutual respect and practitioners in general tend to avoid power differentials (Davis-Floyd & St. John, 1998). The structure of the integrative facility created a vertical hierarchy, which then established differences in power between the physicians and the practitioners. The wheel model closely resembled a holistic structure since it symbolized the idea that the whole is more than the sum of its parts. As a traditional medical model replaced the wheel model, practitioners became seen as parts or tools that could easily be replaced or removed. Because practitioners were without a voice in the structure of the facility and experienced a lack of collaboration, negotiation, and communication, their preference to practice in accord with holistic values was deeply compromised.

The environment and the overall culture of the facility challenged the holistic concept of balance. From the holistic perspective, balance teaches practitioners to look

for patterns of disharmony as indicators of diseased states when working with patients. It is quite possible that practitioners saw the environment of the facility contributing to their own patterns of imbalance. Many practitioners commented that they experienced less than optimal health as a result of being in a toxic environment as evidenced by the number of issues (weight gain, confusion, etc.) already mentioned. Patterns of verbal abuse, the culture of fear, and the lack of support and visibility from senior leadership, undoubtedly contributed to the perception that the facility was not a balanced or healthy place to work.

The structure of the facility challenged CAM practitioners' desire to learn from other practitioners since patterns of communication and collaboration were restricted. A disconnect was observed between CAM and biomedical values associated with learning. While there is much less written about the socialization process for CAM practitioners, they generally interact and troubleshoot with other colleagues who are in proximity and who share similar values and practices. In this study, CAM practitioners were eager to learn from other modalities but the medical director, on the other hand, was disinterested in learning from other practitioners. CAM practitioners frequently worked alongside or scheduled sessions with colleagues to better understand their practices. They also engaged in a great deal of self-directed learning about integration. It seems clear the CAM practitioners' desire to collaborate was not rewarded or supported by the medical director, since they frequently had to do it behind closed doors. Furthermore, the medical director was not interested in learning from other practitioners. In fact, he often rebuked invitations to sample CAM services and did not refer patients to CAM practitioners, which would have initiated a dialogue with CAM practitioners and would

have opened lines of communication for the sake of learning.

It is hypothesized that the difference between the degree to which a practitioner is open or closed to learning could be related to whether or not a practitioner engages in an introspective process. Many of the practitioners I interviewed told me they regularly practice a contemplative tradition, such as yoga, meditation, or tai'chi. Contemplative traditions teach practitioners how to be aware of their own patterns of behavior and ultimately how to overcome their conditioned habits and behaviors. Throughout many interactions with biomedicine, many of the practitioners I interviewed observed that the training and socialization most medical personnel go through in medical school teaches them to be closed to other modalities. Indoctrination, lack of respect, and the culture of medical school inhibited biomedical practitioners from learning more about other healing systems. The contemplative traditions affirm the notion that one should approach any practice with a beginner's mind, and consciously practicing this idea on a daily basis might also encourage practitioners to be more tolerant of other healing modalities.

CHAPTER 5

FINDINGS & CONCLUSION

Many of the tenets, values, beliefs and ideals precious to CAM practitioners did not survive the integration process. Integrative medicine, as described by the leaders in its field, is defined as, “the availability and use of both conventional and alternative therapies to meet the needs of the patient without a strong bias for one modality over the other” (Clohesy & Lathram, 2003: 32). In this study, the experience of the CAM practitioner working in an integrative environment was significantly influenced by a changing structure and a domineering style of leadership. The result produced a type of integrative care favoring the medical model.

The center began with a grassroots community effort, but was later transformed into an institutional machine with a top-down approach to leadership. The switch from a bottom-up to a top-down approach brought many significant changes, which fueled practitioners’ perceptions that their expectations were no longer being met. One of the most important changes was that practitioners were not able to share or to collaborate with colleagues to the degree that they had hoped. Communication and collaboration were inhibited by leadership, and practitioners quietly engaged in these efforts on their own. It seems, then, that the desire to practice integrative medicine in a manner consistent with their ideals was perhaps greater than the need to follow orders. As

structural changes occurred, practitioners were required to focus more on financial matters, so time with patients was budgeted and practitioners grew uncomfortable with the quality of care they were providing to their patients. The medical values of mechanization, standardization, and a hierarchical division of labor pushed out many of the holistic values such as interconnectedness, collaboration and a deep connection with patients. Under the gaze of the medical director, practitioners lost a certain amount of autonomy while working at the integrative facility and assumed a greater amount of accountability in terms of their time and productivity.

Recall the child metaphor Mittleton-Kelly (2006) used to describe the product of mergers in co-evolutionary integration. The author asserts that an ideal merger would resemble the creation of a child, comprised of some characteristics from each organization, but would have an identity of its own. Practitioners expected that the integration of CAM and biomedicine would produce a practice that featured characteristics of both healing systems. With that said, if holism was leaving its imprint on biomedicine, I would have expected to see evidence that some holistic values or tenets, such as collaboration, acceptance of other modalities, or patient empowerment, fused with the traditional medical model to create an entirely new organization. Instead of transforming biomedicine as they had hoped, practitioners stated that the organization favored biomedical characteristics rather than incorporating a healthy balance of both. Practitioners constantly reiterated that integration did not occur and nearly all expressed disappointment that their expectations were not met. Perhaps this is because CAM and biomedical practitioners have different expectations for the structure of integrative organizations. It could be quite possible that CAM practitioners expected the structure to

resemble or reflect some of the same holistic notions that inform their practice. The structure of an integrated facility in a university setting is comprised of layers upon layers of bureaucracy, which is more consistent with the structure of biomedicine since departments are broken down into parts that ultimately contribute to the whole. Working in this kind of environment is probably more intuitive for biomedical practitioners, who are familiar with the politics, procedures and policies therein. CAM practitioners working in this setting, however, might have experienced some discomfort with the university structure, which is quite different from the organic or web-like structures typically defining their place of work.

Additionally, day to day operations at the facility for integration medicine were plagued by unhealthy working conditions. Many practitioners naturally assumed they would be working in a healing environment, but soon found themselves amidst a culture of fear and intimidation. Issues with leadership contributed to practitioners' perceptions of negative working conditions and this was exacerbated by the fact that practitioners felt as though they had no voice in the direction of the center.

Because practitioners defined integrative medicine differently from staff at the center, practitioners eventually believed they were perpetuating the only the appearance of integration. Generally, patients seeking integrative medicine are those dissatisfied with biomedicine and are searching for a different kind of healing experience. From the practitioner's perspective, patients seeking care in this setting are essentially receiving a repackaged version of the medical model. In this new model, patients develop relationships with their primary care provider over time, but are still restricted by short

appointment times as stipulated by managed care. In the end, practitioners felt as though they were deceiving patients because they were not delivering the best brand of integrative care.

CAM practitioners portrayed themselves to be highly inquisitive and were motivated to learn from their colleagues through observation and direct experience. Practitioners also engaged in many self-initiated or self-directed activities related to the study of medicine. Additionally, most practitioners interviewed stated that they maintained some kind of contemplative practice. The majority of the practitioners perceived themselves as learners, not only in the acquisition of new knowledge but also learning about themselves. For this reason CAM practitioners appeared to be part of a learning culture. Although their biomedical counterparts do engage in on-going study in order to keep abreast of current trends in medicine and to maintain credentials, the difference is that CAM practitioners generally appeared to be more open and tolerant towards other modalities in this study. Biomedicine, on the other hand, as depicted through the actions of the medical director, appeared to somewhat more closed to other healing modalities. Of course, this idea needs to be fleshed out more formally through research, but it is speculated, however, that the contemplative practices CAM practitioners engage in contribute to a greater openness towards other modalities.

Implications and Suggestions for Further Research

All of the above findings, the experience of the CAM practitioner absorbed in an integrative facility, the strategies used for integration, the barriers inhibiting integration,

and the clash between holistic and biomedical values, have distinct implications for future integration efforts and career paths for CAM professionals, medical education, and the commodification of integrative medicine as discussed below.

Future integration efforts

The experience of CAM practitioners in an integrative facility as described in Chapter 4 provides evidence suggesting that CAM therapies are being co-opted by biomedicine. If the goal of integrative medicine is to bring medicine back to a balanced state, we would expect to see medicine move more toward the middle of Davis-Floyd & St. John's (1998) continuum and start to resemble humanistic medicine. In this study, CAM products and services were incorporated to enhance traditional medical care and were imported into a family practice without their philosophies and values, which is consistent with theoretical speculation regarding the impact of the mainstreaming of CAM (Collyer, 2004). CAM and biomedical practitioners are not equal partners in this processes and the focus on high productivity seems to indicate that the intention to incorporate and mainstream CAM in this setting was financially motivated.

Although CAM appears to be co-opted by biomedicine in this study, there is some evidence to suggest that traditional medicine is adopting new behaviors as a result of its association with CAM. In considering a more broad perspective, medicine has actually made significant changes towards its former position on CAM. The creation of integrative centers, for example, shows that medicine has reconsidered its once standoffish position towards CAM. I also observed physicians at the clinic dispensing

nutritional advice and even counseling and prescribing herbal supplements to patients, where previously such practices were regarded as either taboo or outside the scope of physician care. Moreover, the facility offers dozens of classes to the community as a means to teach them about various aspects of integrative medicine, which suggests a movement towards more a preventative rather than a reactionary kind of care. Lastly, the facility was willing to grant credentials and to create new titles in the university system for CAM practitioners, indicating that the boundaries of this system are slightly more porous than it has been in the recent past. Although these changes have not totally transformed the field of medicine, they do signal a change from the conventional model of care.

As CAM therapies continue to grow in popularity, the frequency and type of training programs geared towards physicians will also increase. It has been noted in this study, that some training programs are believed to dilute the essence of certain modalities, such as acupuncture and ayurveda. This finding is also consistent with other research identifying differences in the methods used to obtain CAM knowledge (Hsiao et al, 2006). There is a tendency for some integrative facilities to have a preference for hiring MDs who are cross-trained in other modalities. It is believed cross-training practitioners will reduce some of the language barriers inherent in combining modalities across different healing philosophies. While this may circumvent the language problem, acupuncture becomes stripped of its context and history. Physicians are able to earn certification in medical acupuncture by taking a 200 hour course, but these courses by and large do not teach the theory behind the practice. Some practitioners suggest that phases such as this are necessary for the natural progression and evolution of medicine.

Practitioners of TCM most likely interpret these programs as diluting the specialized knowledge they acquired through many years of formal schooling. As programs continue to be offered to physicians and other biomedical practitioners, this process will undoubtedly create a number of new CAM inspired hybrids. Future research efforts are needed to explore this diluting effect and how it influences practitioners' perceptions of efficacy.

Because issues with leadership were central to this study, more research should be conducted to explore how leadership influences the integration process. The Bravewell Collaborative, a philanthropic organization devoted to integrative medicine, released a study highlighting the various ways integrative medicine has been implemented in spas, community hospitals and hospice (Henry, 2005). One of the findings of this study was that physician leadership can be an important force responsible for moving the field of integrative medicine from a peripheral status to a more ubiquitous model of care. If the model described in this study represents a trend in other settings, it might be useful for facilities to consider specific training programs designed with the physician leader in mind to appropriately groom them to work alongside other practitioners. Additionally, depending on the goals and values expressed by each facility, it may also be of importance to remind such leaders of the importance of modeling behaviors. In this study, a number of practitioners indicated that the physician leader was "playing the part" but was not leading a balanced lifestyle as evidenced by patterns of behavior. Other studies could explore the intersection of physicians' beliefs and practices with patients' interpretation of the quality of care.

As other institutions look to integrate CAM with biomedicine, they can benefit

from some of the best strategies and practices for merging two cultures as identified in Chapter 3. In this study, integration appeared to break down mainly due to mismatched expectations. One way around this issue is to make sure the vision and mission for any new center is expressed to incoming practitioners as soon as possible. Once the strategy has been identified, it should be easily accessible for all parties involved.

It is may also be helpful to have a coordinator or person in place to oversee the integration efforts. The coordinator becomes a neutral and stable partner in the process who can routinely check in with practitioners to see how integration efforts are progressing. In addition, cultural training should target both CAM and biomedical populations, since both have blind spots in their training about the other's culture and healing approach. It could also prove useful to create some specific activities, such as a book club, to promote focused integration and collaboration between CAM and biomedical practitioners. Most importantly, effective lines of communication need to be established not only from practitioner to practitioner, but also from practitioner to patient since communication is the true hallmark of integration. Lastly, agencies should also contemplate the setting well in advance given the barriers a university environment produced in this study. Other settings, such as freestanding clinics or hospitals, might prove to be a better fit depending on direction and intent.

Institutions are not the only ones who stand to gain from this kind of research, but CAM practitioners can benefit as well. From this study, CAM practitioners begin to get a sense of what it is like to work in a university setting, which may help some practitioners decide what types of integrative settings are more conducive for the type of work they aspire to do. Knowing in advance that university facilities have a tendency to emphasize

productivity and generally resemble the medical model, some CAM practitioners might make the decision to secure employment elsewhere. Future studies conducted on this topic may wish to explore CAM practitioners' experiences working in other integrative settings such as hospitals, spas, primary care and universities. Through other research projects, CAM practitioners may come to realize over time that certain integrative settings might be more supportive or sympathetic to CAM practices and values.

Medical education & Somatic Training

Related to the lack of communication and collaboration as described above, there needs to be more education for CAM practitioners about biomedicine and for biomedical practitioners about CAM. Most medical schools now offer courses in CAM and some have proposed establishing core competencies as standards on integrative medicine to be included in medical school curricula (Kligler, Maizes, Schachter, Park, Gaudet, Benn, Lee, & Remen, 2004). While many strategies are recommended to expand medical curriculums to make them more integrative, the ideas of experiential learning and self-care are associated with some of the findings of this study. Kligler et al (2006) propose that medical students could benefit from learning about CAM through experiential or applied situations. They recommend that physicians and students should also engage in self-care or self-reflecting activities to cultivate the central values of integrative medicine, namely empathy and compassion. In this investigation it was noted that CAM practitioners conveyed the impression that biomedicine is generally intolerant of other modalities. Since many of the practitioners I interviewed engage in a contemplative practice of some kind, it is speculated that these activities cultivate a greater openness

toward learning about other modalities. For biomedical practitioners on the other hand, the intolerance to other modalities is believed to be related to the socialization and indoctrination that occurs during medical school. So, research needs to be conducted with biomedical practitioners to better understand the barriers to learning about other modalities. Other research agendas may want to explore the influence of contemplative disciplines on physician and practitioner practices.

Although most practitioners I interviewed did not feel as though their modality specific language was a barrier when collaborating with colleagues on the side, it did become apparent that both CAM and biomedicine practitioners do have limited knowledge about each other's practices. Due to these blind spots, there might also be some confusion about when to refer patients to other modalities. At the very minimum, medical and CAM schools need to better teach the art of referral.

Commodification of CAM

Biomedicine's continued co-option of CAM practices, products and services, provide more evidence of the increasing movement to commercialize and commodify aspects of CAM. Some modalities, like yoga for example, have become highly commercialized. Yoga has been featured by such stars as Madonna and Oprah, and it has even graced the cover of Time magazine. One can find rows of books on the subject at Barnes & Nobles. ESPN has also created a show called Yoga Zone, where one can do yoga at home guided by thin models on a beach. The identification with these megastars and popular symbols has increased the popularity of yoga.

Responding to this popularity, companies have created specific yoga products to

enhance one's practice. Special yoga clothing, like Prâna named after one of the eight limbs of yoga, has been designed so practitioners can use their wallets to become enlightened as well. Music and videos have been created to accompany one's practice at home and special mats have been designed with lines painted on them so practitioners know how to properly place themselves in alignment (even though yoga is not so much about performance as it is the process).

Conferences and certifications are happening all over the country and many charge hefty admission prices. Yoga teachers convince their students that they need to attend a certain workshop to gain knowledge to progress to the next level, thus perpetuating the cycle of consumption. Yoga classes are targeted to special populations like prenatal yoga, yoga for a better back, and yoga for fibromyalgia. While yoga has been reinvented and marketed towards specific populations, there are even other hybrids that blend yoga with other disciplines. Yogalates is one such example, a blend of Yoga and Pilates.

This movement towards commercialization emerged in this investigation as well. Many practitioners implied that the university was interested in adopting CAM services as a marketing ploy or because they perceived such services as having the ability to generate large sums of money. Because there was also evidence suggesting that the physician leader was uninterested in other modalities, practitioners were left with the impression that the medical director's personal agenda was two-fold: to make money and to be recognized as a national figure in integrative medicine.

While reviewing documents for the analysis section, it was difficult to miss the amount of coverage physicians received compared to CAM practitioners in articles

written about the center. In press releases it was interesting to note that physicians were featured more often in the text and in the photos of such articles. It is unclear as to whether or not this was an intentional maneuver on the director's part to further censor practitioners' voices or whether these were solely journalistic decisions. I have also noticed over the years, that there is movement for certain physicians to obtain celebrity status through their affiliation with integrative medicine. Integrative medicine is a huge industry, and for celebrity doctors like Andrew Weil and Deepak Chopra, they have become household names for the programs or products they endorse. Even within a discipline like yoga, there are famous teachers but few have achieved the same status as celebrity doctors who can fill an auditorium. More research could be conducted to critically explore the intersections of commercialization, integrative medicine and popular culture.

Conclusion

The goal of this research was to provide a vehicle for CAM practitioners to vocalize their experiences related to working in an integrative medical facility. Integration, in this instance, was a difficult path for some, which was complicated by a changing structure and challenging leadership. As more studies like this one emerge, integrative facilities will be able to develop better strategies for integrating CAM and biomedicine. Lastly, CAM practitioners will be better prepared to make informed choices about the decision to work in an integrative environment since they will have greater knowledge about the benefits and repercussions of working integratively.

APPENDICES

APPENDIX A

CONSENT FORM

CONSENT FORM
2005 Integration of Alternative Healing Modalities

Principle Investigator: Sy Kleinman
Representative: Jennifer Olejownik

Protocol # _____

CONSENT FOR PARTICIPATION IN RESEARCH

I consent to participating in research entitled: The Integration of Alternative Modalities.

Sy Kleinman, Principle Investigator, or his/her authorized representative Jennifer Olejownik has explained the purpose of the study, the procedures to be followed, and the expected duration of my participation. Possible benefits of the study have been described, as have alternative procedures, if such procedures are applicable and available.

I acknowledge that I have had the opportunity to obtain additional information regarding the study and that any questions I have raised have been answered to my full satisfaction. Furthermore, I understand that I am free to withdraw consent at any time and to discontinue participation in the study without prejudice to me.

Finally, I acknowledge that I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: _____

Signed: _____
(Participant)

Signed: _____
(Principle Investigator or Agent)

Signed: _____
(Person authorized to consent for participant, if required)

Witness: _____

APPENDIX B

INTERVIEW GUIDELINES – ROUND 1

Interview Guidelines – Round 1

1. Background Questions
 - a. How did you come to work at the facility?
 - b. What is your employment status at the facility?
 - c. How are you reimbursed for your services?
 - d. Location in building (central vs. peripheral)
 - e. Content of Care (alleviate pain vs. diagnosis)
 - f. Do you have a voice in the decision making process?
2. Process Questions: How have alternative practitioners gained entrance and established a basis for practice?
 - a. Entry (informal vs. formal)
 - b. Credentialing (biomedical or alternative)
 - c. Modeling/isomorphic processes
 - d. Legitimization (research, professional organizations, labeling mechanism, etc)
 - e. Who is eligible for inclusion within biomedicine?
 - f. How are alternative practitioners controlled or regulated by biomedical staff?
3. Paradigm Clash Questions:
 - a. Should these practices be incorporated in to biomedicine? Why/Why not?
 - b. What do you identify as the problems associated with integrating?
 - c. What kind of benefits do alternative practitioners receive from working in a biomedical setting?
 - d. Degree to which alternative practitioners feel pressure to adopt authority of science?
4. Occupational Questions
 - a. To what extent does biomedical staff accept alternative practitioners?
 - b. Is there collegiality between alternative & biomedical staff?
 - c. To what extent are alternative practitioners included in collaborative research?
 - d. Do you think that the medical model is changing as a result of alternative practices operating within this setting?
5. Values/Beliefs/Practices
 - a. Do you have a practice?
 - b. If so, how does it inform the work that you do?

APPENDIX C

INTERVIEW GUIDELINES – ROUND 2

Interview Guidelines – Round 2

1. How was the center's strategy or mission expressed to you?
2. Prior to your work at the center, what was your expectation for integration? Were your expectations met?
3. In what way did leadership influence integration?
4. How would you describe overall patterns of communication with leadership?
With colleagues?
5. Can you provide an example of anything the center did to promote learning about the various cultures of medicine? Could this be improved in any way?
6. Provide some examples of when integration was done well. How could integration efforts be improved?
7. How were opportunities afforded to you for continuous learning or improvement as a practitioner?

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