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# Trailblazing healthcare: Institutionalizing and integrating complementary medicine

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## Abstract

*Objectives* — This study examines three integrative health centers to understand their (1) historical development, organizational goals, and modalities, (2) the processes and challenges of integrating complementary and allopathic medicine, while encouraging staff collaboration, and (3) how each center becomes institutionalized within their community.

*Methods* — We focus on three organizational case studies that reflect varying forms of integrative health care practices in three U.S. cities. Participant-observation and in-depth interviews with center directors were analyzed qualitatively.

*Results* — Important patterns found within the three cases are (1) the critical role of visionary biomedical practitioners who bridge complementary and allopathic practices, (2) communicating integration internally through team interaction, and (3) communicating integration externally through spatial location, naming, and community outreach.

*Conclusion* — IM centers continue to blaze new trails toward mainstream access and acceptance by gathering evidence for IM, encouraging team collaboration within organizational contexts, constructing organizational identity, and negotiating insurance reimbursements.

*Practice implications* — IM is not the enactment of specific modalities, but rather a philosophy of healing. Though scheduling conflicts, skepticism, and insurance coverage may be obstacles toward IM, collaboration among specialists and with patients should be the ultimate goal.

**Keywords:** Complementary medicine, Health care teams, Integrative medicine, Organizational communication, Qualitative research

## 1. Introduction

Complementary medicine, a classification for therapies that are different from and viewed as harmonious with conventional or allopathic biomedicine, is being assimilated and institutionalized in a variety of settings. Increasingly, the term *integrative medicine* (IM) is preferred to indicate “a combination of biomedicine and [complementary modalities] for which there is evidence of safety and effectiveness” [1] employed for the betterment of those receiving treatment. A related term is holistic medicine, which refers to a wholeness of mind, body, and spirit, in contrast with the tendency toward reductive specialization in biomedicine. In some settings, “medicine” is supplanted with alternative words such as “health,” “healing,” and “well being,” connoting an emphasis on prevention and wellness. This study reports an initial formative effort to examine organizational processes enacted as complementary practices shift from a position in societal margins toward mainstream acceptance, including interfacing with conventional medicine, and the role of communication in these processes. Such movement re-

quires the ability to create new pathways, literal and symbolic, and forms of organization; in effect, to blaze trails through unfamiliar, sometimes inhospitable, terrains.

Many reference Engel’s [2] biosychosocial model of health care as a precursor to the contemporary IM movement. The philosophy of IM centers on practitioners assisting people’s innate healing abilities through an array of modalities to overall wellness, in addition to treating and preventing disease [3]. According to the 2007 National Health Survey, 38 percent of adults and 12 percent of children have used some form of non-allopathic health care [4]. Patients often seek out health solutions on their own, [5] by adding complementary methods to doctor-prescribed allopathic treatments.

Mainstream medicine is beginning to take note of the shift in patients’ attitudes and actions, as well as the effectiveness of IM [3]. Holistic practices address the need for patient involvement by emphasizing partnerships, in turn, impacting healing [3, 6–12]. Mainstream practitioners have begun to accept complementary modalities as legitimate and cost-effective [13], and a new gener-

ation of physicians refer patients to complementary providers [14, 15]. IM centers are opening around the U.S. [3, 16, 17] to address the changing landscape of patients' needs.

This paper describes variations and commonalities among three integrative health centers in terms of objectives, practices, internal organization, and outreach with the communities in which each is embedded. Specifically, we seek to address the following research questions:

- RQ1: How do selected centers of integrative health care and education function in terms of historical development, organizational goals, and practice components?
- RQ2: In what ways has integration of services and expertise occurred (or not) among the various complementary and biomedical practitioners within each center?
- RQ3: How has each center attempted to become institutionalized within its respective community, including interfacing with conventional medical entities?

## 2. Methodology

### 2.1. Design, data gathering and analysis

Through a combination of participatory observations and semi-structured interviews in three health centers that use complementary practices, we sought to understand the processes of trailblazing and institutionalization. Each center was selected because of its geographic accessibility to the research team and its unique organizational structure, location, cultural surroundings, developmental stage, and degree of integration with conventional medicine. Initial contacts with center directors via and/or phone calls were made by the co-principal investigators to introduce our project. These contacts were followed with visits to the centers to discuss and gain cooperation toward in-depth investigation. In all instances, institutional approval was granted; some actual names of centers and people are used at participants' explicit request. Data collection included interactions with all center directors and some staff, as time and opportunity allowed. In one case, two authors attended yoga and reiki classes. In another case, three authors attended a four-day observational visit organized by the center including presentations by administrators and clinicians in numerous modalities. Investigators spent between 8 and 32 h gathering data at each center.

Some conversations were audio-recorded and written field notes were maintained to document participatory observations. The goal of data gathering was to understand the narrative of each of the three centers, in terms of its evolution, mission, components, and internal and external communication. The combined thematic/narrative analysis [18] emanated from each investigator separately reading through transcripts of all interviews and field notes, followed by a conjoint discussion by the research team in terms of what was learned about forms of integration, with special attention to the metaphorical language used by participants in describing their centers.

### 2.2. Center descriptions: history, goals, and practice/educational components

#### 2.2.1. Brazos Healing Center (BHC)

BHC, located in College Station, TX, celebrated its first year in operation in spring, 2011. The two co-founders, Lisa and Filipa, both hold credentials in yoga and reiki. They manage the Center, jointly making decisions related to educational offerings, staff employment, and community outreach. The organization's mission is to provide a central place to (1) access complementary therapies and holistic health consulting, (2) learn about enhancing personal

development, and (3) exchange ideas for balancing and strengthening the mind-body-spirit connection.

Services provided at BHC include energy and massage therapies, yoga, pilates, tai chi, and holistic nursing consultations. They have struggled with an initial identity of yoga studio, but stress that there is much more. BHC has worked to create "*an atmosphere for change*" in the community. BHC focuses on prevention as well as healing, and strives to help "*people feel empowered to make themselves feel better.*" The Center does not refer to its patrons as patients, but rather as "clients" because, according to Filipa, "*clients just feels better or maybe more equal, working-on-it-together kind of thing.*" She describes their clientele as "*sophisticated*" but says there is no one particular demographic targeted. The evolution of BHC is described by Lisa as an "*organic unfolding.*" Declares Filipa: "*I think the sky is the limit in what we can do.*"

#### 2.2.2. Center for Well-Being (CWB)

CWB, located in a large Californian city, has been in operation for 14 years. Carol Silver, M.D., co-founder and Medical Director, leads the team of 17 providers who take a "*whole-person approach*" providing a "*healing experience that bridges the gap between conventional allopathic medicine and alternative and complementary therapies.*" At CWB, practitioners work as a team "*in a healthcare continuum that emphasizes prevention, education, and lifestyle management.*" CWB is open to the public and encourages the use of medical insurance to cover a majority of their services, including family medicine, naturopathic medicine, neurotransmitter restoration, oriental medicine and acupuncture, chiropractic, massage therapy, transformational counseling, podiatry, health screenings and lab testing, bio-identical hormone therapy, weight management, and skin rejuvenation.

CWB's website describes its vision as "*providing integrative medicine that emphasizes the patient-provider partnership and encourages patients to take an active role in their healthcare.*" Dr. Silver is a conventionally trained primary care physician who visualizes a bigger, interconnected picture. Establishing CWB in this location in 1997, she brought on an acupuncturist and a chiropractor right away and from the beginning "*started accumulating a team, sort of envisioning this integrated model, still evolving myself.*" It was important "*to find a cover that wasn't too far out there*" where patients who were more familiar with a medical model would be willing to try other therapies. The challenge CWB faces on a regular basis is collaborating across the different modalities so that the clinical group brings together all perspectives of the patient. Dr. Silver states, "*The integrated work that we have been trying to do here [means that] the client's voice shows up equally to the provider's.*"

#### 2.2.3. Integrative Medicine Program (IMP)

IMP, started in 1998, is the largest, most established of the three organizations. It is located within the University of Texas MD Anderson Cancer Center, an academic tertiary cancer hospital in Houston. IMP's integrative services include meditation, music therapy, nutrition, acupuncture, massage, expressive arts, yoga and other movement-based therapies, and more, which are available to patients, caregivers, and family members.

The educational component of IMP distributes "*evidence-based information on complementary and alternative therapies to help patients and health care professionals decide how best to integrate such therapies into [their] care.*" IMP's monthly lecture series, journal club, and research presentations seek to enhance discussion of clinically proven IM research within the hospital. The group also works with other local institutions to incorporate IM education as part of medical school training.

A crucial organizational development has been the appointment of medical oncologist, Richard Lee, MD, as IMP's Medical

Director. He plays a central role in working with faculty and staff to oversee its clinical center. In describing the evolution of IMP's philosophy, Dr. Lee stated that the program was initially too diverse. Under the leadership of the Program Director, Lorenzo Cohen, PhD psychologist, the IMP has focused energies on doing fewer things well. Both Drs. Cohen and Lee emphasized that the terminology they prefer to use is Complementary and Integrative Medicine (CIM). Both Drs. Cohen and Lee are active researchers, as are several other faculty and staff. With a third mission of research, IMP has been the recipient of several sizeable grants for preclinical research and clinical trials of complementary medicine.

### 3. Results

#### 3.1. Forms of integration

##### 3.1.1. Integration of complementary and allopathic medicine

Each center works to integrate health care through bridging complementary and allopathic approaches. The key in all three centers is a biomedically trained, licensed practitioner, distinguished by a broad vision, strong motivation to find as many viable options as possible to help their clients "optimize health, quality of life, and clinical outcomes" (IMP). For BHC, that person is Filipa who offers the unique service of a holistic nursing consultation in which the client is assessed across a full range of health-related problems with suggested options for coping, if not complete healing. An example is Filipa's description of a recent consultation:

*She's got arthritis. She's in a symphony. She's really concerned. At high risk for self-concept disturbance related to altered role performance as flute player for symphony secondary to deteriorating range of motion of joints in rheumatoid arthritis ... she can adapt in a healthy way and she can find ways to cope and so how are we going to do that, and right there I brought in something about ... daily range of motion exercises, support group with people in similar situations, ... I think definitely she left there with a sense of 'there's something else I can do when medicine isn't helping anymore.'*

Added her partner Lisa, "... finding a way to adapt under the conditions of their suffering ... there's difference between having pain and having hope."

Dr. Silver, CWB Director, serves as the connection through her creation of a concept of "functional medicine," meaning working toward "optimal health" for patients. She defines this notion by explaining how naturopathy fits as one of the components of CWB:

*They go to what they call medical school ... they get the traditional science, the chemistry and physiology and anatomy and all that. But then ... the third and fourth year ... they focus mostly on healing through nutrition and supplements and really understanding more functional medicine. Well, integrative holistic medicine, functional medicine is really the bridge between naturopaths and medical doctors because ... they are really looking at the person, how they feel, the optimal health, their functioning, that's why it's called functional medicine, not allopathic and not naturopathic, but functional.*

The integrative lynch pin at IMP's clinical center is Dr. Lee. His credentials include specialties in oncology and palliative medicine, a research track record, and additional training in traditional Chinese acupuncture. Institutionalized within a formal hospital organization, IMP is one of several clinical services for patient referral. Dr. Lee consults with physicians on other services to devise therapeutic interventions and informally educate his colleagues about the IM clinical model and the kinds of therapeutic options available within the IMP. Thus, beyond his clinical expertise, Dr. Lee

serves as an important emissary of the program within the larger organization.

##### 3.1.2. Communicating integration internally

The key to integration of expertise within each center is team work. As a start-up organization, BHC has the least complex, though nonetheless significant, type of teamwork embodied in the relationship between the two founders. All decisions about the operation of the Center are made jointly by Lisa and Filipa. What is striking is the shared vocabulary of the two managing partners with repeated references to "synchronicity" and "evidence-based" practice, a symbolic representation of a right-brained and left-brained integration of how their center functions. Synchronicity refers to the fortunate, unplanned concordance of events, a by-product of life-forces beyond conscious planning or control, such as noticing a long-vacated space within a medical professional building for which they were able to negotiate a half-price rental for the first six months, allowing them to have sufficient capital to launch the Center. Evidence-based practice, on the other hand, is the use of scientific research upon which they claim the activities of the Center are based; and is a necessity for attracting physician referrals. As Filipa illustrated, "Doctors are not going to do, you know, some woowoo high in the sky kind of treatment. Dr. Di Rocco, for example, will only send us patients who have fibromyalgia to do Tai Chi. Why? Because he has read research studies in the *Annals of Internal Medicine*." Internal integration in this sense is a shared melding of both intuitive and methodical beliefs. However, due to the part-time schedules of its staff, BHC has yet to realize a fully integrated team.

For Dr. Silver at CWB, integration within the Center is enacted through the establishment of a team of complementary specialists and encouraging collaboration among them: "It is shared vision as, opposed to my vision superimposed upon others and say this is your vision, right? No, ... that's really what we tried to work towards." She elaborates further:

*I am really interested in how the conversations overlap and where it is we get to know each other's disciplines and take interest in each other because this can still turn into everybody in their silo, you know everybody just doing their own thing. ... And how [sharing] could be offering something to the patient that we might not be able to offer [otherwise].*

However, this ideal vision must confront the realities of a business model, creating difficulties in administering the CWB:

*Even though it's more expensive and at sometimes often more pain in the butt because now you have to manage more people, ... I created a monster that now needs to be fed, and yet the little monster is this friendly little monster that has a lot of great attributes but nevertheless needs to eat. ... They need to see patients and we need to pay our bills so it's like asking people to take time to meet and collaborate. And most of them are pretty willing, but it is hard sometimes to get people together.*

IMP, the most complex organization, appears to have similar goals for team collaboration, and like CWB, uses a combined patient charting system. Significantly, there is a weekly clinical team meeting chaired by Dr. Lee in which current patients' situations and care plans are reviewed by team members from all specialties. In this way, a patient's spectrum of needs – physical, social, psychological, and spiritual – are taken into account concurrently, creative approaches are generated, and additional team members may be suggested. During our visit, we observed a team meeting, and were struck not only by the humane ways in which patients were discussed, but also by the respect accorded to every team member's contributions and abilities.

IMP also resembles BHC in its emphasis on evidence-based practice. As a Program within a large academic medicine institution, the importance of research informing clinical practice is understandable; the Program's director, Dr. Cohen, is a researcher, not a clinician. Programmatic choice of component modalities and how they are implemented is based on where the evidence is strongest. Every clinician cited significant literature underscoring the efficacy of the particular practice, such as meditation or acupuncture. However, beyond application of modality-specific evidence, there is a common body of theory and research that is known and cited by every member of the team. This shared knowledge includes an IM model elaborated from Engel's biopsychosocial paradigm [2] and the work of at least two nationally prominent researchers who have visited the center and are linked on IMP's website. Thus, deference to research generally, as well as specific sources, is a hallmark of team cohesiveness at this site.

### 3.1.3. Communicating integration externally

Each center operates within a cultural and geographic community, and deals with the tasks of communicating its identity and attracting a client/patient base. While the challenges and resulting tactics vary, there is one overarching strategic issue – how each center communicates its identity, both symbolically and materially, to its outside community.

A major facet of communicating the concept of IM is identification through geographic location. While this was not a topic discussed by CWB, it is located in an urban neighborhood known for its tolerance, diversity, local businesses, as well as its large lesbian, gay, bisexual and transgender community, which may well be a conducive environment for this unconventional practice. Location was discussed by the other two centers.

In establishing BHC, Lisa and Filipa set their sights on locating in the “*medical corridor*,” which includes a medium-sized hospital, several medical office buildings and outpatient clinics, and a second hospital under construction. The discovery of the space off the main lobby of the professional building connected to the hospital allowed the Center to have visibility. The space is versatile enough to serve as a yoga studio, massage suite, or classroom. With a goal of obtaining referrals from community physicians, Lisa observed, “*Just kind of being plugged into this side of town already helped a lot, so there's no doubt about that.*” Still, they are well aware that they are “*tenants ... outsiders looking for a way in.*”

For IMP, embedded in a complex campus with several buildings, their administrative and practitioner offices were initially spread out in a variety of places and are now centralized. The clinical center has two separate locations. One is a cluster of rooms in one of the main hospital outpatient buildings where patients come to participate in group activities like yoga, music therapy, or cooking demonstrations. This location represents a major expansion for IMP, which began with a different name, in a small building outside the hospital entrance, conveying a separate identity from regular hospital activities. This original unit was recently remodeled to accommodate individual interactions such as medical consultations or massage therapy, and is now perceived as an integral part of the hospital.

An essential aspect of communicating externally is each center's website, linked to Facebook and other social media. Naming the organization is, of course, an important part of establishing identity. Historically, IMP had started, in its separate facility, as “*The Place of Wellness*,” but is now a formally designated medical program and clinical center, essential within its hospital setting. BHC is in a formative stage, with some ambivalence about its name and mission. Lisa is concerned that the word “*healing*” may deter some potential clients because they infer religious connotations or a guarantee of recovery from medical problems.

All three centers discussed the importance of open, empowering communication with patients, but BHC is especially adamant about being distinctive from the allopathic medical model, as Filipa explained:

*[B]eing holistic is meaning that we are a partnership ... My doctor will tell me what I do and I don't need to understand it and then it will just happen. I mean we're throwing that to the wayside ..., We are collaborating in your health and it's not me to tell you what to do but rather it's me to kind of walk with you in that road to something better.*

And yet, as an integrative center, there is a need to be linked with medicine. States Lisa: “*I think of us more as a therapeutic yoga studio; if people are looking for yoga, than we offer more therapeutic type of applications.*”

Beyond naming and establishing a mission, BHC does community outreach in order to convey its identity. In addition to radio and newspaper interviews, health fairs, women's programs, BHC sponsors a monthly “*energy share*,” open to the public; for a \$5 contribution, neophytes to experienced practitioners can participate in energy healing while gaining exposure to the Center.

For IMP, community outreach includes the visitor program in which we participated, but their most important target community is the patients and health professionals in their own hospital. In addition to Dr. Lee's consultations, the Program sponsors Grand Rounds (complete with healthy lunches), open meditation sessions, and other educational opportunities. However, Dr. Cohen is adamant that the research published by Program staff is the most powerful way of establishing credibility. Also important is physicians witnessing positive effects of integrative medicine on patients they have referred to IMP. A third significant way of conveying credibility is clinicians from other units gaining personal experiences with IM, such as the surgeon who had suffered an injury that interfered with his ability to perform operations. After being convinced to allow the Program's acupuncturist to treat him, he was delighted to have renewed surgical ability.

### 3.1.4. Reimbursement issues

A problem discussed at all three centers was reimbursement. The current situation frequently necessitates out-of-pocket payment for complementary modalities even when they are integrated within a comprehensive care plan. Dr. Silver indicates, “*I can't tell you how many discussions I got into having to talk about the money issue.*” Filipa suggests that “*what needs to happen is ... a contract with the insurance companies ... right now there's no billing code for, you know, guided imagery.*” Dr. Cohen believes that within the near future as the evidence for efficacy increases, more complementary modalities will be reimbursed through insurance.

## 4. Discussion and conclusions

### 4.1. Discussion

The comparison of the three IM centers reveals in each not only an array of biomedical and complementary specialties, but also a key clinician who has one foot in allopathic medicine, in terms of initial training, with the other rooted in holistic ways of thinking. These factors stand in stark contrast to the more typical problem of fragmentation: “[F]ocusing and acting on the parts without adequately appreciating their relation to the evolving whole. This unbalance ... is at the root of the more obvious healthcare crises of unsustainable cost increases, poor quality, and inequality” [19]. Another interesting observation is that all the centers, even the fledgling BHC, did not report problems in developing clientele; still, most frequently those clients/patients are self-referred, even

at IMP. Thus, a major issue is convincing physicians, the potential source of referrals, and third party payers about the credibility, efficacy, and safety of complementary therapies. A significant question yet to be thoroughly explored is whether IM is following a path similar to that tread by allopathic medicine toward institutionalization [20], including the adoption of large scale clinical trials as a gold standard.

#### 4.2. Conclusion

Trailblazing integrative medicine includes a multitude of challenges that require novel ways of thinking, ranging from accumulating evidence of effectiveness and safety, designing new practice models that encourage team collaboration, devising ways of interfacing with biomedical practitioners, bolstering organizational identities through symbolic and material means, and negotiating new reimbursement categories.

#### 4.3. Practice implications

As Dr. Cohen clarified, integrative medicine is not enacted in the form of particular modalities. Rather it is a philosophy of and attitude toward what constitutes health. In the words of Dr. Silver, “*The goal is to really provide the most healing possible ....*” In a multidisciplinary context, achieving that goal entails a practice model based on accumulated evidence that encourages collaboration among specialists directed toward optimizing patients’ well-being and self-care capacities. Obstacles may include scheduling time for staff interchange, addressing skepticism of conventional biomedical clinicians, and refusals for insurance reimbursement.

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