

Investigation into Factors Influencing Roles, Relationships, and Referrals in Integrative Medicine

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Abstract

Introduction: Integrative medicine (IM) is a recent phenomenon within primary care practice. It is defined variously as a process of integration or convergence of complementary and alternative medicine (CAM) with mainstream medicine or as the incorporation of alternative therapies into mainstream medical practice. Little is known about the attitude of complementary medicine practitioners regarding their place within this model or the factors that influence referral between them and medical practitioners.

Objectives: The aim of this research was to explore practitioners' perspectives of the theory and practice of the IM model, relevant to factors influencing referral among them.

Design: This research applied a qualitative method with semi-structured interviews to determine practitioner perspectives of factors influencing referral in the IM setting. One family practice physician (called a general practitioner [GP] in Australia), one osteopath, and one naturopath were interviewed at each of two IM clinics in regional Australia. Thematic analysis was used to identify themes and concepts.

Results: Thematic analysis of the transcribed data allowed for an in-depth understanding of themes and concepts surrounding practitioner perceptions of IM. Predominant themes centered on the notion of inter-practitioner relationships and collaborations. Insight into these relationships within IM revealed concepts of interpractitioner trust and respect. In addition, sharing a philosophy of care and a common understanding pertaining to scope of practice and area of expertise appeared to support the IM framework. These concepts and themes were determined as important factors influencing referrals between GPs, osteopathic physicians, and naturopathic practitioners in the IM clinics studied.

Conclusion: This research has highlighted the significance of interprofessional relationships and multidisciplinary referral networks as pivotal in the efficacy of the IM clinics represented in this sample. Further research is needed to define the practitioner roles and the factors influencing referrals within IM.

Introduction

INTEGRATIVE MEDICINE (IM) IS A RECENT phenomenon within primary care practice. There is not a clear consensus on its definition,¹ but it has been defined variously as a process in which integration or convergence of complementary and alternative medicine (CAM) with mainstream medicine occurs “for which there is some high-quality evidence of safety and effectiveness,”² or the “incorporation of alternative therapies into mainstream medical practice.”³ Despite these variations, it is clear that CAM health professionals have roles to play in this model of care.⁴

Little is known of the attitude of the various practitioners regarding their place within the IM model. Two of the major health professions that have been identified as CAM and have been reported as practicing in integrative models are

naturopathy and osteopathy.^{4,5} Naturopathy is one of the largest and most recognized CAM professions in Australia,^{6,7} whose members are primary health care practitioners not currently registered by government statute. Their scope of practice is broad and encompasses both traditional and evidence-based treatments, with varying degrees of acceptance from the conventional medical community.² CAM modalities used by naturopaths include, but are not limited to, botanical medicine, homeopathy, diet, and clinical nutrition. Osteopathy in Australia has evolved from the CAM sector and is a government-registered form of manual medicine, with a primary health care–limited scope role in the treatment of musculoskeletal symptoms.⁴

To date, the literature supports an emerging theme regarding referral networks and reinforcement of interprofessional relationships between general practitioners (GPs) and

CAM practitioners as being significant in the context of integrative practice.^{8–10} Some of the themes that have been explored regarding integrative practice are the patterns of referral, practitioner perspectives of CAM, and the dynamic of interprofessional relationships among practitioners.^{9,11–14}

The aim of the current research was to explore perspectives of the theory and practice of the IM model with GPs, osteopaths, and naturopaths who practice together in integrative medicine clinics.

Materials and Methods

Participants

Participants were two GPs, two naturopaths, and two osteopaths from two primary care clinics that identify as providing IM. The selection criteria for the recruitment of participants was pragmatic and opportunistic because these IM clinics are located in the region and had clinical teaching links with the university in which the study was conducted.

Methodologic approach

Data collection was based on semi-structured in-depth interviews. This allowed for some flexibility of direction of the interviews, with the central issues identified and explored by all participants. All participants were asked to comment on their perceptions of the definition of IM, practitioner roles in IM, what factors influence interpractitioner referral, and the structure of integration adopted within their clinic. The interview questions facilitated a guided conversation to determine the participants' perceptions of the IM model with regards to their understanding, experience, and interprofessional interaction. The method chosen was thematic analysis because it is appropriate to establish patterns and common themes from the transcribed interviews.^{15,16} Constant analysis and interpretation of data continued throughout the interview process, which adheres to the naturalistic paradigm of qualitative research.¹⁶ The principal investigator (first author) conducted the interviews, preliminary coding, and thematic analysis, and the assistant investigator (second author) reviewed and further explored these themes. Both investigators are practitioners of naturopathy and osteopathy.

The Human Research and Ethics Committee of Southern Cross University approved the study. Participants' identities were coded to be kept anonymous. Before the study began, all participants were mailed an information sheet and a consent form stipulating all aspects of the research. The interviews were audiotaped and transcribed. In adopting the qualitative method of thematic analysis, the principal investigator became immersed in the transcribed text so as to be familiar with all aspects of the data. The transcriptions were analyzed through summative content analysis, with coding and development of key themes to interpret the underlying context.^{15,16}

Results

The two clinics represented in this sample have GPs, naturopaths, and osteopaths, as well as other practitioners practicing different modalities. One IM clinic has five GPs, one naturopath, two osteopaths, and six psychologists and is also a teaching clinic for GPs in training. The other IM clinic has three GPs, one naturopath, one osteopath, an

acupuncturist, and a dietitian. All practitioners who were invited participated in the interviews.

IM appears to encompass different practice styles, which are adopted according to the individual clinical setting.^{1,10,17} Common practice styles reported are as follows: interdisciplinarity in a shared location; direct integration, where one practitioner has training in both mainstream medicine and CAM; and multidisciplinary referral network systems.

Often, clinics incorporate a combination of these styles,^{10,18} as is true of the two clinics that participated in this study.

The interviewees reported that the practitioners within the sample clinics drive the integration, with shared files via the clinic intranet, structured case-based meetings, and informal corridor and lunchroom chats. Integration was also led by patients' autonomy and request for referrals. One clinic also performed combined patient consultations between the practitioners, which was perceived by those involved as especially effective. The style of integration provided in the two sample clinics appears to demonstrate a multidisciplinary team approach to primary health care.

The thematic analysis revealed central issues relating to the practice of IM in the two clinics in this sample: lack of a clear definition of IM, inter-practitioner relationships in IM, shared philosophy of care, and trust in referral.

Lack of a clear definition of IM

The question regarding the practitioners' definition of IM was not consistently or clearly answered. The lack of definitional precision was expressed by one osteopath:

"My perception [of integrative medicine] is that there is mixed terminology, that it is both integrative between different practitioners and therefore different skill sets are obtained, but also it is referred to as being integrative within a particular practitioner's approach, so for example the medical practitioner who does some complementary therapies." (Osteo 2)

Interpractitioner relationships in IM

The participants detailed that professionalism is founded on the concept of respect for the other practitioners:

"As fellow practitioners there is an underlying level of respect for each other and the services we provide. In general I have respect for the other practitioners, I know them, I have socialized with them and we have shared patients." (Osteo 2)

The integrative medical setting was described as a supportive environment for the practitioner in terms of continued learning, professional and interpersonal relationships, and providing a team approach to health care.

"The professional relationships are somewhat united by the integrative nature of the clinic in terms of the shared responsibility of cases; it is a supportive environment to work in." (Osteo 1)

Informal communication was highlighted as an important factor for reinforcing interpractitioner relationships and interdisciplinary collaboration:

"[Informal conversation] really makes practice so much better, in the corridor, in the tea room there are nice people there, people that are interested in what you are interested in, and we share. We share a lot, as one of the doctors has said it is a bit like we have become a team with some social relationship between a number of the people." (Osteo 2)

This relationship between the practitioners appeared to revolve around a commitment to a patient-centered environment, which enables the patient to get the most from conventional and complementary and alternative medicine in the one location. The respondents expressed that this supports a nonhierarchical multidisciplinary referral network, where all members of the health care team are considered equally important.

"Integrative medicine looks at developing a team approach to patients' problems, that basically allows the patient to source the most appropriate treatment course or diagnostic specialist for whatever problems they are presenting with and then coordinating that amongst the team." (GP2)

One osteopath believed that the sharing of belief systems is a quality that reinforces interpractitioner collaborations in the integrative health care setting.

"There are definite friendships as well business relationships; this may be a recognized feature of integrative practice, that if you are all into the same thing and philosophically inclined towards integrative practice and multidisciplinary, then maybe that means you will be working with people that you are more matched to in that sense." (Osteo 2)

Shared philosophy of care

The interdisciplinary referrals observed between the practitioners in this sample appeared to be based on the concept of a mutual philosophy pertaining to delivery of primary health care. An osteopath reported:

"It is the practitioners themselves that influence my referral. I refer to the practitioners inside this clinic because I agree with their philosophy, their style and how thorough they are." (Osteo 1)

And from a naturopath:

"We are all coming at it from different angles...we are on different but converging paths and I know this is where the patient gets cared for best." (Nat 2)

According to one osteopath, the sharing of a health care philosophy creates a sociable and supportive working environment.

"...we are bonded on a philosophy of health and therefore it's relaxed, it's more comfortable, we can talk to one another, and it is a supportive environment for the practitioner and for their knowledge." (Osteo 2)

According to one GP, there existed parallel dynamics centering on a multidisciplinary team approach:

"Personally I see it as a team approach, where we are all equal, where sometimes the team leader is the osteopath, sometimes it is the naturopath and sometimes myself as the doctor. This is determined by whoever seems appropriate or who the patient chooses as their primary care practitioner. I have never had ownership problems within a patient relationship, but I know that other doctors do have this problem and I think it is one of the biggest obstacles within integrative medicine. The true integrative model is a shift towards a patient-centered approach as opposed to an ownership approach to the patient." (GP 1)

In this instance, the primary care practitioner is established by patient choice.

"There is no one practitioner in here that thinks that they know it all, or that they think they are at the top of the hierarchy, there are no hierarchical dynamics, it's more a linear

relationship working towards the same goal and that is to get the patients better and support our patients where we can. I think fundamentally that is why it [IM] works." (Nat 2)

This reference to a shared philosophy of health care appears to point to both a holistic and a preventive approach. Both naturopathy and osteopathy as professions have established guiding principles of holism,^{7,14} and the respondent GPs expressed an acceptance of the need for a focus on a patient's lifestyle and psychosocial issues as part of their care, as expressed by one:

"Integrative medicine is light-years ahead of the mainstream medical model and I know this because I have been there, I did a lot of that in my first decade of practice which was very mainstream, essentially I was putting Band-aids on people, forever. And forever saying to myself when they come back and when I have got more time then I will look at their smoking or then I will look at their weight management, but you never get the time because you are always picking up the pieces of an acute medical problem and sticking on another Band-aid because of time constraints so it's fraught with disaster, basically, and it's becoming less and less of an appropriate model when we are looking at chronic disease management and preventative care—preventative care just doesn't happen in mainstream medical practice." (GP 1)

Trust in referral

The issue of trust was a recurring theme among the respondents when asked about their motivation behind referrals to the other practitioners within the integrative setting. According to one doctor, the theme of trust within practitioner relationships influences referrals with respect to legal duty of care and professional responsibility of the referral:

"I have to trust that they [CAM practitioner] know where the medical boundaries lie and they are able to identify a serious issue that becomes essential to address within the mainstream medical realm." (GP 1)

To the same extent, some CAM practitioners perceived trust as being an important feature of the professional relationship when considering outward referrals to other CAM and medical practitioners.

"I get a little bit nervous when I have never heard of the doctor before because at the end of the day it comes back on me, it is my referral and if the patient doesn't get looked after then it is bad advice by me. I have duty of care and a legal responsibility regarding that referral." (Osteo 1)

This concept of trusting a referral therefore appears to be reciprocal as CAM practitioners also felt their duty of care was relevant when referring to GPs. However, according to another osteopath, trusting a referral to CAM practitioners compared with a referral to medical doctors carries a different weight:

"Trusting a referral to a GP is different to trusting a referral to a complementary medicine practitioner. Trusting a referral to a particular naturopath needs to be based on the understanding and agreement of their approach. It's nice to know that if you refer to them within your clinic your patient will receive quality care." (Osteo 2)

This issue of trust conveys medico-legal concerns surrounding safety and duty of care of a referral. According to some CAM practitioners, knowing their own limitations of

primary care assessment and treatment is an essential component of the integrative framework within the clinic.

“I am aware of my limitations as a practitioner and I am really comfortable to say that this is out of the scope of my expertise so let’s get the doctor involved.” (Nat 2)

Some practitioners agreed that there is a medico-legal responsibility to provide an environment where patients feel comfortable discussing their CAM use. One osteopath believes that patients want to feel open to discussing CAM therapies with their GP, and the integrative medical model facilitates this disclosure:

“Patients want to be able to discuss their use of complementary or alternative therapies with their doctor, they don’t want to see a GP who is anti-complementary medicine because they are worried what their GP might think. So seeing a GP who is clearly practicing alongside or with osteopaths, naturopaths, or psychologists means that they are integrative and allows for patients to openly discuss with their doctor their use of complementary therapies.” (Osteo 2)

The practitioners from the two IM clinics shared the belief that the multidisciplinary referral network provides a comprehensive, holistic, and supportive team environment. There is an acceptance and recognition of efficacy for all modalities, established by the themes of interpractitioner relationships, shared philosophy of care, and trust; ultimately, this is what drives the multidisciplinary referrals within IM.

Discussion

The relationship of the practitioners within this model of primary care practice appears pivotal to its perceived success. This is not formally structured, but more experiential and informal. The themes that emerged, however, touch on important issues of patient safety and ethical rights, and so research into the model is vital to further establish these interconnected roles and responsibilities. The variability of the practice styles encompassed in IM will influence these practitioner roles and relationships, and an exploration of how these differing roles integrate would be important in establishing this model of primary care.

The varied logic of GP referral to CAM practitioners is influenced by educational exposure and training and to an extent may be determined by practice location and patient requests.¹² Retrospective data analysis of inter-referral patterns in one study determined that referral from GPs to CAM practitioners is predominantly driven by patient requests.⁸

Convergent beliefs regarding professionalism and philosophy are essential components within the integrative medicine setting.^{10,13,18} Sharing a common philosophy that is aligned with beliefs and values surrounding primary health care delivery concedes trust in the other practitioners’ professionalism and ability. This is an especially important concept for IM clinics, where medicolegal and ethical responsibilities are paramount in each practitioner’s mind. It appears that the importance of concepts of holism (that is, taking into account the patient’s physical, mental, and spiritual health), and prevention, involving looking at lifestyle factors, is shared between the practitioners. The congruence of health care values promotes an environment that is both patient- and practitioner-centered.¹⁹

A nonhierarchical team approach to integrative care allows for the CAM practitioner to act as a patient’s primary care giver.²⁰ As determined by this qualitative study, practitioner perceptions highlighted a preference toward this patient-centered nonhierarchical model of IM. Perceptions of the interpractitioner collaborations within the two clinics studied revealed that mutual empowerment and balanced relationships existed.

This professional respect among the practitioners in the clinics supports the referral of patients and further enhances the collaborative experience for the practitioner and the patient.⁸ It may be extrapolated that it is the professional and personal collaborations within the IM setting that facilitate respect for practitioners of various disciplines and allows for recognition of their area of expertise.

These data support the notion that IM clinics are a supportive environment for practitioners, providing access to the safety of GP services and high-quality CAM. It is fundamental for GPs and CAM practitioners to understand the scope of practice of practitioners within their referral network. Furthermore, it is also important for all IM practitioners to understand and acknowledge their own limitations in terms of diagnosis and treatment.

Limitations of this study include the convenience sample and the small sample size. This means these results cannot be generalized to the broader population. A bias in thematic analysis may be present because there was just one coder; in addition, both investigators practice in the professions under study, which may influence their perceptions of the emerging themes.

Conclusion

This sample of medical and CAM practitioners who practice together in two integrative medical clinics has revealed themes that will assist in defining this model of practice and can be used to construct a phenomenon that may be studied further. These themes will assist other clinics that wish to ensure the success of integrative clinics. This research project has also established that there a better definition of the models of IM is needed.

The GPs, osteopaths, and naturopaths shared philosophy and beliefs pertaining to holistic and integrative practice. This provided a common understanding with regard to each practitioner’s scope of practice and area of expertise relative to the IM model.

Interpractitioner relationships and collaborations supported referral networks within the IM setting. Personal and professional relationships between IM practitioners demonstrated themes of trust and respect, augmenting reciprocity of referrals. Furthermore, the presence of professional collaborations in the IM setting unites practitioners of mainstream medicine with CAM modalities, allowing for a higher level of patient-centred primary care.

When mainstream medicine is integrated with the CAM philosophies, it informs a wider understanding of the patient and the complex interactions that influence primary care delivery in an IM setting. This potentially broadens the scope of both CAM practice and mainstream care.

Author Disclosure Statement

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