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Preferred Models of Integrative Care

A Survey of Complementary and Alternative Medicine Practitioners and General Medical Practitioners

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Abstract

Introduction and Objectives: The opinions of healthcare providers play a crucial role in the debate around integrating complementary and alternative medicine (CAM) into the current healthcare system. The aim of this study is to explore the issue of CAM integration from the provider viewpoint by determining (a) what working relationship CAM practitioners and general practitioners (GPs) prefer or find acceptable, (b) whether there is agreement in the responses of CAM practitioners and GPs and (c) whether expressed opinions differ by CAM modalities.

Methods: A cross-sectional random sample of CAM practitioners (acupuncturists, chiropractors, massage therapists, naturopaths, homeopaths and herbalists; n = 1112) and GPs (n = 413) from Alberta and British Columbia, Canada, were mailed a questionnaire at three timepoints in 2003. In total, 457 questionnaires were returned from CAM practitioners (41% response rate) and 85 from GPs (21% response rate). Participants were asked to rate four models of integration (independent model, collaborative model, supervised model, assimilation model) for six CAM therapies (acupuncture, chiropractic, massage therapy, naturopathy, homeopathy and herbology).

Results: The collaborative model was rated as the most acceptable by all CAM practitioners and GPs, across all therapies. The least acceptable model, for both CAM practitioners and GPs, was the assimilation model. CAM practitioners and GPs disagreed on the acceptability of the independent model and the supervised model, and these differences were statistically significant.

Conclusion: A collaborative working relationship is preferred by both CAM practitioners and GPs. An integrative healthcare system would need to faciliate such working relations.

The public demand for complementary and alternative medicine (CAM) therapies continues to be an issue for health professionals and healthcare policy makers, as growing numbers of patients utilise these therapies in Western nations.[1-14] Currently, complementary and conventional medical care coexists with little contact or communication between the two treatment approaches. Many patients employ CAM therapies in conjunction with conventional care; however, they do so at their own expense and risk, with little – if any – guidance from their physician. The tendency for conventional practitioners to not discuss CAM usage with their patients is well documented.[4,15-19] In addition, there is a lack of communication between CAM and conventional practitioners regarding patient treatment.[20] These communication issues combined with the need for more rigorous evidence concerning the risks and benefits of complementary therapies affects patient care and practitioner responsibility.[21-24]

Surveys in Canada, the UK, Australia and the US indicate a substantial proportion of physicians (>40%) already refer patients to CAM therapies and/or find CAM therapies acceptable and/or believe in the efficacy of CAM for their patients.[12,25-30] In Cana-

da, previous studies[12,14] have shown that 42% of general practitioners (GPs) in Alberta and 83% in Quebec consider CAM therapies 'useful'; however, opinions on how integration of CAM might be achieved have not been explored.

Integration may occur by a variety of strategies,[14,31-35] including co-optation whereby conventional healthcare practitioners deliver CAM therapies, coexistence where conventional and complementary therapies remain distinct, and systemic integration whereby healthcare policies recognise the different levels of integration and facilitate integration at and between each level.[36] Best and Glik[37] attempt to define integration by noting its impact at the health systems, healthcare delivery and personal health level and its influence on the three areas of healing, learning and research. From these theoretical discussions, it becomes clear that healthcare providers have a key role in the integration process; however, little is known about how CAM practitioners and physicians understand and conceptualise integration and if they view integration in compatible terms. Therefore, the research presented in this article aims to examine and answer the following questions: (a) what kind of working relationship do CAM and conventional practitioners prefer or envision as acceptable?; (b) would the working relationship between *all* CAM practitioners and conventional physicians be the same, or would it vary according to CAM modality?; and (c) do CAM practitioners and conventional physicians envision the same working relationship, or does the vision vary across the two sets of practitioners?

Methods

Study Population

This study was a cross-sectional survey of a random sample of CAM practitioners and GPs residing in cities with populations >30 000 in Alberta or British Columbia, Canada. The *Canadian Medical Directory*[38] and the *Yellow Pages*™ [39] were used to create sampling frames to select GPs and practitioners from six CAM modalities (acupuncturists, chiropractors, herbalists, homeopaths, massage therapists and naturopaths).[12] The sampling aim was to obtain 200 practitioners in each province for each of the seven practitioner groups (GPs plus six CAM practitioner groups). When <200 practitioners were listed in the sampling frame for a specific modality, all practitioners were included. Also, the GP sample was extended because of the low response rate. The final sample consisted of 1770 potential respondents: 1299 CAM practitioners and 471 GPs.

Survey Instrument

To design a relevant survey questionnaire, issues regarding integration were first explored through in-depth, face-to-face, semi-structured interviews with ten GPs and ten CAM practitioners. The aim of the interviews was to elicit what integration meant to interviewees, what they perceived as the most important obstacles towards integration, their thoughts on how to overcome these obstacles, and models for how to integrate conventional and complementary medicine. Interviews were recorded, transcribed and analysed. Findings were used to draft a survey questionnaire that was subsequently piloted by first mailing it to the interviewees for their comments. The revised questionnaire was then pilot tested with another ten GPs and ten CAM practitioners.

The first part of the final survey instrument asked for information on individual professional practices, educational background and other sociodemographic data. The second part presented four scenarios/models of potential CAM practitioner and GP working relationships. CAM practitioners and GPs were asked to rate the four working models as either *acceptable* or *not acceptable*, or to state *don't know*, with regard to each CAM modality. The scenarios/models were as follows.

1. *Independent scenario/model*. GPs and CAM practitioners would practice independently of one another. CAM practitioners would treat patients without medical supervision or collaboration with GPs. GPs could, if they chose, recommend the use of CAM therapies to their patients.
2. *Collaborative scenario/model*. GPs and CAM practitioners would work collaboratively in the management of patient treatment and care. GPs and CAM therapists would work together in a collaborative fashion, either at the same site or at different individual practices. There would be active communication on patient management and each 'team' member's opinion would be valued. In such a system, GPs and CAM practitioners would make joint decisions regarding patient care.
3. *Supervised CAM care scenario/model*. CAM therapies would only be provided through medical referral and under medical supervision. CAM practitioners would provide CAM therapies under the supervision of a GP. GPs would be responsible for patient care and would make treatment decisions.
4. *Assimilation scenario/model*. Only GPs would provide CAM therapies, and CAM practitioners would no longer practice without conventional medical accreditation.

We hypothesised that the independent model, in which CAM practitioners have little to no communication with GPs (or with one another) with respect to patient treatment, was the current

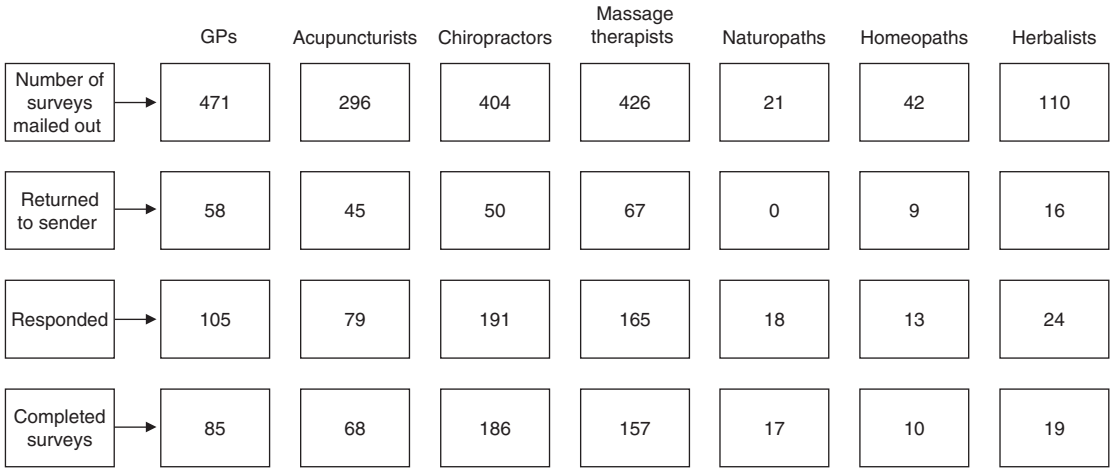

Fig. 1. Practitioner type and mail-out respondents. **GP** = general practitioner.

working relationship. The collaborative model and the supervised model represent integrative relationships. Both models enable communication between CAM practitioners and GPs; however, while the collaborative model allocates equal power to the CAM practitioner and GP, the supervised model places the decision-making power in the domain of the GP. The assimilation model explores the openness of GPs to CAM practitioner involvement in the healthcare system and CAM practitioners' views of each other.

Survey Procedures

The questionnaire packages were mailed out a total of three times between September and November 2003. Each mail package included a letter of introduction that addressed consent and confidentiality, the questionnaire and a postage-paid return envelope. In order to achieve a higher response rate, the introduction letter was modified at each mail-out, and a special appeal was made to all practitioners to act as representatives for their profession. No monetary incentive was included, as it appears not to affect response rates.[40]

Ethics approval for the project was received from the Conjoint Ethics Board of the University of Calgary, Alberta, Canada.

Analysis

Data management and analysis were performed using SPSS® for Windows® (SPSS Inc., Chicago, IL, USA). Descriptive statistics were employed to summarise the data. Chi-squared analysis was used to test for significant differences between groups. The significance level was set at $p < 0.05$.

Results

Response Rate and Demographic Profile

Figure 1 shows the practitioner type and mail-out respondents. Of the 1299 CAM practitioner mailings, 187 were returned due to wrong address. In total, 490 surveys were returned from CAM practitioners, 457 of which were completed. From the 471 GP mailings, 58 were returned due to wrong address. From the GP sample, we received a total of 105 surveys, 85 of which were completed. As such, our response rates were 41% (457/1112) for CAM practitioners and 21% (85/413) for GPs. Amongst responders, both CAM practitioners and GPs were more likely to be males and more likely Canadian born (table I); however, these differences were not found to be statistically significant.

Table I. Demographics of survey sample

Demographics	Practitioner type [n (%)]	
	CAM	GP
Sex		
male	258 (56.5)	54 (63.5)
female	199 (43.5)	31 (36.5)
Age (y)		
mean (SD)	42 (9.9)	49 (9.8)
Native-born status		
foreign born	116 (25.4)	27 (31.8)
Canadian born	341 (74.6)	58 (68.2)

CAM = complementary and alternative medicine; **GP** = general practitioner.

Model Preference

Findings on model preference are summarised in figure 2 and table II. Both CAM practitioners and GPs rated the collaborative model the most acceptable model of integration. Depending on modality (acupuncture, chiropractic, massage therapy, naturopathy, homeopathy and herbal medicine), between 76% and 90% of CAM practitioners supported this model. GP support varied more by modality, with between 32% and 79% of GPs backing collaboration. GPs showed the greatest willingness to collaborate with acupuncturists (79%), massage therapists (78%) and chiropractors (67%) but were less willing to work collaboratively with herbalists (48%), naturopaths (36.5%) and homeopaths (32%).

The independent model was rated the second most acceptable working scenario for all modalities by both CAM practitioners (57–81%) and GPs (23–71%). Amongst all modalities, CAM practitioners felt least comfortable about homeopaths (59%) and herbalists (57%) working independently. Similarly, GPs gave the lowest acceptance rate to naturopaths (29%), herbalists (29%) and homeopaths (24%).

CAM practitioners and GPs differed regarding their acceptance of the supervised model. Depending on modality, 3–10% of CAM practitioners versus 21–46% of GPs considered the supervised model acceptable. Amongst all modalities, massage therapy received the highest acceptance rate for supervision both from CAM practitioners (10%) and GPs (46%).

The least acceptable model, for both CAM practitioners and GPs, was the assimilation model. Depending on modality, between 1% and 3% of CAM practitioners and between 7% and 19% of GPs found this model acceptable. GPs showed the least interest in having manipulative therapies delivered by physicians (chiropractic treatment 7%; massage therapy 8%) but showed more acceptance for physicians providing acupuncture (19%) and making herbal prescriptions (14%).

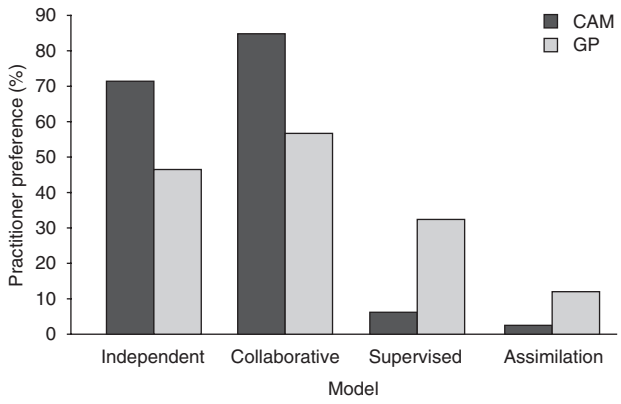

Fig. 2. General working model preference of general practitioners (GPs) and complementary and alternative medicine (CAM) practitioners.

Finally, both CAM practitioners and GPs frequently chose the response option 'don't know' when asked to decide about working scenarios for naturopaths, homeopaths and herbalists. This was particularly notable when GPs considered the independent, collaborative or supervised model for naturopaths and homeopaths. For these modalities, the number of 'don't know' responses resembled or even outnumbered the other answer options.

Discussion

This is the first study of its kind to examine potential models of CAM integration from the perspective of CAM practitioners and conventional GPs. The general pattern for both practitioner groups across all studied modalities rated the collaborative model first, independent model second, supervised model third and assimilation model fourth. The consistent preference for collaboration amongst CAM practitioners and GPs is encouraging and suggests a basic approach to CAM integration that could be built on.

Interestingly, both CAM practitioners and GPs showed little support for the assimilation model. Although CAM practitioners' rejection of assimilation is not surprising, it is notable that GPs in Western Canada appear to prefer an involvement with CAM practitioners over physicians assuming the practice of CAM.

Whereas GPs provided moderate support for a supervised model, CAM practitioners were clearly opposed to it. CAM practitioners favoured independence over supervision, thus indicating that they prefer to work under the present conditions (e.g. independent of the conventional healthcare system) rather than become subordinate to medical doctors.

Examining model preference further shows that GPs were far more consistent in their support of a collaborative model for acupuncture, massage therapy and chiropractic compared with the other modalities (naturopathy, homeopathy and herbal medicine). These results are in keeping with the comprehensive review of Astin et al.[25] that showed the highest physician referral rates for acupuncture, chiropractic and massage, and weak physician support for homeopathy and herbal medicine. This is also related to knowledge.

GPs' model preferences were less distinct for naturopathy, homeopathy and herbal medicine. The diffusion of GP ratings thus points to a wider variance of opinion about these CAM modalities. However, it needs to be stressed that 'don't know' constituted a common response, indicating that naturopathy, homeopathy and herbal medicine are less familiar to GPs.

Table II. General practitioners (GPs) and complementary and alternative medicine (CAM) practitioners' working model preference by modality

Modality and model type	CAM practitioners (n = 457)			GPs (n = 85)			p-Value
	model preference [n (%)]			model preference [n (%)]			
	acceptable	not acceptable	don't know	acceptable	not acceptable	don't know	
Acupuncture							
Independent model	365 (79.9)	62 (13.6)	30 (6.5)	60 (70.6)	18 (21.2)	7 (8.2)	0.143
Collaborative model	412 (90.2)	27 (5.9)	18 (3.9)	67 (78.8)	14 (16.5)	4 (4.7)	0.003
Supervised model	28 (6.1)	409 (89.5)	20 (4.4)	33 (38.8)	44 (51.8)	8 (9.4)	0.000
Assimilation model	14 (3.1)	433 (94.7)	10 (2.2)	16 (18.8)	61 (71.8)	8 (9.4)	0.000
Chiropractic							
Independent model	370 (81.0)	69 (15.1)	18 (3.9)	49 (57.6)	27 (31.8)	9 (10.6)	0.000
Collaborative model	408 (89.3)	29 (6.3)	20 (4.4)	57 (67.1)	21 (24.7)	7 (8.2)	0.000
Supervised model	16 (3.5)	426 (93.2)	15 (3.3)	28 (32.9)	47 (55.3)	10 (11.8)	0.000
Assimilation model	7 (1.5)	440 (96.3)	10 (2.2)	6 (7.1)	69 (81.2)	10 (11.8)	0.000
Massage therapy							
Independent model	362 (79.2)	74 (16.2)	21 (4.6)	58 (68.2)	20 (23.5)	7 (8.2)	0.075
Collaborative model	405 (88.6)	32 (7.0)	20 (4.4)	66 (77.6)	15 (17.6)	4 (4.7)	0.006
Supervised model	44 (9.6)	396 (86.7)	17 (3.7)	39 (45.9)	40 (47.1)	6 (7.1)	0.000
Assimilation model	6 (1.3)	443 (96.9)	8 (1.8)	7 (8.2)	69 (81.2)	9 (10.6)	0.000
Naturopathy							
Independent model	331 (72.4)	69 (15.1)	57 (12.5)	25 (29.4)	28 (32.9)	32 (37.6)	0.000
Collaborative model	387 (84.7)	28 (6.1)	42 (9.2)	31 (36.5)	25 (29.4)	29 (34.1)	0.000
Supervised model	16 (3.5)	396 (86.7)	45 (9.8)	18 (21.2)	33 (38.8)	34 (40.0)	0.000
Assimilation model	13 (2.8)	421 (92.1)	23 (5.0)	10 (11.8)	54 (63.5)	21 (24.7)	0.000
Homeopathy							
Independent model	268 (58.6)	78 (17.1)	111 (24.3)	20 (23.5)	32 (37.6)	33 (38.8)	0.000
Collaborative model	349 (76.4)	30 (6.6)	78 (17.1)	27 (31.8)	29 (34.1)	29 (34.1)	0.000
Supervised model	27 (5.9)	356 (77.9)	74 (16.2)	20 (23.5)	32 (37.6)	33 (38.8)	0.000
Assimilation model	14 (3.1)	412 (90.2)	31 (6.8)	10 (11.8)	56 (65.9)	19 (22.4)	0.000
Herbology							
Independent model	262 (57.3)	99 (21.7)	96 (21.0)	25 (29.4)	35 (41.2)	25 (29.4)	0.000
Collaborative model	363 (79.4)	31 (6.8)	63 (13.8)	41 (48.2)	26 (30.6)	18 (21.2)	0.000
Supervised model	39 (8.5)	356 (77.9)	62 (13.6)	27 (31.8)	32 (37.6)	26 (30.6)	0.000
Assimilation model	15 (3.3)	419 (91.7)	23 (5.0)	12 (14.1)	53 (62.4)	20 (23.5)	0.000

Internationally, GPs also have concerns about models of integration. On 1 January 2004, Norway became the first Scandinavian country to fully integrate CAM therapies into its nationally funded healthcare system. The new legislation gave GPs the authority to refer, but did not address the need for additional knowledge or training in CAM therapies. Norwegian GPs have expressed their reservations with this approach, as they wrestle with how to "exercise most responsibly their new role as the 'gatekeeper' to alternative healthcare".[41] Norwegian GPs questioned their ability to responsibly make referral decisions about CAM treatments that they may know little about.[41] Issues surrounding the CAM educational gap that GPs may experience, in Norway and other Westernised countries such as Canada, need to come to the forefront if GPs and CAM practitioners are to successfully collaborate within an integrated healthcare system.

Research in the UK reveals integrated healthcare trends that demonstrate the existence of multiple models of collaboration between GPs and CAM practitioners. Increasing numbers of GPs are practising CAM medicine to treat their NHS patients;[42] however, patient access to CAM therapies in the UK also occurs by referral to outside services, in-house specialists or to another primary care team member.[29,30] Although GPs in the UK were reportedly satisfied with this arrangement,[42] it is unknown how CAM practitioners perceive this trend. Easthope et al.[27] report similar trends in Australia; GPs increasingly refer patients to CAM practitioners, as well as adopt CAM modalities within their own practice. An American study reports that CAM practitioners in the US are eager to work collaboratively with conventional practitioners within a patient-centred integrated healthcare system.[43]

A major limitation of this study was the poor response rate, especially that of the GPs. The GPs who responded to this survey may represent only those who hold high interest in CAM.[44] Additionally, our study sampled only practitioners in Western Canada; therefore, a regional effect may be present in the data. As a result, our findings must be interpreted with caution and may not be generalisable to practitioners across Canada.

Conclusion

Although our findings reflect similar attitudes between CAM practitioners and GPs to models of integration, generally GPs' acceptance of, or support for, any of the integration models was more conservative than that of CAM practitioners.

CAM practitioners did not discriminate their acceptance of a model based on the modality, whereas for GPs, the therapeutic modality influenced the form of preferred integration. This may be related to GPs' lack of familiarity with certain CAM therapies, particularly with naturopathy, homeopathy and herbal medicines.

Our findings demonstrate the potential for CAM practitioners and GPs in Western Canada to work collaboratively towards a more integrated healthcare system. At the same time, our results support the continued development of CAM therapies in an independent service delivery environment.

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