The New Trend in Health Care: Motivations, Perceptions, and Care Coordination in Integrative Medicine

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The New Trend in Health Care: Motivations, Perceptions, and Care Coordination in Integrative Medicine

By

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Submitted in partial fulfillment of the requirement for Honors in the Department of Sociology

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ABSTRACT

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Integrative medicine (IM) has been a new approach to health care that has increasingly emerged over the past two decades in America. This care approach focuses on patient-centered care, preventative health, care coordination, and includes practitioners from both Western and Complementary and Alternative Medicine (CAM). Unfortunately, the emergence of IM can be hindered by differences in medical paradigms and stereotypes between Western and CAM practitioners. These differences and false perceptions have prevented IM, an effective form of care, from being offered to many patients. However, the number of IM centers has been increasing over the recent years and there has not been research on how Western and CAM-based practitioners perceive IM when working in the same clinical setting.

This thesis focuses on the experiences and attitudes of CAM providers delivering IM with practitioners from different medical backgrounds. Face-to-face interviews and questionnaires to self-selected samples from local IM centers are conducted. The results suggest that CAM providers are motivated to integrate care because of positive personal experiences with IM and the collective expertise that can be used to deliver better care. Perceptions of CAM practitioners have also shifted in time from not desiring working relationships with Western providers to valuing highly their care approaches. The findings from CAM respondents reveal that they can coordinate care effectively with providers who have different medical paradigms in the same IM center. Further research would be benefitted by a larger and more representative sample as well as comparative analyses with conventional and CAM care outcomes.
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Chapter One: Literature Review

1.1. Western Medicine in the United States (US)

Western, or conventional, medicine is an approach to medicine by which medical professionals (doctors, nurses, pharmacists) use surgery and drugs to combat diseases and their respective symptoms. This type of medicine has widely characterized healthcare in the US compared to the practice of medicine in other cultures and tribes (McClure 2002; Unschuld 2009; Willard 2005). In its preconception, American medicine began with the use of prehistoric treatments, such as herbs and plants, to care for patients (Mantri 2008). However, over the course of several years, American medicine became grounded in science to explain pathology and generate treatments (Mantri 2008). This process was accelerated by the emergence of anatomy and technology, such as using microscopes to examine cells, that further ingrained medicine as a subject of science (Mantri 2008). Only from understanding the science behind medicine did physicians believe they could serve their patients.

The early scientific breakthroughs in Western medicine led to many medical advancements seen today and the preservation of countless human lives (Nathan & Cars 2014). These breakthroughs in medicine led to the emergence of pharmaceutical drugs and resulted in a reliance on pharmaceuticals to eliminate many acute diseases rampant at the time (Green 2000). Due to this forward path of medical advancement, the medical community in the US primarily defined combating disease as healthcare (Green 2000). Of the most notable, the methods to combat disease have been body examinations, pharmaceutical drugs, and invasive surgeries – all of which have been integral to saving millions of lives. These methods that save lives have been a paramount strength to Western healthcare and have drawn the dire attention of patients in need.
Pharmaceuticals and invasive procedures are heavily relied upon to combat disease because they are extremely beneficial in repairing the body. For instance, many of the existing Western medical interventions used in health centers were devised using the best technology, evidence, statistics, and medical research available (Green 2000). The primary focus to create the best treatments generated hundreds of medical drug therapies to fight against illnesses, and thus, the effectiveness of these treatments has been cited as a strength to conventional medicine. Despite the large focus on finding specific cures for certain illnesses, many Western physicians still realized that mental states, patient’s families, and other factors could contribute to a patient’s illness (Shyrock, 1956). However, the focus for research to find a cure for any disease resulted in an intense production of pharmaceutical drugs to combat illnesses and preserve health, instead of more preventative efforts to alleviate the health determinants of disease. As a result, a weakness of this medical approach was a lack of attention to preventing illnesses and a lack of considering other factors (environmental, mental, lifestyle) that may have resulted in one’s disease.

Another defining characteristic of Western medical practice in the US has been the biomedical model to deliver care. In this model, health is defined as the absence of disease (McClure 2002, Willard 2005). From this perspective of health, conventional medicine seeks to define disease as a malfunction of the body that is caused by abnormalities in the biological and physiological aspects of bodily systems (McClure 2002, Willard 2005). This approach has been advantageous for doctors as it allows physicians to solely focus on the symptoms and deliver a correct diagnosis (McClure 2002). As a result, patients can receive an accurate treatment for their health issues. However, this approach has caused patients to be observed as machines that are broken and needed to be repaired (McClure 2002, Willard 2005). This reductionist perspective of
patients is often a criticism of Westernized medicine as it objectifies patients and deprives them of dignity.

Due to the immense scientific knowledge required to understand the evidence behind conventional treatments and how to repair the body, many physicians perceive themselves to be the expert during doctor-patient relationships (McClure 2002; Willard 2005). As a result, physicians practicing within the biomedical model have taken a more paternalistic approach to care and expect patients to take a more passive role in receiving medical treatment (McClure 2002; Willard 2005). The sheer amount of knowledge from Western health professionals that can be leveraged to cure patients is widely regarded as a strength of conventional medicine. Since medical knowledge can be so convoluted, patients have been accustomed to just trust physicians because “the doctor knows best,” making health decisions seemingly easier to make (McClure 2002). However, a drawback of this approach is that the amount of medical knowledge can also be leveraged to control the health decisions of patients (McClure 2002). Unfortunately, many doctors can be dominating towards their patients when prescribing treatments because of the preconceived notion that patients will not be able to understand the medical knowledge behind the disease (Willard 2005). This paternalistic doctor-patient relationship can put pressure on patients in the decision-making process, reduce their autonomy to make choices, and leave patients still confused about their health condition because of the medical jargon that doctors use (Willard 2005). Therefore, although the amount of medical knowledge from Western healthcare has streamlined the decision-making process and created many treatments, weaknesses are that these perceived benefits can deliver paternalistic care and devalue patients.

Overall, the perspective of health, reliance on pharmaceuticals and invasive procedures, and paternalistic approach to doctor-patient relationships have been the three pillars of the
biomedical model of Western medicine. While these aspects have been crucial to saving many lives in conventional healthcare, they have also been the most criticized among patients. Many individuals express concerns that the absence of illness does not constitute the full meaning of health. Furthermore, patients also describe negative side-effects from relying on pharmaceuticals and feelings of condescension from the doctor-patient interactions in the biomedical model of care. These are legitimate concerns that patients continue to express, despite the fact that many patients still utilize conventional medicine in the US healthcare system.

1.2. Complementary and Alternative Medicine

Complementary and alternative medicine (CAM) encompasses a wide array of treatments from various cultures and tribes. These treatments include natural products (vitamins, herbs, minerals), homeopathy, naturopathy, and mind-body practices (yoga, meditation, acupuncture) (Agarwal 2018). This type of medicine draws from various cultural beliefs, rich histories, indigenous philosophies, and also science to create the modalities used to preserve health (Agarwal, 2018). Due to the path from which CAM has emerged, CAM has been characterized as holistic healthcare and differs in many aspects to Western or conventional medicine.

A defining characteristic of CAM that differs from Western medicine is its shift away from the biomedical model of care. Instead, CAM seeks to provide care holistically. As a basis for this type of care, health in the context of CAM is not only defined as the absence of diseases, but also acknowledges the emotional, mental, spiritual, and relational well-being of an individual (Sointu 2011; Willard 2005). Therefore, CAM practitioners also try to focus on the myriad of concerns that patients feel may be connected with their illness (Sointu 2011; Willard 2005). This directly contrasts conventional medicine because CAM evaluates health beyond the tangible
symptoms that Western physicians primarily measure. In addition, CAM accounts for factors that cannot be touched, seen, and health determinants (social, environmental) that may contribute to the onset of one’s illness.

Another distinct characteristic of CAM is that CAM treatments do not rely on surgery or pharmaceuticals, but rely on therapy, lifestyle changes, and traditional practices. For instance, patients of CAM practitioners will take nutritional supplements, go to therapy or yoga, or may receive acupuncture treatment based from traditional Chinese medicine (Willard, 2005). While there are many criticisms that these treatments have not been tested rigorously enough or are not effective, these treatments are still utilized and sought out by many patients (Olson, 2001). Although Western medicine can focus on lifestyle changes like CAM treatments do, the focus of Western medicine is primarily to treat the illness itself while the focuses of CAM treatments are to treat the illness and the causes of illness (Willard 2005). In this manner, the approach to treatments and treatment modalities of CAM differ from conventional medicine.

It is also important to recognize that the CAM practitioners collaborate, empower, and create relationships with their patients (Sointu 2011; Willard 2005). Within these doctor-patient relationships, CAM patients describe participative decision-making and more autonomy in their health care compared to conventional medical approaches (Willard 2005). CAM practitioners are described to address patients’ myriad of concerns, unique life experiences, and give full attention to patients when they speak (Nissen 2011; Wyatt and Furnham 2011). The recognition of patients’ history outside of their immediate medical concerns and autonomy empower patients to take control of their health and gives confidence in the care they receive. This attentive approach from CAM practitioners has been addressed as a strength of CAM, but can be very time-consuming for CAM practitioners who may have other patients to care for. Also, this approach
can lead to unnecessary details in the diagnosing process that may not be relevant to a patients’ health condition. Nevertheless, it is important to realize that the CAM doctor-patient relationship starkly contrasts with the type of doctor-patient relationship practiced in Western medicine.

1.3. Users of CAM

All types of patients have been known to use CAM. The most recent statistic shows that 38% of patients employ CAM therapies, indicating that a considerable number of patients desire this type of medicine (Barnes 2004; NCCIH 2008). Nevertheless, within this population of CAM users, women are primary consumers of CAM (Holden et al. 2015; Keshet and Simchai 2014; Willard 2005). The larger use among women can be attributed to the unique approach by which CAM practitioners form doctor-patient relationships. In the literature, women report that the focus on holistic health, well-being, and attentiveness in CAM settings served as emancipating alternatives to the paternalism sensed in Western settings (Keshet and Simchai 2014, Willard 2005). CAM usage also became an avenue in which women could experience empowerment to challenge power relations and inequalities in Western healthcare (Keshet and Simchai 2014; Willard 2005). Thus, women could gain strength through CAM usage and oppose stereotypical gender roles found in Western healthcare by avoiding conventional medicine (Willard 2005).

Based on the opportunity to improve their well-being, experience empowerment, and dismantle oppressive institutions, women became primary users of CAM.

CAM users are predominantly made up of individuals with higher socioeconomic status. For example, research shows that middle-class and upper-class women predominantly comprise of the female population that utilizes CAM (Keshet and Simchai 2014). A contributing factor for this pattern may be due to the fact that many CAM therapies are paid for out-of-pocket and therefore, have a greater utilization among groups that can afford healthcare (Branson 2014;
Lafferty et al. 2006). Practically, the higher cost of affording CAM treatments is a valid reason for why those with higher socioeconomic status are greater users of CAM.

It was also important to account for the race and ethnicity of primary CAM users. When socioeconomic status was controlled for in a study of Non-Hispanic White, African American, Mexican American, and Chinese American individuals, Non-Hispanic White women were shown to be the greatest users of CAM therapies and used the greatest variety of CAM treatments (Kronenberg et al. 2006). Considering that this study was done in America, Non-Hispanic White women may have greater access to CAM therapies because they are likely to have access to more social resources compared to minority women (Kronenberg et al. 2006). Nevertheless, the other populations still used CAM. Specifically in the African American population, different research showed that racial discrimination in conventional settings was associated with greater CAM use (Shippee et al. 2012). This does not refute the conclusions regarding how lower socioeconomic status is correlated with lower CAM use, since African Americans disproportionately make up the indigent population (Keshet and Simchai 2014; Keshet and Simchai 2014). Instead, this research shows that racial discrimination can cause minorities to use CAM in order to avoid experiences of discrimination in Western institutional settings (Shippee et al. 2012). Thus, in regard to ethnicity, Non-Hispanic White women were the greatest aggregate users of CAM, but minorities are also CAM users who may further utilize this care if they have experienced prior racial discrimination in conventional medical settings.

1.4. Effectiveness of CAM

There is considerable debate regarding the effectiveness of CAM treatments. While many of these treatments have historically and traditionally been utilized across cultures and time,
many specific CAM modalities have been tested to understand their true health outcomes (Hopf et al. 2016; Hu et al. 2013; Rubinstein et al. 2010; Wanchai et al. 2010).

Some researchers and critics of CAM treatments expressed that scientific proof and evidence-based clinical trials are not enough to understand the true health outcomes of CAM modalities. Opponents to CAM describe that the benefits of holistic treatments are difficult to measure because studies evaluating the effectiveness of CAM are too short (i.e. less than 6 months), have a small sample size, and are rarely placebo-controlled or a double-blind study (McClure, 2002). The implication is that CAM research must meet certain qualifications in order for researchers to truly evaluate the efficacy of CAM treatments. Based on these presumptions, it may be skeptical to draw implications about the health benefits of CAM treatments from investigations that do not meet these qualifications.

However, it is important to recognize that the emphasis on meeting these research qualifications and drawing empirically palpable outcomes from CAM research operates within a biomedical model of medicine – not a holistic model. This is because these arguments suggest that empirical and statistical evidence are needed in order to understand if one’s illness can be eradicated by a CAM treatment, thus, hinting at the biomedical definition of health (Green 2000). However, one must realize that while tangible benefits to health and empirical evidence are important, CAM treatments can be still be considered “effective” if they improve any aspect of one’s well-being (emotional, mental, spiritual) as discussed in holistic medicine (Sointu 2011; Willard 2005). Therefore, criticisms of lackluster CAM research models are not sufficient to disregard the efficacy of CAM research since the criticisms are not based on definitions of health or a focus on patient well-being as exemplified in CAM clinical settings.
Two important studies of CAM show that CAM modalities are effective in treating symptoms and comorbidities stemming from chronic illnesses. Research on 157 autistic children with digestive, sleep and immune comorbidities showed that approximately 80% of the autistic children used CAM modalities (Hopf et al. 2016). In particular, the CAM therapies most used were multivitamins, methyl B-12 injections, and a gluten-free casein diet (Hopf et al. 2016). Based on self-reported survey responses using a 1-5 Likert scale, the mean response of CAM effectiveness in relieving the comorbidities was 4.00, indicating that the CAM therapies were effective (Hopf et al. 2016). Another study showed similar results in regard to the health outcomes of CAM treatment for chronic illnesses. In an investigation of 236 CAM users with hypertension, the most widely used CAM modalities were acupuncture, mind-body medicine, vitamin supplements, and other natural products (Hu et al. 2013). This study also gathered data in a similar fashion as surveys were used to collect self-reported data on CAM efficacy. The researchers found that 70% of respondents reported how the CAM therapies were effective in improving their health outcomes and mitigating comorbidities associated with hypertension (Hu et al. 2013). These studies were cross-sectional, and thus, would not meet that research qualifications stated by McClure (McClure 2002). However, based on the holistic definition of health, the CAM therapies were shown to have improved well-being based on self-reported data from individuals. If individuals report a greater sense of well-being and comfort, then it is necessary to acknowledge CAM therapies for improving patients’ health in some manner.

A systematic review of CAM therapies in treating low-back pain looked more broadly at multiple studies to fully comprehend the effectiveness of CAM therapies, rather than making conclusions from just one investigation. In particular, researchers focused on the health outcomes from utilizing acupuncture and spinal manipulative therapy (SMT) – two types of CAM
modalities (Rubinstein et al. 2010). Acupuncture was specifically shown to provide short-term health improvements compared to the control group that did not use acupuncture, which was consistent with existing literature (Rubinstein et al. 2010). However, a lack of studies and low-quality evidence evaluated in the systematic literature review suggest that SMT is not effective in improving health outcomes for low-back pain (Rubinstein et al. 2010). This is significant as SMT is widely used as a CAM therapy, but is one of the few CAM therapies that is deemed ineffective. This review provides important implications that not all CAM therapies may be effective and their usage may only prove advantageous depending on patients’ conditions.

One example of a situation when utilizing CAM may be ineffective is in the treatment of breast cancer. Another systematic literature review that evaluated breast cancer patients who used natural products (e.g. herbs, vitamins) and/or mind-body medicine (e.g. meditation, prayer) showed that none of the studies have yet to show altered cancer progression due to CAM use (Wanchai et al. 2010). The investigation through the literature may suggest that CAM therapies are ineffective for specifically treating breast cancer and its symptoms. However, it is important to note that the review did not evaluate improvements in one’s emotional, mental, or spiritual well-being – rather, it only focused on the cancer progression. Moreover, only two studies in the review investigated the effects of homeopathy and acupuncture, which are two of the most widely known treatments for their improvements in health outcomes (Wanchai et al. 2010). From these two limitations in the review, one cannot fully generalize the results to state that all CAM therapies are ineffective in treating breast cancer. However, it would be valid to conclude that breast cancer progression is not affected by mind-body medicine and nutritional products.

1.5. An Overview of Integrative Medicine (IM)
To understand IM, it is first important to distinguish IM from conventional, alternative, and complementary medical care. IM is different from conventional medicine in that IM integrates aspects of CAM along with Western medicine in order to provide medical care. (NCCIH 2016). Therapies outside of conventional medicine but used in place of conventional medicine are “alternative” (Barret 2003). CAM therapies used on the side of conventional medicine is “complementary” (Barrett 2003). However, IM comes from an incorporation of the values and concepts from all three types of medicinal approaches in order to provide patient-centered care (Barrett 2003). Overall, there are various definitions of IM expressed in the literature, but all involve bringing complementary and conventional approaches together to provide coordinated healthcare (NCCIH 2016). To better conceptualize IM, there are four prominent themes that distinguish an integrative approach to medicine.

The first theme found throughout IM is that IM is a new model and approach to healthcare (Ng et al. 2016). IM is not conventional or CAM, but builds upon both types of medical approaches to create a novel health model more adept in improving the well-being of patients (Ng 2016; Synderman and Weil, 2002). One primary example of how IM builds upon CAM and Western medicine is the team-based approach to care that is emerging in Western healthcare contexts, but is foundational in IM. In IM, practitioners work in interdisciplinary teams to care for individual patients and coordinate care (Baer 2008; Diamond 2000; Mann et al. 2004). Utilizing interdisciplinary teams of various practitioners allows clinicians to better communicate among each other and provide the best combination of therapies to address patients’ health concerns. Put simply, building upon the best practices from CAM and Western medicine has allowed CAM to provide a new and possibly better model of healthcare.
The second theme prominent in integrative medical care is the combination of CAM and conventional therapies (Ng et al. 2016). The goal has been to incorporate positive aspects of both conventional and non-conventional medicine in order to deliver better healthcare (Ng et al. 2016). However, this goal comes with the challenge to filter through conventional and CAM therapies in order to know which ideas and practices are the most effective, cost-effective, and safest (Ng et al. 2016; Weil 2000). As a result of integration, some aspects of these medical approaches have had to be compromised. For instance, IM does not view health simply as the absence of disease as discussed in the biomedical model. Instead, IM emphasizes compassion, active engagement, and holistic care when improving the health of patients – an aspect more salient in the holistic approach to care (Ng et al. 2016; Synderman and Weil 2002) On the other hand, IM utilizes Western treatments, but only integrates the CAM therapies that are accepted, effective, and backed by evidence (NCCIH, 2016). This approach to creating treatments parallels how pharmaceuticals are generated and tested within the biomedical model. Nevertheless, practitioners within IM realize that science has its limitations, and that unconventional therapies can still showcase therapeutic ability and be accepted, despite research lacking data specifically on disease progression (Diamond 2001; Ng et al. 2016; Synderman and Weil 2002). Moreover, IM looks beyond theoretical approaches of medicine, and also seeks to have hospital-based integration (Mann et al. 2004; Ng et al. 2016). Doing so allows for better team-based coordination of care and promotes both types of therapies to work in conjunction with each other. A combination of therapeutic models and treatments uniquely distinguishes IM from other care approaches.

The third theme prevalent in IM is patient-centered care (Ng et al. 2016). Patient-centered care is care that accounts for all aspects of an individual and his/her health (Ng et al. 2016). This
includes delivering care that is personalized, focusing on the biological, psychological, mental, social, and spiritual wellness of an entire patient (Bell et al. 2002; Diamond 2001; Kigler et al. 2004; Maizes et al. 2009; Ng et al. 2016). Moreover, factors outside of an individual, such as the environment and community, are important aspects that are accounted for by IM practitioners (Maizes et al. 2009). This approach to care differs from the biomedical model, but ensures that holistic medical care is offered to patients.

The last theme associated with IM is preventive health (Ng et al. 2016). Instead of combatting illness upon its onset, IM practitioners seek to prevent disease before its onset and even after treating a disease (Flaherty et al. 2015; Ng et al. 2016). One avenue that preventative health is exercised is through maintaining a healthy lifestyle (Ng et al. 2016; Syderman and Weil 2002). For a healthy lifestyle, IM practitioners encourage an individualized diet, stress management, exercise, and emotional well-being (Ng et al. 2016; Syderman and Weil 2002). Motivating patients to take control of their health outside of medical institutions can prevent illnesses, and this is uniquely emphasized more often within IM.

Overall, these four themes prominent within IM show that IM is an approach to medicine that widens the amount of treatment options for individuals to holistically treat the myriad of factors that can cause an illness (Dog and Maizes 2010). Building upon two primary models of health, IM is a novel approach to healthcare expected to improve the health of many patients.

1.6. Users of IM and Reasons for Its Use

Individuals seeking IM share many of the same characteristics and demographics of those seeking CAM. Research from a variety of studies shows that patients using IM are likely to be female, well-educated, and have a relatively higher socioeconomic status (Leach et al. 2017; Joel et al. 2014; McCubbin et al. 2017; Wardle 2017). Moreover, a survey of 27,225 patients between
2007 and 2014 showed that 73% of individuals seeking IM in an integrated healthcare system were non-Hispanic white patients (McCubbin et al. 2017). These characteristics show that patients utilizing an IM approach parallel the demographics of those using CAM modalities. If IM patients have similar demographics with those who use CAM, then it is likely that motives for CAM may be similar to the motives of IM patients as well.

Typical of patients seeking CAM, a primary reason patients use IM is due to the strong therapeutic relationship practiced by IM practitioners. In this patient-doctor relationship, practitioners give intentional time to listen to all factors that might influence a patient’s well-being (McCaffrey et al. 2007). In fact, the quick appointments and paternalistic approach found in the doctor-patient relationships of conventional medicine were disliked by patients seeking IM insofar as it pushed them towards seeking IM instead (McCaffrey et al. 2007). Patients feel that the patient-centered doctor-patient relationship used in IM allows patients to utilize a holistic model of health that is able improve all aspects of their well-being and not just the physical.

Patients are more likely to seek out IM services if they have a chronic illness (Edman et al. 2014; Leach et al. 2017; McCubbin et al. 2017). This is a trend found in patients utilizing CAM as well (Solomon and Adams 2015; Rao et al. 2016). In particular for IM, patients at IM centers use IM to relieve pain from symptoms related to the primary illness as well as to manage symptoms caused by comorbidities (Edman et al. 2014; McCubbin et al. 2017). An investigation on 353 cancer patients discovered that the main reason patients sought an IM center was to receive health care that addressed spirituality as part of its care (Edman et al. 2014). This was so that patients could receive treatment to manage their depressive symptoms, perceived stress, and pain resulting from cancer (Edman et al. 2014). Moreover, the study provided substantiation that patients seeking IM treatment are demographically similar to those seeking CAM, as the
majority of participants were non-Hispanic white, female, and well-educated (80.4% completed college) (Edman et al. 2014). A cross-sectional analysis of 2,105 patients admitted to an inpatient Western primary care setting showed similar findings. The researchers discovered herbal medicine use was more common among chronically ill patients (Leach et al. 2017). Also, majority of patients who used herbal medicine in the IM center were female, well-educated (complete high school), adopted healthier lifestyles, and did not want to use pharmaceutical drugs if they could be avoided (Leach et al. 2017). These reasons for IM use are consistent with the literature that reports similar demographics and motivations for using CAM. Overall, these studies indicate that primary IM users are those with chronic illnesses and have similar motivations as CAM users.

Other reasons for IM utilization are unique to IM and are not motivations for using conventional medicine or CAM. One primary reason patients seek IM, instead of CAM or conventional medicine, is because they believe that IM is superior to each approach on its own (McCaffrey et al. 2007). This is because IM was established and continues to advance by only incorporating the best values, concepts, and treatments that are the most effective from both CAM and conventional medicine (Ng et al. 2016; Weil 2000). Additionally, because both CAM and conventional medicine each have some limitations, patients feel that IM accounts for the drawbacks of each approach to ensure that IM can provide the highest quality of medical care (McCaffrey et al. 2007). As a result, patients who receive IM feel that they are receiving the best and most holistic care possible.

Preventative health, one of the prominent themes of IM, is also another reason patients seek out IM. A longitudinal study of 27,225 patients between 2007 and 2014 showed that patients used IM for pain relief from prior treatment, functional impairment that hindered
enjoyment in daily activities, and current pain (McCubbin et al. 2017). This study reflects that many patients will continue to use IM in order to maintain a healthy lifestyle and prevent the onset of another illness. This aspect of medicine exercises preventative health, a primary purpose of IM, and aids individuals in maintaining a satisfactory well-being.

1.7. Effectiveness of Integrative Medicine

IM has been largely effective as a medical approach for patients (Kabel 2015; Majumdar et al. 2013; Pechacek et al. 2015; Panozzo et al. 2016; Trahan 2014). Despite the recent success of IM, there continues to be a debate on the effectiveness of IM as some studies show that IM may not have a significant effect on health outcomes (Judson et al. 2011). It is important to note that IM has recently emerged into medical practice, meaning that there are not as many studies on its efficacy compared to studies on CAM or Western medicine. Thus, as IM continues to emerge, the effect of IM on patients’ health will become more discernable.

Studies show that IM is effective and conducive to managing illnesses more common in women (Kabel 2015; Pechacek et al. 2015; Panozzo et al. 2017; Trahan 2014). In fact, IM’s ability to treat reproductive, endocrine, and immune system-related illnesses enables IM to treat a wide variety of women health issues (Trahan 2014). A longitudinal study on 1388 women between 2003 to 2013 tested the effectiveness of integrative homeopathy for gynecological disorders (Panozzo et al. 2017). The investigation was undertaken in a homeopathic clinic within a public hospital, indicating that the type of practice was indeed IM (Panozzo et al. 2017). At the end of the decade-long research in which majority of the patients (54%) sought help for menopausal disorders and menstrual irregularities, improvement was found in 74.1% of patients (Panozzo et al. 2017). Although every patient did not have physical improvement from IM
treatment, IM can still be considered physically effective as a large part of the patient population had better health outcomes.

Research shows that IM may be significant in increasing the well-being, quality of life, and perseverance of female patients fighting cancer (Kabel 2015). Throughout the literature, it was observed that many cancer patients use IM for a wide variety of reasons (Kabel 2015; Judson et al. 2011). A longitudinal case study on four cancer patients ranging in age between 55 to 70 years old using qualitative interviews was conducted in an integrative outpatient setting where chemotherapy was the main course of conventional treatment while each patient had individualized CAM treatments (Kabel 2015). These IM treatments consisted of new diets, a new lifestyle, vitamin infusions, and herbal supplements (Kabel 2015). Fighting cancer felt like the “main occupation” for patients which was tiresome and a strain on finances (Kabel 2015). However, participants described that IM was integral in aiding the fight against cancer and maintaining a healthy identity (Kabel 2015). They went further to describe that IM was important for maintaining a satisfactory quality of life and well-being after completing chemotherapy treatment (Kabel 2015). These results shed light on how IM can also be important in helping patients maintain a high-level of wellness and motivate patients to continue fighting against a significant illness. However, the small sample size and low representativeness of the sample limit the conclusions to be generalized to a larger population.

Another study presents conflicting evidence that IM may not actually be effective in improving health outcomes of cancer patients. 43 women with ovarian cancer used conventional chemotherapy along with hypnosis, therapeutic massage, and healing massage as part of their IM treatment within the University of Minnesota Medical Center (Judson et al. 2011). The incorporation of CAM modalities within a Western healthcare center signifies that IM is offered
for patients. After a randomized trial, the results showed that IM did not have a significant effect on patient quality of life, complication rates, and other immunologic measures (Judson et al. 2011). While the IM modalities did not interfere with the chemotherapy, this study shows that IM did not have a significant effect on quality of life. The researchers mentioned that the lack of a significant effect could be due to the low power of the study and the type of IM interventions used, since they are not the most effective CAM treatments according to the literature (Judson et al. 2011). Nonetheless, the experimental design and larger sample size help support that these IM therapies have little efficacy on patient quality of life and physical well-being. Based on the two conflicting studies, more research is needed to better understand the effectiveness of IM on cancer since many individuals use IM in cancer therapy.

Aside from cancer, IM has been observed to be effective in treating mental health issues (Gaddy 2017; Pechacek et al. 2015). Instead of only utilizing psychotropic drugs and peer therapy in conventional medical settings, the incorporation of CAM into Western medical centers has led to improved mental wellness and prevention (Pechacek et al. 2015). A case study on 9 females who all reported depressive symptoms prior to receiving a 6-week long IM education showed that there was a 16% reduction in depressive symptoms after knowing which IM therapies could be used in their daily lives (Pechacek et al. 2015). While there was only a small decrease in depressive symptoms, the results were significant and suggest that there is potential for better IM therapies to treat depression. Furthermore, a four-week IM treatment program for 42 veterans diagnosed with mental illnesses in the Mental Health Residential Rehabilitation Program at the Dwight D. Eisenhower Veterans Affairs Medical Center shows that guiding patients through IM therapies, and not just teaching patients about them, can improve mental health outcomes more successfully. In fact, the results saw improvements in a
variety of areas, including the amount of time feeling calm, the degree to which pain interferes with daily living, the degree to which mental health issues interfere with social activities, amount of time with adequate energy, and mood (Gaddy 2017). The results can be attributed to how patients actually participated in holistic pain management activities, tai chi, healing foods, and yoga along with conventional therapies instead of simply learning about them (Gaddy 2017). Thus, this study is significant as it exemplifies how IM can improve mental health and be effective for male patients also.

Analysis of cost and clinical outcomes show that IM is also economically effective (Sarnat and Winterstein 2004; McDaid and Park 2012). Data on 21,742 patients using IM over a period of four years demonstrated a 43% decrease in hospital admissions per 1000, 58.4% decrease in hospital days per 1000, 43.2% decrease in outpatient procedures per 1000, and a 51.8% decrease in pharmaceutical costs when compared to conventional medicine (Sarnat and Winterstein 2004). These results can also be supported by economic models that predict that IM can result in positive returns on investment larger than 2:1 if viewed from a long-term investment (McDaid and Park 2012). Thus, IM has the potential to not only lead to successful health outcomes, but also to reduce health expenditures in our costly US healthcare system.

1.8. Barriers to Integrative Medicine

Despite the existence and general effectiveness of IM, the incorporation of Western medicine and CAM has historically been met with obstacles (Agarwal 2018; Barrett et al. 2003; Coulter et al. 2007; Ross 2009). These barriers make it difficult for IM centers to be established and prevent individuals from seeking integrative medical care.

One immense barrier is the misperceptions and stereotypes that Western physicians and CAM practitioners have of each other. In general, CAM and Western medicine can be analogous
to two clashing cultures (Coulter et al. 2007). When considering that CAM uses a holistic model of health and Western medicine uses a biomedical model of health, practitioners feel that the two approaches to healthcare have different philosophies regarding illness, disease, values, and even jargon (Agarwal 2018; Barrett et al. 2003; Coulter et al. 2007). These differences can function as barriers to integrating medicine because practitioners from both fields sense that the different ideology undermines the integrity of the medical approach they practice (Agarwal 2018).

However, it is important to recognize these differences are not always in conflict with each other, but can be aligned to create a diverse knowledge base to approach care depending on the patient (Agarwal 2018). Therefore, a lack of clarity and misconceptions between practitioners from CAM and Western medicine negatively impact the integrative medical coordination that could emerge.

For many Western physicians, prejudices and biases of CAM’s medical nature discourage their desire to provide IM (Barrett et al. 2003; Ross 2009). One example is how Western physicians often disregard the legitimacy of the spiritual and emotional factors related to the holistic health of an individual (Barrett et al. 2003; Ross 2009). The lack of recognition for these factors transitively ignores the practical nature of CAM, making it difficult for these physicians to incorporate CAM modalities (Barrett et al. 2003; Ross 2009). Another stereotype frequently noted from conventional medical practitioners is the belief that spirituality is simply organized religion (Ross 2009). This misperception of the spiritual components of health from Western clinicians make it seem that CAM is an illegitimate approach to care and deters IM from developing. Overall, stereotypes and biases that conventional medical doctors hold function as barriers preventing IM from being provided to patients.
It is important to recognize that many CAM practitioners harbor preconceived reservations about Western medical institutions that hinder the emergence of IM as well (Barrett et al. 2003; Olson 2001). While more CAM practitioners encourage integration than Western practitioners, many still express distrust and skepticism of biomedical models of care (Barrett et al. 2003). In particular, CAM practitioners are hesitant to work with large medical institutions because they fear the bureaucracies and authoritative policies of these institutions will coopt the delivery of holistic care (Olson 2001). One primary example heard in the CAM community is how Western medical institutions will “standardize” herbs by isolating the active compounds and utilizing them in percent dosages (Olson 2001). This pharmaceutical process contradicts CAM philosophy, and imbalances the herb making them largely ineffective (Olson 2001). Reports such as this quickly spread throughout the CAM community, creating preconceptions and stereotypes that IM will result in a similar manner. Due to these reservations that all Western medical institutions will incorporate CAM in the exact same method, many CAM practitioners do not want to integrate their practices for IM.

Another barrier for the emergence of IM is the belief that CAM treatments are not adequately tested to be considered effective (Abbott et al. 2011; Olson 2001; Ross 2009). Many herbs and CAM therapies undergo trials that empirically prove the efficacy of the treatments (Olson 2001). However, common among conventional medical institutions is the concern that these tests are not “qualified” enough (Abbott et al. 2011; Ross 2009). This is because conventional medical practitioners claim that the studies are not “rigorous” compared to the clinical trials that pharmaceuticals must be tested through (Olson 2001). Due to this concern, many Western physicians refuse to incorporate CAM modalities into their practice and institution. The issue is exacerbated because even if CAM treatments were to be tested under
clinical trial conditions, conducting these tests for each herb and CAM therapy can be costly, laborious, and time-consuming (Olson 2001). Thus, these research procedures make it even more difficult for CAM modalities to be integrated with Western medicine. As a result of CAM treatments not being tested under pharmaceutical conditions and the research protocol necessary to test treatment efficacy, Western physicians do not want to provide IM.

A case study on an integrative center that did not survive shows that the inability to coordinate care between CAM and Western physicians can lead to failure in the institution. Specific barriers preventing successful integration were that both groups of practitioners did not share the same norms, and were not familiar with the referral process and hospital protocols (Coulter et al. 2007). The clinicians were unable to work together because of the different actions that practitioners used when operating in the same medical setting. More unsettling were the worries of Western physicians when referring patients to CAM practitioners (Coulter et al. 2007). Conventional doctors worried that CAM practitioners would not follow the protocol to return referred patients, and that the conventional doctors would not get their patients back (Coulter et al. 2007). This speculation led Western clinicians to have animosity towards CAM practitioners, obstructing the ability to successfully coordinate patient-centered care. Eventually, the differences in hospital protocols and behavior in the integrative medical center caused the center to not survive (Coulter et al. 2007). Overall, this case shows that physical behaviors and poor interactions between practitioners in integrative settings can also be a barrier to successfully integrate care.

1.9. Emergence of Integrative Medicine:

Integrative medicine has recently emerged as a novel approach to care, despite certain barriers and obstacles. The incorporation of CAM and conventional medicine has been
considered a natural step of growth in American healthcare systems insofar as 42% of hospitals provided integrative medicine in 2010 – tripling the amount since 2000 (Barrett et al. 2003; Brown 2015). Findings throughout the literature show that patients have become dissatisfied with conventional medicine because it does not facilitate autonomy, empowerment, or control for patient’s own care (Baer and Coulter 2008; Barrett et al. 2003; Brown 2015). Thus, medical institutions have slowly started to incorporate a holistic approach that is patient-centered while incorporating CAM modalities in order to provide care that meets patients’ desires and needs (Barrett et al. 2003; Brown 2015). Overall, this step in healthcare is a radical shift in approaching care, and continues to permeate in many American health systems.

One stakeholder of healthcare that has further propelled the emergence of IM is insurance companies. After hospitals began to incorporate IM upon realizing patients were dissatisfied with conventional approaches to care, health insurance companies began covering various CAM therapies because the market demand of IM from patients increased (Brown 2015; Goldstein 2002; Olson 2001; Willard 2005). Not only has this made IM more affordable, medical coverage of IM has enhanced the perceived legitimacy of IM in medicine that has, in turn, increased demand from patients (Brown 2015). This positive feedback loop has further mainstreamed IM, encouraging insurance companies to cover more IM services and hospitals to incorporate IM.

The development of IM has been supported by many outside stakeholders as well. Pharmaceutical firms, media conglomerates, political parties, lobbying groups, and ethnic or gender-based movements have advocated for IM within American healthcare systems (Goldstein 2002). One primary example was when lawyers and political groups helped win the landmark court case, Wilk v. American Medical Association (AMA), that forbade the AMA from discriminating against CAM practitioners (Brown 2015). This support, that has been rooted in
patient dissatisfaction and patient demand, has enabled IM to become more prominent, even if outside stakeholders primarily advocate for IM for economic benefits (Brown 2015; Goldstein 2002; Olson 2001). Overall, the immense backing for IM from multiple stakeholders has demonstrated that IM continues to develop, despite there being barriers.

IM has emerged and will continue to emerge because clinical schools have started to embrace IM (Baer and Coulter 2009; Olson 2001; Ross 2009). In 2009, more than two-thirds of medical schools have taught CAM courses (Ross 2009). Additionally, nursing school have begun to offer classes on alternative modalities (Baer and Coulter 2008). The University of Arizona has even created an IM fellowship program to teach conventional physicians on how to provide CAM therapies and over 600 doctors each year attend a 200-hour program at UCLA to learn Eastern approaches to healing (Baer and Coulter 2008). All of these institutions go beyond simply learning about CAM treatments for IM, but educate clinicians on how to choose which treatment – conventional, complementary, alternative – to use for a patient’s spiritual, emotional, and physical personal needs (Ross 2009). This incorporation of CAM in Western medical institutions significantly changes the landscape of American healthcare and establishes IM as a growing trend in medical care.

Marketing and publicity have additionally been useful in spreading IM and establishing it as useful approach to patient-centered care. With the increase of CAM and IM in medical journals, IM has become more legitimate to patients and conventional clinicians (Brown 2015). Moreover, press releases, radio and TV programming, and the use of celebrities when marketing has increased the popularity of IM among consumers (Brown 2015). These marketing initiatives have directly led to an increase in patient demand by which many Western institutions have had to adapt to and incorporate IM (Brown 2015; Olson 2001). Therefore, marketing and publicity
have increased the acceptance of IM in healthcare and continues to establish IM as a novel approach to care in the medical community.

With the emergence of IM, CAM practitioners have further solidified their position in healthcare and gained greater legitimacy by successfully instituting formal educational curricula. Specifically, requiring all IM practitioners to complete CAM education, pass standardized examinations, achieve certificates, and gain licensure has improved the creditability of IM (Brown 2015). The enhanced reputation has been important as it creates more acceptance of IM among those who may still hold preconceived stereotypes about CAM effectiveness. Breaking false preconceptions and increasing credibility has been vital to IM emergence and establishment within the medical field.

1.10. Perceptions and Attitudes towards IM

It is important to acknowledge the medical community’s attitudes toward IM because these perceptions can help assess the probability that IM will continue to be incorporated within medical institutions (Agarwal 2018). Without evaluating the perspectives from the medical community, incorporating CAM into Western practices could prove costly and result in failure (Coulter et al. 2007). This is because IM cannot be successfully provided with a patient-centered approach if clinicians and patients do not have a favorable disposition towards it (Agarwal 2018; Barrett et al. 2003). Thus, this last section will highlight the current perceptions towards IM from patients, students, and both CAM and Western practitioners.

In general, patients have a favorable view towards IM. One study surveying 161 patients discovered that 62.7% of respondents would be likely to use CAM services if offered at the medical center (Dancisak et al. 2016). If patients had more knowledge about CAM, 68.3% of respondents would be more likely to utilize IM modalities (Dancisak et al 2016). These
responses clearly show that majority of patients have motivations to adopt IM when seeking medicine, and these results imply that there is some dissatisfaction from patients only receiving conventional medicine. In fact, one aspect of IM that attracts patients is the acknowledgement that health is a combination of emotional, physical and spiritual factors that must be evaluated holistically – not simply an absence of disease as described in conventional medicine (Dancisak et al. 2016). Patients actually expressed a disliking toward how conventional medical practitioners would often not make the connection between lifestyle and health (Dancisak et al. 2016). Due to this, patients felt that the Western healthcare they were receiving did not encompass all of their needs and would rather receive IM.

Another primary motivation that draws patients toward IM is that there is individual time with the practitioners that extends to an hour or more for the initial visit (Dancisak et al. 2016). In conventional healthcare, many patients were dissatisfied by how they felt rushed, not listened to, and dismissed so much so that some patients even expressed traumatic experiences with the paternalistic approach to care (Dancisak et al. 2016). In contrast, patients desired medical encounters that were longer, invited questions, had shared decision making, and acknowledged all the aspects of health that patients felt compelled to share (Dancisak et al. 2016). Patients found this approach in IM where they were listened to by the provider and thus, would rather pursue IM than conventional healthcare if given the option (Dancisak et al. 2016). Overall, the encompassing care of all health factors and patient-centered attention in IM have given many patients a positive view towards IM.

Similar to patients, nonmedical and medical students also have a positive attitude towards IM (Abbott et al. 2011; Reeves and Cheung 2014; Song et al. 2007). A cross-sectional study at the University of California at Irvine surveyed 371 undergraduate students about their attitudes
towards IM before and after taking an IM related course (Reeves and Cheung 2014). After completing the course, students perceived IM to be more effective (from 3.79 to 4.89 on a Likert scale) and had greater interest in learning more about IM therapies (Reeves and Cheung 2014). In general, these results show that students with an interest in medicine have a positive view of IM. Even though the students may not have been part of a medical institution, the study provides valuable insights about how attitudes towards IM can become more favorable when there is increased exposure and knowledge regarding IM therapies. If this is true, a possible solution to overcome negative stereotypes that clinicians hold about IM may be to increase their exposure to and knowledge of IM.

Research specifically focusing on medical students found that majority of students agreed that IM was effective and should be taught in medical curriculum; however, many still expressed reservations of incorporating IM into their own future practice (Abbott et al. 2011; Song et al. 2007). A cross-sectional study of 1784 US medical students discovered that 77% of students agreed that patients would benefit more from IM than conventional medicine and 98% agreed that physicians should consider all aspects (physical, emotional, spiritual) of a patient’s health – an approach that is not as common in biomedical models of conventional medicine (Abbott et al. 2011). This data could be substantiated by a cross-sectional study conducted at Johns Hopkins Medical Institution that observed how 69% of 110 responses were in favor or neutral for an IM clinic within the medical center (Song et al. 2007). These responses indicate that most of the medical community is in support of IM. However, despite support for IM, most students were hesitant to incorporate IM because they conveyed that there were not enough studies that have evaluated the effectiveness of it (Abbott et al. 2011; Song et al. 2007). The lack of studies exemplifies one of the primary obstacles hindering the proliferation of IM. Nevertheless, it is
clear that medical students generally are more open to IM and would be willing to incorporate IM if they were exposed to more of its effectiveness.

Finally, it is important to recognize the views and perspectives of physicians towards IM since these individuals are the main providers of this medical care. The only research that specifically evaluates the perceptions of practitioners toward IM in the US was an investigation that utilized semi-structured interviews and focus groups to study 50 CAM and conventional practitioners (Hsiao et al. 2006). This study examined physicians’ openness toward integration, and discovered that younger practitioners were more open to CAM integration than older physicians. (Hsiao et al. 2006). Unlike older physicians, younger doctors had more exposure to IM in medical school curriculum resulting in greater rates of acceptance among the younger population (Hsiao et al. 2006). Therefore, this exploratory suggests that IM may continue to spread because of the increased exposure and openness to IM within an increasing number of younger cohorts receiving a medical education.

Despite having acceptance to integrate CAM and Western medicine, many practitioners (both CAM and Western) still are skeptical of integration because they lack confidence in IM effectiveness and cite a lack of collaborative working relationships among practitioners in IM centers (Hsiao et al. 2006). For instance, common among both groups of clinicians was the reluctance to work in the same office space with the other group of practitioners because of differences in egos, medical paradigms, and lack of exposure to the other medical approach (Hsiao et al. 2006). Coupled with an inadequate proficiency of IM effectiveness, practitioners felt that these perceived differences make it extremely difficult or impossible to work collaboratively within an IM center (Hsiao et al. 2006). As a result of these differences,
practitioners were skeptical of the ability to actually integrate CAM and conventional medicine, even though many expressed acceptance and positive attitudes towards the idea of IM.

Despite contrasting views toward IM among current clinicians, there has been a recent increase in IM centers throughout the US. The emergence of this phenomenon invokes two vital questions: how have attitudes towards IM changed in the recent years to motivate many practitioners to work with different-minded providers, and what are the perceptions of IM practitioners towards IM? When sifting through the literature base, there appeared to be no existing study that had evaluated perceptions of CAM and Western physicians when coordinating care within the same IM center. This gap in the literature is the basis for this exploratory investigation. Conducting this study will shed light on how perceptions toward IM have changed over time, attitudes about coordinating care with different types of practitioners, and how barriers can be overcome to provide IM care.
Chapter Two: Methodology

2.1. Purpose and Procedure

The purpose of the investigation is to understand the attitudes that complementary and alternative medicine (CAM) and Western providers have towards IM when coordinating care in the same clinical setting. This research adds to our knowledge because it helps us understand how coordinating IM care among practitioners with different medical paradigms actually is executed and how challenges can be potentially resolved. Moreover, understanding perceptions that current Western and CAM practitioners have towards the practice of IM can reflect the changes in attitudes of IM throughout history. Although individual data will be analyzed, the general focus will be on how providers feel about using an IM approach with practitioners from different medical backgrounds. Almost no mention of this type of research exists in the literature, so collecting any information on the perceptions of these IM providers from both CAM and conventional medical disciplines will be important.

This was an exploratory study using a small sample size. Both the interviews and the questionnaires included similar questions that focused on practitioners’ understanding of IM, their motivations for working in an IM setting, and their experiences coordinating care with health professionals from different fields.

2.2. Data Collection

To collect data, IM centers were first selected and chosen using purposive sampling. This method of sampling was used to ensure that a true integrative medical center, and not a CAM or Western medical center, was utilized to invite possible practitioners to participate in the study. The primary concern was that many “integrative medical centers” are, in fact, actually Western
or more CAM related, based on the practitioners and treatments offered. Therefore, these medical centers do not truly approach medicine from an integrative perspective.

When choosing an integrative center, three common characteristics were necessary for a center to be considered “integrative.” First, the IM center should have a balanced number of practitioners from a variety of different disciplines, including from both Western and CAM. For example, a center with five MDs, two RNs, and one CAM practitioner would not be integrative, but more Western, because conventional treatments and insights would be dominating the practice’s approach to patient care. However, a center with two MDs, three RNs, and six different types of CAM practitioners would be integrative because a variety of practitioners from different disciplines would be available to offer insight, modalities, and approaches to patient care in an equitable manner. Second, practitioners at each center must provide team-based, patient-centered care. Determining this characteristic could be noticed based on patient reviews and jargon from the facilities’ websites, where “personalized care” or “collaboration,” indicated that IM care was offered. Websites with words, such as “complements” or “additional treatments,” would show that these centers are more CAM focused and not IM focused. Lastly, the center must focus on preventative health. This could also be discerned from patient reviews and the medical center’s website where a focus on maintaining a healthy lifestyle or taking control of one’s health would signify a more preventative health model compared to Western, acute care settings or CAM settings.

Based on these exclusionary criteria, the Stram Center for Integrative Medicine, the Center for Integrative Medicine at St. Francis Hospital, and the Integrative Medical Center at Hartford Hospital were chosen to participate in the study because they have a balanced number
of practitioners, approach patients using a team-based approach with patient-center care, and encourage better lifestyle choices and preventative care to their patients.

Participants (practitioners) from these IM centers were recruited using convenience sampling. The director of each IM center was first contacted by phone and asked if providers in the practice would be inclined to participate in face-to-face interviews regarding their attitudes toward the system of IM. If the practices were not inclined to participate in interviews, they were asked if they could complete a 10 to 15-minute questionnaire. Only the Stram Center for IM agreed to participate in the interviews, while both the Center for IM at St. Francis Hospital and the IM Center at Hartford Hospital agreed to complete the questionnaires.

For the Center for IM at St. Francis Hospital and the IM Center at Hartford Hospital, the questionnaire was emailed to the director of each IM center who then distributed the questionnaire to all the providers to complete. The questionnaires were distributed through email using Google forms and were completed online by the providers. Administering the questionnaires using this method streamlined the data collection process as Google forms aggregated all individual data that could be accessed immediately upon the participants’ completion.

For the Stram Center for IM, face-to-face interviews were conducted at the practice and recorded on a phone. It is important to note that the interview questions were the same questions used in the questionnaire that was given to the IM centers at St. Francis Hospital and at Hartford Hospital. The same questions were used so that responses among the three different hospitals participating in the study could be compared. The only difference between the interview and questionnaire questions was that providers could be asked to further specify or elaborate on a specific response they had given during the interview; however, this was not possible when
administering questionnaires because participants completed them alone and could only be prompted by the questions they had read.

Participation in the questionnaires and interviews was completely voluntary as participants could withdraw at any point without penalty and omit questions they did not want to answer. The providers were informed that their information would be kept confidential before participating, and that they would be debriefed at the end of the investigation.

Both the questionnaire and the interview could be separated into two different sections: the first section focused on participant demographics and the second section focused on practitioner’s attitudes towards IM. The demographics section asked participants basic questions regarding their age, total household income, education level, sex, race/ethnicity, and years of experience working in an IM setting. The second section asked participants more specifically about their experience working in this field. In particular, this section was to understand how the practitioners understand IM, their motivations for providing care in an integrative setting, and their experience coordinating care with providers with different medical paradigms. A full example of the questionnaire and interview questions can be located below:
Thank you for agreeing to participate. All information will be kept confidential and please feel free to omit any responses.

1. The research calls for us to ask some demographic questions first. So, may I ask, what is your age?

Under 18
18-29
30-39
40-49
50-59
60-69
70-79
80-89
90-100

2. What is your sex

Female
Male
Prefer not to answer

3. What is your race or ethnicity. Please check all that apply.

White, non-Hispanic
Black
Hispanic
Native American
Asian or Pacific Islander
Other (please specify)

4. What is the highest level of education you have completed?

Some high school
High school graduate
Some college
Completed a 2-year college
Completed a 4-year college
Completed graduate degree (please specify degree)
5. Which category most closely reflects your total income?

Less than $20,000  
$20,000-$29,999  
$30,000-$39,999  
$40,000-$49,999  
$50,000-$59,999  
$60,000-$69,999  
$70,000-$79,999  
$80,000-$99,999  
More than $100,000

6. How much exposure did you have to integrative medicine prior to working in this field?

None  
Less than 1 year  
Between 1-2 years  
Between 3-4 years  
Between 5-10 years  
10 or more years

7. If you had previous exposure to integrative medicine beforehand, where was it from?

8. How much experience do you have working for (insert integrative medical center's name)?

Less than 1 year  
Between 1-2 years  
Between 3-4 years  
Between 5-10 years  
10 or more years

9. What is your job title at the integrative medical center? (Examples: Physician MD, administrator, Licensed acupuncturist LAc, Registered Nurse)

10. Which aspects of care are important for your medical practice? Please check all that apply.
   - Preventative health.
   - Patient-centered care.
   - Integrating the best treatments from Western medicine, complementary medicine, and alternative medicine.
   - Collaboration among practitioners.
   - Sole focus on treatment of disease
   - Spiritual health of patients
   - Emotional health of patients
   - Encouraging healthy lifestyle choices
11. On average, how long are the appointments with patients?

Less than 10 minutes
Between 10-20 minutes
Between 20-30 minutes
Between 30-40 minutes
Between 40-50 minutes
Between 50-60 minutes
More than an hour

12. Integrative medical centers include providers from both Western and Complementary/Alternative health fields. Did this aspect influence your decision to work in an integrative medical setting?

Yes
No

12(a). If you answered “yes” to the previous question, can you explain in just a few sentences why you answered this way?

13. If working with both Western and Complementary/Alternative practitioners in the same setting did not or was not the only factor influencing your decision, what factors did influence your decision to work in integrative medicine and why?

14. Please consider this statement: Other medical providers in this integrative medical center have different views than I do regarding medical paradigms (disease etiology, definitions of health, values, how to approach patients). Do you agree or disagree with this statement?

Agree
Disagree

14(a). Would you like to add anything else?

15. Please consider this statement: When I first started working in an integrative medical center, differences in medical paradigms (disease etiology, definitions of health, values, how to approach patients) between Western and non-Western providers made it difficult for me to coordinate care with other providers. Do you agree or disagree with this statement?

Agree
Disagree

15(a). Could you explain in just a few sentences why you answered this way?
16. Please consider this statement: Currently, differences in medical paradigms (disease etiology, definitions of health, values, how to approach patients) between Western and non-Western providers still make it difficult for me to coordinate care with other providers. Do you agree or disagree with this statement?

Agree  
Disagree

16(a). Could you explain in just a few sentences why you answered this way?

17. Whether you disagreed or agreed to the previous two questions, do you enjoy providing healthcare with practitioners who have different medical paradigms?

Yes  
No

17(a). Could you explain in just a few sentences why you answered this way?

18. Prior research shows that some providers hold perceptions that complementary/alternative treatments are ineffective or that Western providers ignore non-physically related symptoms of health (i.e. spiritual, mental, emotional health). Do you feel that similar perceptions among your providers have ever hindered your center’s ability to provide integrated care?

Yes  
No

18(a). Could you explain in just a few sentences why you answered this way?

19. Has coordinating care with providers who have different medical paradigms been a strength or weakness when providing integrative care.

Strength  
Weakness

19(a). Could you explain in just a few sentences why you answered this way?

Thank you for participating.
2.3. Data Analysis

For the questionnaire responses, Google forms was used to organize all demographic, closed-ended, and open-ended responses from the participants. This allowed both the individual and group data to be analyzed in a user-friendly method. Face-to-face interviews were recorded, so that responses could be reevaluated and analyzed after completion of the interview.

When analyzing both the interview and questionnaire data, common themes and perceptions were searched for within the participants’ responses and noted. Since the questions were phrased in a way to collect information about the salient features of IM, the themes from participants’ responses were able to qualitatively express their attitudes about IM practices. The next chapter will examine common themes portrayed in participants’ responses along with general demographic information. The last chapter will analyze common themes, recognize their implications, and offer directions moving forward based on the perceptions of Western and CAM health professionals providing IM care.
Chapter Three: Results

3.1. Demographics

The study used an exploratory approach and had a low response rate for sample collection due to the time constraints that did not allow for pursuing more participants. The small sample also restricted comparisons between the specific types of CAM providers.

There were 15 total participant providers. 15 out of the 36 who were invited to the study completed either the face-to-face interviews or the questionnaire. For the Western sample, there were three total participants. One is an MD, and two are RNs. Only one of these individuals completed a face-to-face interview - the other two completed the questionnaire. Both of the RNs were female, Caucasian, completed a four-year degree as their highest level of education. One of the RNs was between the years of 70-79, had a total income between $80,000-$99,999, had 10 years of prior experience to integrative medicine (IM), and has worked for her current IM center for more than 10 years as well. The other RN was between the years of 60-69, had 3-4 years of experience prior to IM, and has worked between 5-10 years at her current IM years. The MD was a male Caucasian with multiple graduate degrees who was between the age of 60-69, had a total income greater than $100,000, between 1-2 years of prior IM experience, and more than 10 years currently practicing at his IM center.

There were 12 total CAM participant providers. One participated in face-to-face interviews and the other 11 completed the questionnaire. Eight participants were female and the other four participants were male. The age of the participants varied in the sample. In terms of years of age, one was between 18-29 years, two were between 40-49 years, five were between 50-59 years, and four were between 60-69 years. Two participants had only a 2-year degree, four
participants had only a 4-year degree, and six of the participants had a graduate degree as the
highest level of education attained. All participants in this sample were Caucasian.

Roles varied greatly among the 12 CAM providers. These roles consisted of a program
director certified in massage therapy, an art therapy intern, a certified music practitioner, etc.
Due to the small sample of CAM providers, comparisons could not be made among responses
given by the different types of CAM providers. The distribution of the CAM providers and their
roles in IM can be seen in figure 1.

Figure 1. Role distribution of CAM participants.

The income level varied greatly among the participants. This was due to the different
roles of providers that receive different salaries. The pie chart below shows the distribution of
income level for the sample:

Figure 2. Income distribution of participants.
The interview and questionnaire also asked participants about the previous exposure to integrative medicine. This question served to probe if participants were already inclined to integrative medicine before working at the IM center. Previous exposure for CAM providers consisted of attending yoga, receiving CAM-based therapy in IM (naturopathy, chiropractic, acupuncture), and two received education on IM. The distribution of previous exposure also varied greatly, but majority of providers have less than five years of experience.

Figure 3. Previous exposure to IM before practicing at the current IM center.

The last demographic question asked participants about their current number of years practicing at their IM center. The results showed that majority of individuals have worked more than five years indicating that they have practiced at their IM center for a significant amount of
time. Figure 4 below shows this distribution of experience for IM providers working at their current IM center:
3.2. Attitudes towards Integrative Medicine:

There were 12 CAM providers and only three Western providers (2RNs, 1 MD). Three was a small return rate for the sample of Western health practitioners. Due to the small return rate, few responses were gathered from Western providers while more responses could be gathered from CAM practitioners about their attitudes towards IM. Moreover, because of the small sample of Western providers, the results and discussion will analyze responses from the CAM sample in greater detail compared to the responses from the Western sample.

I. Salient Aspects of IM Care:

Important aspects of IM included preventative health, patient-centered care, integrating the best treatments from CAM and Western fields, collaboration among practitioners, spiritual health of patients, emotional health of patients, and encouraging healthy lifestyle choices to patients. All three Western providers thought these aspects were important to integrative care. Only one of the providers thought a sole focus on treating the disease was important - an aspect not emphasized in IM.

Majority of CAM providers thought the salient aspects of IM care were important. Only two of the CAM participants thought a sole focus on treating the physical disease was significant

Figure 4. Distribution of current experience among participants.
while at least 10 CAM providers felt the primary aspects of IM were notable. Table 1 shows the percent of CAM providers who felt each aspect was important to their health care delivery.

Table 1. Aspects of care and the percentage of CAM providers who felt each aspect was important to their provision of health practice. N=12 CAM participants.

<table>
<thead>
<tr>
<th>Aspects of Health Care</th>
<th>CAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Health</td>
<td>75%</td>
</tr>
<tr>
<td>Patient-Centered Care</td>
<td>92%</td>
</tr>
<tr>
<td>Integrating the Best Treatments from CAM &amp; Western Fields</td>
<td>83%</td>
</tr>
<tr>
<td>Collaboration Among practitioners</td>
<td>92%</td>
</tr>
<tr>
<td>Sole Focus on Treating Disease</td>
<td>17%</td>
</tr>
<tr>
<td>Spiritual Health</td>
<td>83%</td>
</tr>
<tr>
<td>Emotional Health</td>
<td>92%</td>
</tr>
<tr>
<td>Encouraging Healthy Lifestyle Choice</td>
<td>75%</td>
</tr>
</tbody>
</table>

II. Appointment Length

Participants were asked about the average length of their appointments with patients. One RN described her appointments being 10-20 minutes. The other RN had appointments lasting 50-60 minutes. The MD had appointments lasting more than an hour.

Majority of CAM providers had lengthy appointments. 6 CAM providers described that their appointments were longer than 50 minutes. 10 CAM providers responded that their appointments were longer than 30 minutes. Table 2 depicts the average length of appointments for CAM providers delivering care in an IM center.

Table 2. Responses for average length of appointment for patients in IM centers. N=12 CAM participants.

<table>
<thead>
<tr>
<th>Length of Appointment</th>
<th>CAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10 minutes</td>
<td>0%</td>
</tr>
<tr>
<td>10-20 min</td>
<td>8%</td>
</tr>
<tr>
<td>20-30 min</td>
<td>8%</td>
</tr>
<tr>
<td>30-40 min</td>
<td>25%</td>
</tr>
<tr>
<td>40-50 min</td>
<td>8%</td>
</tr>
<tr>
<td>50-60 min</td>
<td>25%</td>
</tr>
<tr>
<td>More than Hour</td>
<td>25%</td>
</tr>
</tbody>
</table>
III. Motivations for Working in IM Center

Participants were asked whether the incorporation of both Western and CAM providers in the same health setting influenced their decision to work in their clinical environment. Participants were asked to agree or disagree to this statement: “Integrative medical centers include providers from both Western and Complementary/Alternative health fields. Did this aspect influence your decision to work in an integrative medical setting?” Two of the Western providers responded with “no” to the statement and one responded with “yes”.

Nine of the CAM providers felt that the incorporation of providers from Western and CAM fields motivated them to integrate care; three of them did not. Two practitioners were motivated by how integrating practitioners into the same clinical setting can better treat the whole individual:

“Integrating wholistic modalities with conventional medicine for patients who are sick or in pain gives practical, affordable, often non-pharmaceutical options to patients. That is so important in treating the whole person,” – Director and Founder of IM Center

I think [IM] is a perfect fusion to fully treat “health” in all aspects. Body, mind and spirit.” – Art Therapy Intern

Other CAM providers shared how their past educational experience gave them opportunities to witness the shortcomings of only delivering conventional medicine, and the benefits of also having CAM:

“I am an ICU nurse and saw the value of integration for my benefits first” – Consultant

“As I learned more about the integrative model in my classes, I came to understand how beneficial alternate modalities are in patient care and well-being.” – Music Practitioner
Majority of CAM providers were motivated to administer IM because it incorporated providers from both CAM and Western fields. Table 2 shows the percentage of CAM practitioners who were influenced by the integration of practitioners.

Table 3. Responses from CAM practitioners when asked to consider the statement: “Integrative medical centers include providers from both Western and Complementary/Alternative health fields. Did this aspect influence your decision to work in an integrative medical setting?” N=12 CAM participants.

<table>
<thead>
<tr>
<th>Response</th>
<th>CAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>75%</td>
</tr>
<tr>
<td>No</td>
<td>25%</td>
</tr>
</tbody>
</table>

Participants were also asked to explain any other factors that had influenced their decision to work in integrative medicine. CAM providers responded with a variety of different motivations for working in IM. One motivation was that IM provides the ability to treat the whole individual. A therapeutic musician explains how music can provide mental and emotional relief aside from physical symptoms:

“I believe in the ability of music and tonal therapy to aid patients in the healing process through stress reduction and relaxation.” – Therapeutic Musician

CAM practitioners also were motivated by their past personal experiences with the benefits of IM:

“My own improved health and well-being. [I] Am out to show the world that one can improve their well-being.” – Consultant volunteer

“I have had PTSD since I was 6 years old. After a year of practicing yoga and meditation, I saw the benefits firsthand.” – Yoga and Meditation Teacher

Another CAM provider described how IM gave him opportunities for stable employment:

“Stable employment without ownership of a private practice.” – Acupuncturist

The motivations for CAM providers to integrate medical care ranged widely and included economic reasons, personal experiences, and philosophy of health.
For the three Western participants, other factors that influenced their decision to integrate medicine were the ability to provide holistic care and to use CAM treatments for improved health outcomes.

IV. Medical Paradigms

Participants were asked to agree or disagree to the statement to understand if they held different medical paradigms in IM: “Other medical providers in this integrative medical center have different views than I do regarding medical paradigms (disease etiology, definitions of health, values, how to approach patients).” Two Western providers disagreed with the statement and one agreed that providers in IM had different medical paradigms.

Eight CAM practitioners disagreed with the statement that other medical providers have different views than them. Four providers agreed with the statement. When asked why participants disagreed, the general response was that all of them were behind the similar mission of their center despite differences in specific roles:

“Our center staff and consultants believe in the mission of our center and believe in providing quiet attention to patients both in-patient and outpatient.” – Program Director

“I think we’re pretty much all on the same page!” – Therapeutic musician

“We are all pretty much like minded in our center.” – Certified Music Practitioner

“This department is multi-faceted and I appreciate that we all come from different backgrounds and education but together we work really well together” - Licensed Massage Therapist

CAM felt that being behind the same vision of the IM center with their colleagues aligned their medical paradigms. Participants who agreed to the statement did not elaborate on their response. Table 4 depicts the responses to whether participants felt other providers in their institution had different medical paradigms.
Table 4. Responses from CAM practitioners when asked to consider the following statement: “Other medical providers in this integrative medical center have different views than I do regarding medical paradigms (disease etiology, definitions of health, values, how to approach patients). Do you agree or disagree with this statement?” N=12 CAM participants.

<table>
<thead>
<tr>
<th>Response</th>
<th>CAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>33%</td>
</tr>
<tr>
<td>Disagree</td>
<td>67%</td>
</tr>
</tbody>
</table>

All participants were then asked if any differences in medical paradigms affected their ability to coordinate care when they first started working in IM. They were asked to disagree or agree to the statement: “When I first started working in an integrative medical center, differences in medical paradigms (disease etiology, definitions of health, values, how to approach patients) between Western and non-Western providers made it difficult for me to coordinate care with other providers.”

All three Western practitioners disagreed to this statement. They noted that having the same vision as the medical center allowed the providers to put aside their differences and support one another in order to achieve the common goal of the IM center:

“Since our Center opened our leadership has had a very clear vision and those of us that work here were always aligned with that vision.” – RN

Some CAM providers experienced difficulty when first coordinating integrative care. In response to the statement, five agreed and seven disagreed. Those who agreed shared how differences between medical paradigms were emphasized and caused them to be looked down upon by their Western peers:

“Most MD’s didn’t understand or believed in the efficacy of Chinese medicine.” – Acupuncturist

“training and philosophies vary significantly” – Acupuncturist

“Lack of respect for nonallopathic therapies from many MDs” – Consultant/Volunteer

“When we started Integrative Medicine years ago (2002) there were many nay sayers...” – Program Director and Founder
These responses reveal that different medical approaches to care can be leveraged to criticize different providers and hinder care coordination.

Majority of CAM providers, however, disagreed and did not experience difficulty when they first started coordinating integrative care despite collaborating with providers from different medical paradigms. Some individuals who disagreed simply stated that they have never faced any difficulty:

“Haven’t experienced any difficulties.” – Art Therapy Intern

“…my experience is that the practitioners in this center are all on the same page.” – Therapeutic Musician

Others from CAM disagreed because they felt that providers from other paradigms were able to see the advantages of combining each expertise when they began providing IM care:

“We all bring different approaches to the table but there’s a symbiotic relationship and wonderful atmosphere between colleagues in the Integrative Medicine team at St. Francis Hospital” - Massage Therapist

“Everyone have come into contact at St. Francis has been open and welcoming of the services I provide. This is likely because St. Francis has had Integrative offerings since 2001.” - Music Practitioner

“If everyone is in line with the integrative model... and if our goals are the same and similar, then no matter what our expertise is, whether it’s in pharmacology, or herbs, or homeopathy, or acupuncture, then there is not a lot of disagreement in the treatment protocols” - ND

Table 5 shows the percentages of CAM providers who responded to the statement that medical paradigm differences made it difficult to coordinate care when they first began providing IM care.

Table 5. Responses from CAM practitioners when asked to consider the following statement: “Currently, differences in medical paradigms (disease etiology, definitions of health, values, how to approach patients) between Western and non-Western providers still make it difficult for me to coordinate care with other providers. Do you agree or disagree with this statement?” N=12 CAM participants.
<table>
<thead>
<tr>
<th>Response</th>
<th>CAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>42%</td>
</tr>
<tr>
<td>Disagree</td>
<td>58%</td>
</tr>
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</table>

Participants were then asked about their current experience coordinating care with providers who may hold different medical perspectives. They were asked to agree or disagree with the statement: “Currently, differences in medical paradigms (disease etiology, definitions of health, values, how to approach patients) between Western and non-Western providers still make it difficult for me to coordinate care with other providers.”

All Western respondents disagreed with this statement. Those who elaborated upon their response described how they are all able to work well together, which has been helpful in improving the coordination of treatments delivered to patients:

“I believe that our Center and the modalities we offer are well integrated into the culture of the hospital. As a result, all practitioners for the most part, work well together.” – RN

“We almost always have a team-based approach...you have a whole group of people working together on the same situation to see what they can add and that’s what helps in this situation.” - MD

Three CAM providers agreed and nine disagreed to the statement on if differences in medical paradigms currently make it difficult to coordinate care. Those who agreed that differences in medical paradigms still make it difficult to coordinate care actually cited other institutions, outside of their current IM health center, that undermine the treatment modalities and care outcomes they provide. This was particularly true for those who delivering care through music:

“This is true at OTHER hospitals I know that refuse to accept my work as a therapeutic musician as having any value, this making it impossible for me to work there. This is NOT the case at ST Francis Hospital.” – Therapeutic Musician

“While I haven’t found this to be true at St. Francis, I don't feel that the modality I offer, music, has been embraced at other hospitals or care facilities. When discussing the subject of getting work as a therapeutic musician (not a music therapist, there is a difference) in my classes, they
wished us luck in finding a facility that "gets what we do. Fortunately, I live just outside of Hartford and didn't have to look too far to find a facility that did." – Music Practitioner

“Many feel allopathic is the only way”- Consultant/Volunteer

The nine who disagreed stated, overall, that conventional Western practitioners have become more open to integrating CAM modalities due to their increased exposure to and knowledge of CAM. Additionally, Western providers have seen a greater need for preventative care which they feel can be improved with CAM services. Due to the need for preventative medicine perceived by Western providers, CAM practitioners in IM feel that their expertise has become more attractive to Western providers, and therefore, has facilitated the coordination of care currently observed in their practices:

“When we started Integrative Medicine years ago (2002) there were many nay sayers, but as staff throughout the institution saw results in lowering pain and anxiety, and providing comfort, they came around to see its effectiveness.” – Program Director and Founder

“Doctors are more informed about alternative approaches.” – LAc

“Other providers have been open to the IM model and so this has been a positive experience for biomedical providers.” – LAc

“Paradigms are changing and there is a greater need for prevention and IM services in the centers.” – ND/Lac

Table 6 shows the responses from CAM providers on whether medical paradigms currently hinder coordination of care within their respective IM practice.

Table 6. Responses from CAM practitioners when asked to consider the following statement: “Currently, differences in medical paradigms (disease etiology, definitions of health, values, how to approach patients) between Western and non-Western providers still make it difficult for me to coordinate care with other providers. Do you agree or disagree with this statement?” N=12 CAM participants.

<table>
<thead>
<tr>
<th>Response</th>
<th>CAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>25%</td>
</tr>
<tr>
<td>Disagree</td>
<td>75%</td>
</tr>
</tbody>
</table>
The last question regarding different medical paradigms asked participants the following question: “Whether you disagreed or agreed to the previous two questions, do you enjoy providing healthcare with practitioners who have different medical paradigms?” All Western practitioners responded with “yes”. They shared how learning different perspectives and providing beneficial healthcare makes IM enjoyable:

“It’s fun...this paradigm I believe works, so I believe it needs to be integrated into the system.” – MD

“Everyone is always a student and a teacher - so learning about other people’s thoughts and perceptions is helpful and interesting to me.” – RN

10 CAM providers responded with “yes” that they enjoyed providing healthcare with providers who may have different medical paradigms; two out of the 12 CAM providers responded with “sometimes.” From the 10 who responded with yes, many described how the ability to learn different perspectives and understand different treatments made providing IM care enjoyable:

“It is certainly better than doing [IM care] alone...often times we can get different views and viewpoints...often times were can different ideas on treatments, [all] which make [providing IM care] more enjoyable.” – Naturopathic Practitioner

“The approach of IM is an opportunity to discuss different medical interpretations and suggestions as to approaches to healthcare that other practitioners may not have considered. Some of the language of IM is vague, yet correctly pinpoints patient problems from a differing paradigm, thus opening up novel ways of treatment.” - Acupuncturist

“It’s great to educate providers who come from a variety of backgrounds”- Naturopathic Practitioner & Licensed Acupuncturist

“[In reference to providing non-conventional care] Often helps them open their eyes to the value of IM.” – Consultant/Volunteer

“Keeps things interesting!” – Acupuncturist
Others who responded with “yes” explained that providing IM care with different-minded practitioners is satisfying because it is effective for patients and can be personally empowering. This perspective was described by the music practitioner in particular:

“Because healthcare practitioners at St. Francis understand the benefit of what I do. Even nursing students and medical students who are new to St. Francis get excited when they see me walking around with my instrument. Many stop and ask questions about what I do, and ask me to play for them. I wish I could go to other hospitals that don’t offer music at the bedside so they could see how much patients, and anyone else in the room, benefits from a session.” – Music Practitioner

One individual who responded with “sometimes” commented about being aware of modality effectiveness and the need to always improve care. Although collaborating with other providers can be enjoyable, it can be difficult to challenge the effectiveness of another practitioner’s modalities and test new treatments.

“It is always important to have a devil’s advocate because it helps us to work harder to track results and challenges us to try new modalities and procedures to prove the effectiveness of our services.” – Director and Founder of IM Center

The other individual who responded with “sometimes” actually referred to previous experiences working in IM that were not enjoyable, but was not related to their current experience providing IM care:

“There have been times where it has been obvious the health provider did not buy into the work I was providing. Again, this has NOT been the case at St Francis.” – Therapeutic Musician

General views from CAM-based providers described that learning different medical treatments from other fields made IM care enjoyable. Those who responded with sometimes mentioned the importance of challenging other providers to improve care effectiveness and previous experiences when their treatments did not seem legitimate by others. Table 7 shows responses of CAM participants when asked if providing IM care with practitioners who may have different medical paradigms is enjoyable.
Table 7. Responses from CAM practitioners when asked to consider the following statement: “Whether you disagreed or agreed to the previous two questions, do you enjoy providing healthcare with practitioners who have different medical paradigms?” N=12 CAM participants.

<table>
<thead>
<tr>
<th>Response</th>
<th>CAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>83%</td>
</tr>
<tr>
<td>No</td>
<td>0%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>17%</td>
</tr>
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</table>

V. Stereotypes

Participants were asked if stereotypes regarding IM, CAM, or Western health care have hindered their ability to coordinate care. This was asked using the following question: “Prior research shows that some providers hold perceptions that complementary/alternative treatments are ineffective or that Western providers ignore non-physically related symptoms of health (i.e. spiritual, mental, emotional health). Do you feel that similar perceptions among your providers have ever hindered your center’s ability to provide integrated care?”

All three Western providers responded with “no” that false perceptions about providers in IM did not hinder their ability to provide IM. They each elaborated upon their response with various ways they cope with these stereotypes:

“For the most part, the providers perceptions did not interfere with our providing care - we have done a lot of teaching over the years and continue to do so.” – RN

“In large part our patients are our best advocates. Regardless of their physicians’ views on Integrative Medicine, the patients always seem to love and appreciate the modalities and make their caregivers aware.” - RN

“’no...they motivated me. If someone tells me that I couldn’t do it and that this isn’t good work, then I'm here to show it to you that it does.’” - MD

Eight CAM-based providers responded with “no” that stereotypes among providers have not hindered their center’s ability to provide integrated care; four responded with “yes.”
Those who responded with “yes” explained that some providers still hold rigid approaches to medicine or work in more challenging environments where IM is typically not offered - both of which hinder the center’s ability to integrate care:

“Sometimes providers in the hospital are more rigid regarding our approach. I do feel like there's been a slow paradigm shift in the hospital.” – Massage Therapist

“These modalities are offered in challenging environments in hospitals. Sometimes they are relevant sometimes in acute ER settings they are difficult to incorporate until the [patient] is stabilized.” - Acupuncturist

CAM practitioners shared that a lack of openness to different care approaches and certain clinical situations make it difficult to coordinate care among providers in IM.

Those who responded with “no” mentioned collective support among team members to believe in the treatments and perspectives of one another. This allowed them to coordinate care without false stereotypes functioning as a barrier.

“Within our center we all believe in what we do. Within the hospital we have gained the respect of providers and more importantly our administration to continue to expand our programs and services.” – Program Director and Founder

“The fact that providers are submitting orders for our services shows that they welcome the care we provide. Also, as the medical staff has gotten to know me, and see and hear a session first hand, their response when I come on the floors is proof they understand the benefit. Many times, I am asked to go into rooms of patients in pain or anxious. Blood pressure readings taken before and after sessions, reinforce the belief, understanding that there clearly is a benefit.” - Music Practitioner

“…all of my experience at HHC from other providers (MDs, RNs, APRNs) has been positive.” - Acupuncturist

Another CAM practitioner who did not think stereotypes hindered their ability to provide care shared that support from patients and their desire for IM have motivated him to continue coordinating care:

“Patients come here because they choose to come here…they may not like the current care they are getting so they are looking for something else…when we listen and spend time with our
patients, it provides a type of medicine that a lot of people tend to like and expect.” – Naturopathic Practitioner

The other CAM-based providers who responded with “no” simply have not experienced issues related to stereotypes about different providers and the integration of care:

“Have not experienced this” - Art Therapy Intern

“I can only say this has not been the case TO THE BEST OF MY KNOWLEDGE.” - Therapeutic Musician

Table 8 shows responses from CAM-based providers in regard to whether stereotypes among providers have ever hindered their center’s ability to coordinate care.

Table 8. Responses from CAM practitioners when asked to consider the following statement: “Prior research shows that some providers hold perceptions that complementary/alternative treatments are ineffective or that Western providers ignore non-physically related symptoms of health (i.e. spiritual, mental, emotional health). Do you feel that similar perceptions among your providers have ever hindered your center’s ability to provide integrated care?” N=12 CAM participants.

<table>
<thead>
<tr>
<th>Response</th>
<th>CAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>33%</td>
</tr>
<tr>
<td>No</td>
<td>67%</td>
</tr>
</tbody>
</table>

VI. IM as a Strength

All participants were asked the following question: “Has coordinating care with providers who have different medical paradigms been a strength or weakness when providing integrative care?” All three Western providers responded by stating that delivering IM with providers who have different medical paradigms is a strength and not a weakness. They explained that this type of care coordination is a strength because it is an opportunity to learn more treatment options and gain more insights on an illness from different practitioners who come from various medical backgrounds.

All 12 CAM providers described that coordinating care with providers who may have different medical paradigms is a strength; none described it as a weakness. Those who elaborated
upon their responses commented on how having this model allows the center to provide the best quality care and patient outcomes:

“Better patient satisfaction scores are improved.” - Acupuncturist

“Keeping the patients safe and providing the best care takes all providers with a variety of backgrounds and training.” - Naturopathic Practitioner & Certified Acupuncturist

Others from CAM mentioned the strength was a result of continually learning and educating their colleagues about different medical approaches, treatments, and their effectiveness when providing care:

“Irregardless of differing opinions we keep doing what we're doing; educating patients and staff on a daily basis.” - Massage Therapist

“[Having providers of different expertise] shows that there is not just one way to treat pain, anxiety, etc, and removes obstacles to doing so.” - Music Practitioner

“It is a perfect opportunity to explain IM interpretations, and benefits for patients. I enjoy the challenge of explanation, and because I have some background in western sciences, this has been helpful for interpreting the IM medical model.” - Acupuncturist

There were a variety of reasons; nonetheless, all 12 CAM providers responded that integrating care with providers who have different medical paradigms is a strength.

Chapter Four: Discussion

The discussion will focus more on the CAM participants since the Western participant sample was very small. Overall, the compared among CAM providers represented many different types of CAM practitioners and the small number in each category cannot be statistically compared. However, the general attitudes and emerging patterns on delivering integrative care can be discussed.

4.1. Participant Population

The distribution of roles among the 12 CAM providers matched what should be expected among IM centers. In the participant sample of three IM centers, there were nine different types
of CAM practitioners, suggesting that a wide range of CAM-related fields were integrated. Most of these centers also had three to five Western providers as well, further supporting that these IM centers were, in fact, integrated despite there being a low response rate from the Western providers at these institutions. This was the first necessary requirement of the exclusion criteria whereby IM centers must have a balanced number of CAM and Western-based providers to truly be considered integrative (Ng et al. 2016). The institutions that were sampled reflected what should be expected based on the literature because these IM centers had a balanced number of providers and therefore, were representative of true IM centers (Ng et al. 2016). Nonetheless, the generalizability and representativeness of the data were severely weakened due to the small sample collected from these institutions, even though they may have been reflective of what should be seen in the literature.

Majority of the CAM providers with previous exposure to IM had less than five years of experience. This showed that majority of the providers had some interest in IM prior to working at their current IM center, but many had few years of experience. Considering that no individual had more than 10 years of previous exposure to IM, this data reflects that IM is a relatively new field of healthcare among working providers (Bell 2002; Ng et al. 2016). This data continues to support that IM is a novel form of care that continues to emerge in healthcare.

Those who did have previous exposure to IM generally described that their past experiences consisted of personally receiving CAM therapies firsthand. These experiences ranged from going to yoga to receiving treatment from CAM providers in IM - only two of the 12 CAM providers actually had their previous education expose them to IM. These responses do not align with what is expected because most IM centers emerge from healthcare professionals who have received educational curriculum on IM (Baer and Coulter 2009; Olson 2001; Ross
2009). However, most of these healthcare professionals referred to in this research are Western providers that receive training from nursing schools, medical schools, and fellowship programs, which are educational institutions that many CAM providers do not attend. Therefore, the responses from the CAM providers show an interesting finding that, perhaps, CAM providers may be interested in IM due to previous exposure that differs from the previous exposure of many of their Western colleagues working at the same clinical IM setting. While many Western providers may have an interest in CAM due to previous exposure in their educational background, many CAM providers may have become more interested in IM due to their personal firsthand treatment experiences with CAM and IM modalities.

As for current years of experience, eight of the 12 CAM providers had less than 10 years of practicing at their current IM center. Similar to the previous results, this data supports that IM is a relatively new health field as majority of individuals have only worked in IM for up to 10 years. However, four individuals have been in this field for longer than 10 years. The individual data of these responses show that one of these individuals is the founder of their IM center. The other providers who have more than 10 years of experience are also individuals who have less than five years of previous exposure to IM. This means that those who have worked longer than 10 years are individuals who have mainly practiced at the current center where they provide care. Therefore, these results support that IM is a relatively new form of care as providers have only just begun to work in this field in the past two decades.

4.2. Important Aspects of IM

CAM-based providers were able to distinguish the important aspects of IM care. These salient aspects are preventative health, patient-centered care, the integration of the best practices from CAM and Western medicine, collaboration with providers who have different medical
paradigms, spiritual health, emotional health, and the promotion of healthy lifestyle choices (Baer & Coulter 2008; Diamond 2001; Maizes et al. 2009; Ng et al. 2016 Snyderman 2002). The responses showed that at least nine of the 12 CAM practitioners thought that all the salient aspects of IM care were important for their practice. This revealed that CAM practitioners in IM viewed medicine differently than just a pure CAM approach. Within CAM, practitioners are known to not collaborate with providers from different fields or rely on pharmaceuticals even if they are clinically effective; instead they prefer to use natural products (vitamins, herbs) and mind-body practices, such as yoga and acupuncture (Agarwal 2018; Willard 2005). In contrast to these typical perceptions, these results show that CAM practitioners in IM centers believe that integrating Western treatments and collaborating with providers from different medical backgrounds were important in delivering quality care. Overall, these results show that CAM-based practitioners in IM view and approach medicine differently than how CAM practitioners outside of an IM setting typically view medicine.

It was also important to understand the average length of appointments for IM providers. 10 out of the 12 CAM participants in IM had appointments lasting longer than 30 minutes and half of the participants had appointments lasting longer than 50 minutes. This was expected because typical Western appointments last 17 minutes, on average, and these terse appointments are primary reason that patients seek out CAM and IM services (McCaffrey et al. 2007; Tai Seale et al. 2007). This is because quick appointments give providers leverage to approach patients paternalistically and disregard emotional, mental, and spiritual aspects of care, so that diseases can be diagnosed efficiently (McCaffrey et al. 2007). While there is yet to be any evidence about the general length of appointments in IM, there must be ample time for patients to share about their physical symptoms, spirituality, emotional state, and lifestyle choices - a
characteristic also found in CAM (McCaffrey et al. 2007; Edman 2014). The explanation for the longer appointments is based on the premises that IM approaches a patient’s health holistically and thus, requires doctors to spend more time to evaluate all of the patient’s non-physical symptoms. In line with this approach, it can be concluded from the CAM responses that there would be ample time to discuss a patient’s health fully because majority of CAM providers in the IM centers had appointments lasting longer than 30 minutes. This conclusion also reflects a primary aspect of IM that is influenced by CAM practices where appointments take longer, so that IM providers can care for their patients holistically.

4.3. Motivations for Providing IM

Understanding the motivations of practitioners to join IM was critical to this investigation. One primary characteristic of IM practices is the inclusion of both CAM and Western providers within the same clinical setting (Barrett et al. 2003; Brown 2015). This requirement is distinct from both CAM and Western practices since both groups generally do not have a favorable disposition towards integrating care with one another. Therefore, understanding the attitudes that providers have towards providing care with practitioners from different medical backgrounds was key to understanding how they are able to provide IM.

Although CAM practitioners are known to have a negative perception towards working with Western practitioners, nine CAM providers answered that the inclusion of both CAM and Western providers influenced their decision to deliver health care in an IM setting. This is a paradigm shift and reflects how attitudes towards integration and collaboration among practitioners have changed and are continuing to change. In the past and still today, one of the greatest barriers in emerging IM centers is the skepticism that both CAM and conventional practitioners express towards each other regarding collaborative working relationships in IM.
centers (Hsiao et al. 2006). Differences in medical paradigms (approaches to health, disease etiology, values, jargon) can make CAM and conventional medicine seem like two clashing cultures (Agarwal 2018; Barrett et al. 2003, Coulter et al. 2007). Moreover, logistical issues, such as referral protocols and different methods in coordinating care between CAM and conventional health professionals, have been observed to cause failure in some IM centers (Coulter et al. 2007). However, the results from the questionnaire and surveys suggest otherwise that these barriers did not discourage CAM practitioners from providing care in an IM setting. In fact, their responses indicate that CAM providers wanted to join IM so that they could provide care with practitioners from different medical fields.

Compared to how typical CAM practitioners view integration, CAM practitioners in IM have different attitudes that show how perspectives towards integration are changing. Instead of a lack of collaborative working relationships and fear that different medical cultures will hinder the success of the IM center, CAM providers in IM have shared that these issues have not been evident. In particular, one CAM practitioner described how different medical cultures and collaboration with other providers have improved her center’s care:

“Integrating wholistic modalities with conventional medicine for patients who are sick or in pain gives practical, affordable, often non-pharmaceutical options to patients. That is so important in treating the whole person,” - Message Therapist and the Director/Founder of IM Center

The therapist’s response contrasts the expectation from CAM providers outside of IM that integration will result in poor collaboration among different providers and a clash of different medical cultures (Coulter et al. 2007). Instead, this response highlights the importance of having different medical perspectives and paradigms within the same clinical setting. These providers do not cite problems related to differences, but describe how these differences actually enable the IM providers to have a variety of insights and expertise on the same problem so that the best
solution can be offered to patients. This conclusion and response are further supported by how integrating different medical approaches allows providers to treat the whole patient and not just the physical symptoms (Kabel 2015). Thus, CAM providers in IM view the inclusion of different providers as having many benefits when delivering care in contrast to their counterparts only practicing in CAM settings.

A possible explanation for this shift in motivation and perspective towards IM is that current CAM providers in IM may have more previous exposure to IM than practitioners who are not open to integration. Although majority of CAM participants (eight individuals) had less than 5 years of previous exposure to IM, there was still some exposure to this form of medicine. Therefore, the shift in motivation to integrate care may correspond to the ideas that CAM practitioners have learned and experienced during their previous exposure to IM.

“I am an ICU nurse and saw the value of integration for my benefits first” - Consultant

“As I learned more about the integrative model in my classes, I came to understand how beneficial alternate modalities are in patient care and well-being.” - Music Practitioner

These responses convey how previous exposure and more knowledge about IM may have shifted the attitudes of CAM providers from not accepting IM to supporting IM. This could be concluded because majority of the CAM participants now providing IM had previous exposure that consisted of experiencing the benefits of IM to their own personal health firsthand.

“My own improved health and well-being. [I] Am out to show the world that one can improve their well-being.” – Consultant volunteer

“I have had PTSD since I was 6 years old. After a year of practicing yoga and meditation, I saw the benefits firsthand.” – Yoga and Meditation Teacher

By directly experiencing the benefits, many of the CAM providers viewed integration with more acceptance than before and felt that other patients should be able to share in the improved health outcomes as well.
The literature would substantiate this reasoning for how attitudes toward integration have changed over time for CAM practitioners in IM. This is because individuals with previous exposure to the health benefits of IM are more willing to accept integrative care. One study from the University of California at Irvine found that undergraduate students who were exposed to the clinical benefits of IM during a course on IM perceived it more positively, and also more effective than conventional and CAM approaches alone (Reeves and Cheung 2014). The participants in this thesis study may not have been undergraduate students. However, the same conclusions from the study could be applied to the CAM participants because the study on undergraduate merely indicates that attitudes towards IM can change to become more favorable when individuals gain increased knowledge and exposure to integration (Reeves and Cheung 2014). It would seem that in this situation, CAM providers working at their respective IM centers may have shifted their opinions about integration because of their own personal experiences seeing the benefits of IM and learning its unique advantages to patient well-being.

Overall, these perspectives from CAM-based providers working in the IM settings convey how previous exposure to IM can influence providers to shift their attitudes towards IM and motivate them to work with healthcare professionals from other medical fields. Additionally, the responses provide more detail to show how CAM providers in IM were further motivated to join these practices so that they could provide improved health care that they have personally experienced and felt was only possible by integrating the best treatments from each medical field.

4.4. Stereotypes
Understanding how false perceptions affect the ability to coordinate care among providers was also important for this investigation. Countless narratives from CAM and Western providers show that they are unwilling to collaborate with providers from the other medical field because of certain stereotypes - this often serves as a large barrier to emerging IM centers (Agarwal 2018; Barrett et al. 2003; Coulter et al. 2007; Ross 2009). Discerning how these stereotypes function and exist in an integrative environment can provide insights into how these false perceptions can be overlooked so that IM can be coordinated for patients.

When asked whether stereotypes about CAM or Western approaches to care hindered their ability to provide IM, eight CAM participants responded with “no.” Only 4 CAM providers responded with “yes”, indicating that the majority did not think these preconceived notions and false perceptions of one another were observable. In fact, many of the CAM providers described how they are welcomed by their Western colleagues:

“Within our center we all believe in what we do. Within the hospital we have gained the respect of providers and more importantly our administration to continue to expand our programs and services.” – Program Director and Founder

“The fact that providers are submitting orders for our services shows that they welcome the care we provide. Also, as the medical staff has gotten to know me, and see and hear a session first hand, their response when I come on the floors is proof they understand the benefit. Many times, I am asked to go into rooms of patients in pain or anxious. Blood pressure readings taken before and after sessions, reinforce the belief, understanding that there clearly is a benefit.” - Music Practitioner

These responses actually reflect how conventional practitioners have changed their perceptions about CAM from one of unacceptance and skepticism to approval and affirmation. This is because these responses refer to how CAM providers are perceived by their Western colleagues in the IM setting. In general, Western providers have been known to think that CAM treatments are ineffective or that spiritual assessments in CAM seem like organized religion (Abbott et al. 2011; Ross 2009). However, these responses convey that Western providers actually “welcome
the care” that CAM utilizes and view CAM approaches to care with greater respect. The dissimilarity between what would be expected of Western practitioners and how CAM providers are perceived by their Western colleagues demonstrate how Western providers in IM have changed their attitude towards CAM and currently value CAM providers with more appreciation.

One reason for a decline in stereotypes is that Western providers are becoming more aware of the clinical effectiveness of CAM that runs contrary to the false stereotypes that they may hold of CAM practitioners administering IM care. Two CAM practitioners describe how this process occurs:

“When we started Integrative Medicine years ago (2002) there were many nay sayers, but as staff throughout the institution saw results in lowering pain and anxiety, and providing comfort, they came around to see its effectiveness.” – Massage Therapist & Program Director and Founder

“Doctors are more informed about alternative approaches.” - LAc

The responses from CAM providers help illustrate how conventional providers have become more aware of the clinical effectiveness of CAM when used in IM. The clinical benefits of CAM when used in the context of IM is supported by the other CAM participants who spoke about improved patient satisfaction scores, higher quality care, and clinical effectiveness with the IM care that they provide. The efficacy of IM is also substantiated by studies that have empirically shown the significant value of IM as a medical approach (Kabel 2015; Majumdar et al. 2013; Pechacek et al. 2015; Panozzo et al. 2016; Trahan 2014). When Western providers understand these advantages that CAM modalities can offer in IM, the false stereotypes that they may have of CAM practitioners and their modalities do not align. Therefore, when conventional providers hear that IM is clinically beneficial and that CAM practitioners are not accurately described by the stereotypes about them, their perception of CAM practitioners in IM begin to change.
Through this process of awareness, false stereotypes about CAM providers in IM have been reduced.

The increasing institution of formal CAM education is another explanation for the decline in stereotypes and the increased awareness among Western providers regarding the benefits of CAM. With the increasing emergence of IM, the institution of formal licensure and certifications in CAM-related fields have also increased (Brown 2015). This has not only enhanced the reputation of CAM providers in IM, but it has also generated greater acceptance of CAM modalities among Western providers who may have held false perceptions of CAM care (Brown 2015). This is because certified education and licensure further show Western providers that CAM holistic approaches to care are legitimate— not ineffective, insufficiently tested, or a form of organized religion (Abbott et al. 2011; Olson 2001; Ross 2009). This acceptance from Western providers is significant because it suggests that they have removed their stereotypes about CAM providers and recognize them with higher regard. Thus, one of the reasons CAM providers may sense less stereotypes when they coordinate care is because of the formal education that has been instituted and has enhanced their legitimacy in IM to Western providers.

Nonetheless, there were still four CAM providers in IM who thought that stereotypes from their Western colleagues hinder the ability to integrate care. The CAM respondents described that these providers still hold rigid ideas about health and medicine which made it difficult for CAM practitioners to deliver care freely. These rigid ideas may include how health is more related to physical aspects of an individual, rather than the emotional and spiritual aspects, or how CAM treatments are fully ineffective because they are not as adequately tested when compared to Western therapies (Abbott et al. 2011; Ross 2009; Sointu 2011; Willard
2005). However, CAM providers are starting to see Western providers also shift their perceptions and paradigms about IM and CAM treatments.

“Sometimes providers in the hospital are more rigid regarding our approach. I do feel like there's been a slow paradigm shift in the hospital.” – Massage Therapist

Due to the rigid approach that Western providers may express to about CAM approaches, CAM providers can be discouraged from incorporating their modalities with conventional approaches when coordinating care for a patient (Barrett et al. 2003; Ross 2009). However, the observation by the massage therapist sheds light on how medical paradigms and approaches to medicine are changing in Western medical fields. This would result in more CAM providers being comfortable with integrating their modalities with Western treatments to provide IM. Although stereotypes can be a large barrier in providing IM, the responses convey that these false perceptions are slowly starting to be reduced and that the majority of Western providers in IM settings do not hold false perceptions about their colleagues; instead, they view their approaches to care with great respect.

All Western providers did not think stereotypes hindered their ability to integrate care.

One of the barriers to integrate Western providers into IM is the perception among CAM practitioners that Western institutions will coopt their treatments or that they will delegitimize the non-physical aspects of health (emotional, spiritual, mental) (Barrett et al. 2003; Olson 2001; Ross 2009). The fact that all Western-based providers did not think that stereotypes similar to these discouraged them from integrating care may suggest that CAM providers within IM do not hold these preconceived perceptions towards their Western colleagues anymore.

4.5. Medical Paradigms and Coordination of Care

When asked whether providers in their IM institution have different medical paradigms (disease etiology, definition of health, values, how to approach patients), eight CAM providers
disagreed. This means that many of these IM providers feel that their colleagues have similar medical paradigms, despite having different roles within the IM center. This result was not expected because this is contradictory to the mainstream assumption that CAM practitioners and Western providers will have different medical paradigms due to their differences in education, treatments, and definitions of health. For instance, Western practitioners have a biomedical approach to care in which health is the absence of disease and the goal is to eradicate a patient’s illness while CAM practitioners believe health is an inclusion of all aspects of well-being (emotional, spiritual, mental) that must be holistically managed along with a patient’s physical symptoms (Agarwal 2018; Barrett et al. 2003; Coulter et al. 2007). When considering these stark differences, these responses indicate that majority of CAM providers delivering IM actually have either changed their perspectives on healthcare, resulting in a similarity of medical paradigms, or overlook the differences in medical backgrounds among each other.

Based on the responses from the CAM participants, it seems that the CAM providers still maintain the same perspectives on healthcare, but are more able to overlook the differences in medical approaches so that they can work in the same clinical setting with their Western colleagues.

“This department is multi-faceted and I appreciate that we all come from different backgrounds and education but together we work really well together” - Licensed Massage Therapist

The CAM provider acknowledges that there are differences in medical background and education among one another, suggesting that the providers in IM maintain certain perspectives unique to their medical perspective. Nevertheless, the CAM provider describes how they are still able to collaborate well together. This implies that most of the providers in IM are able to set aside their differences related to medical paradigms and focus more on their similarities to coordinate care. This was also the case with other CAM providers, such as the music practitioner
who shared that “[all the providers] are pretty much like minded in [their] center] and the therapeutic musician who described that “[they’re] pretty much all on the same page!”. These comments reveal how most CAM providers feel that medical paradigms are not different, despite their acknowledged differences in medical backgrounds, because they are able to overlook the differences and focus more on being able to coordinate care with one another for their patients.

The four CAM providers who agreed that medical paradigms are different stated that the expertise and approach to care can vary among practitioners. However, those that elaborated described that they still follow the same vision and goals of IM, despite having different medical paradigms. Therefore, the differences in paradigms are not as pronounced as the literature describes within the clinical environment.

One of the most significant requirements for the success of IM is the ability for different providers to be able to coordinate care effectively. Therefore, participants were asked whether differences in medical paradigms made it difficult for participants to coordinate care when they first started delivering IM and also currently.

For the Western sample, all Western providers did not report difficulties when they first coordinated care with providers from different medical backgrounds. The general reason for this was because Western providers described that their fellow CAM practitioners had the same general vision and support for IM just as they did. Their responses may suggest that differences could be set aside by uniting under the goals of IM; however, further investigation is required for this finding due to the small sample of Western practitioners.

For CAM-based providers, majority of them (seven) did not experience any difficulties either when they first started providing IM care. Factors that would discourage CAM practitioners from entering the field are Western practitioners criticizing the efficacy of their
treatments and differences in medical paradigms (Abbott et al. 2011; Olson 2001; Ross 2009).

However, it does not seem that these factors were relevant for CAM practitioners since they did not encounter difficulties when they first entered IM. Based on their responses, CAM practitioners did not face initial obstacles coordinating care within IM because they viewed the differences in expertise as tools to provide the best quality care and treatments to their patients.

“We all bring different approaches to the table but there’s a symbiotic relationship and wonderful atmosphere between colleagues in the Integrative Medicine team at St. Francis Hospital” - Massage Therapist

“If everyone is in line with the integrative model... and if our goals are the same and similar, then no matter what our expertise is, whether it’s in pharmacology, or herbs, or homeopathy, or acupuncture, then there is not a lot of disagreement in the treatment protocols” - ND

This was a new finding that has never been reported in the literature. Nevertheless, the CAM responses indicates that although there are differences among them, they can have collaborative relationships without much disagreement as long as providers are in line with the goals of IM. This implies that despite recognizable differences in medical education and approaches to care, viewing a different expertise as simply a tool to provide better care with other providers can help overcome issues related to differences among CAM and conventional practitioners.

There were still five CAM providers who felt that differences in medical paradigms created difficulties when they first began coordinating integrative medical care. Their reasons for experiencing difficulties were related to how Western providers have been known to view CAM practitioners. A few of the CAM practitioners described how MDs do not trust in the efficacy of their treatments, have different philosophies regarding medicine, and do not respect nonallopathic therapies.

“Most MD’s didn’t understand or believed in the efficacy of Chinese medicine.” – Acupuncturist

“training and philosophies vary significantly” – Acupuncturist
“Lack of respect for nonallopathic therapies from many MDs” – Consultant/Volunteer

These responses indicate that Western clinicians may still look down and discredit the medical paradigms of CAM caretakers. When this occurs, CAM providers do not feel welcomed to integrate their modalities and coordinate care with other Western providers. Therefore, it seems that these perceptions and stereotypes among Western practitioners still function as an initial barrier to IM because it can hinder CAM providers in IM from coordinating care.

These same critical perceptions and attitudes toward CAM practitioners are still a barrier for a few CAM practitioners currently coordinating care in IM centers. Even though there were less participants who felt that differences in medical paradigms hinder their ability to coordinate care, there were still three CAM providers who felt that these differences still interfere with care coordination among providers. CAM providers who responded this way felt that Western practitioners continued to undermine their treatment modalities and their care outcomes. They described how conventional clinicians do not view their work as having therapeutic value, do not embrace their modalities, and feel that allopathic medicine is the only way for providing care. These attitudes are similar to common views in Western medicine, which tends to distrust the efficacy of CAM treatments and also place low value on holistic approaches to care (McClure 2002, Willard 2005, Sointu 2011). Moreover, these responses from CAM providers make it clear that some Western providers still do not generally appreciate the care delivered by CAM practitioners (Abbott et al. 2011; Olson 2001; Ross 2009). As long as these critical perceptions of CAM practitioners remain, CAM practitioners in IM will continue to encounter obstacles when coordinating care with Western providers.

One explanation for these critical perceptions and the barrier created by them is the lack of exposure to IM. Research shows that older Western physicians and individuals with less
exposure to IM in medical school have lower rates of acceptance towards care integration (Hsiao et al. 2006). This research corresponds to the responses from the CAM participants because the conventional providers with less awareness and knowledge of IM may be those who express negative attitudes toward CAM practitioners. While these negative attitudes were not directly found in the responses of the Western providers participating in the study, CAM responses did reflect negative attitudes from Western providers who worked in different hospitals or centers. Having a negative attitude towards CAM care approaches creates tension and awkwardness between CAM and Western practitioners giving care to the same patients. As a result, CAM providers are more tentative and less willing to incorporate their modalities with conventional treatments. Moreover, the opposite is true as well. Western providers who have less exposure to IM and view IM as ineffective do not want to incorporate CAM modalities into their practices (Olson 2001). Therefore, the lack of exposure to IM and subsequent unacceptance towards IM would explain why some CAM providers in IM may still currently observe difficulties when coordinating care with Western providers.

However, majority of CAM providers do not encounter obstacles when coordinating care with providers who have different medical paradigms. The questionnaire responses showed that this is because many Western providers have realized their need for preventative care and have become more aware of alternative approaches to medicine, as one CAM practitioner described:

“Paradigms are changing and there is a greater need for prevention and IM services in the [Western] centers.” – ND/Lac

Due to the greater awareness and need for CAM modalities from their Western peers, most of the CAM providers are able to coordinate care more effectively with Western providers in IM settings, despite having different medical backgrounds. This result was not expected because the literature explains that majority of Western providers do not focus on preventative medicine, but
focus more on pharmaceuticals and procedures to alleviate illnesses (McClure 2002; McCubbin et al. 2017). Therefore, it seems that Western providers are starting to understand that they are limited in administering certain aspects of care, such as preventative medicine, but that they can integrate their care with CAM providers who have different medical expertise so that their limitations are compensated. As a result, their patients also receive better care. This finding is also substantiated by how health professionals with greater knowledge and awareness of IM are more likely to be accepting of this form of care (Hsaio et al. 2006; Song et al. 2007). Due to the increasing awareness that Western providers have regarding the benefits of CAM modalities in IM, both types of medical professionals are more willing to collaborate and coordinate care effectively. Thus, increasing a practitioner’s awareness of the beneficial care that is provided through CAM modalities in IM can help improve relationships among the different types of practitioners, so that care can be well coordinated.

For the Western sample, all three providers reported that differences in medical paradigms do not currently hinder the IM center’s ability to hinder care. They explained that all providers are able to work well together despite their differences in medical approaches. The reasons behind this explanation should be further researched because it still does not explain how IM providers are able to collaborate effectively. This lack of information can be attributed to having a small sample of only three Western providers.

Based on the overall responses from CAM providers, it seems that differences in medical paradigms can still function as a barrier to care coordination. However, overlooking differences in medical backgrounds, combining different expertise to improve care, and having an increased awareness of the unique clinical benefits from IM can help overcome the divisiveness of medical paradigms.
4.6. Enjoyment of IM

When asked whether participants enjoyed providing care with providers who have different medical paradigms, all CAM participants responded with “yes,” except for two who responded with “sometimes.” This was not surprising because practitioners must enjoy some aspect of IM care in order to provide a novel form of medicine. Nonetheless, this finding was new and not found within the literature that describes CAM and Western providers having negative attitudes towards integrating care with one another (Agarwal 2018; Barrett et al. 2003; Coulter et al. 2007; Ross 2009). CAM providers elaborated upon two substantial reasons that made IM enjoyable. One reason was because these providers appreciate learning different views and approaches to deliver care. One acupuncturist described that it “keeps things interesting” and another naturopathic physician described that “different ideas on treatments” make providing IM care “more enjoyable.” The other reason was due to the effectiveness of IM. CAM providers expressed excitement in their responses, describing how administering health care with better health outcomes than Western and CAM approaches alone has been deeply empowering. The efficacy of IM referred to by the CAM providers has been supported by research (Kabel 2015; Majumdar et al. 2013; Pechacek et al. 2015; Panozzo et al. 2016; Trahan 2014). However, the responses from the CAM providers further elaborate and explain how the effectiveness of IM could be another reason that CAM participants were motivated to integrate care - simply because it has been more effective than the medicine that they were using before IM.

The only substantial reason that IM care was enjoyable “sometimes” was because of instances when treatments and insights were challenged so that the best care could be delivered. This response was also expected because medical paradigms entail different approaches to care, which providers may sometimes disagree on (Coulter et al. 2007). However, challenging current
approaches to improve care only functions as a feedback loop to deliver more effective care - one of the main reasons for why coordinating care with providers who have different medical paradigms is enjoyable. Therefore, it seems that the “sometimes” response is rooted in how CAM providers try to enjoy their delivery of integrative care as much as possible.

4.7. IM as a Strength

All CAM participants agreed that coordinating integrative medicine with providers who have different medical paradigms is a strength and not a weakness. There has not yet been research on the perceived strength of IM in the literature; nonetheless, this response was expected based on the reasons that patients seek IM and the clinical effectiveness of this medical model. Compared to CAM and conventional medicine, IM attracts patients and has improved health outcomes because it aggregates the best values, treatments, and approaches to produce the best quality of care (McCaffrey et al. 2008; Ng et al. 2016; Weil 2000). Additionally, many studies convey the effectiveness of IM in managing chronic pain, improving quality of life, and mental health issues (Gaddy 2017; Kabel 2015; Pechacek et al. 2015; Panozzo et al. 2017; Trahan 2014). Based on these findings, the research aligns well with CAM responses about IM being a strength. Many of the CAM responses mention positive patient feedback after treatment, improved patient satisfaction, and excellent patient outcomes when providers each with a different expertise work together to care for patients. Since the responses agree well with previous research, it is understandable that CAM providers view IM as a strength.
Chapter Five: Conclusion

5.1. Summary of Thesis

The increasing emergence of integrative medicine (IM) has drastically changed the landscape of American healthcare and has become a new focus for research. However, there is limited research on the perceptions of IM practitioners working in these clinical settings where providers with different medical paradigms must deliver care together. Thus, this thesis investigated how Western and Complementary and Alternative Medicine (CAM) providers in IM centers perceive how care is delivered in IM. Through the use of interviews and questionnaires, this study was able to explore change in attitudes towards IM, motivations for providing integrative care, and attitudes about coordinating care with providers who have different medical paradigms. Due to the small sample of Western providers, this study analyzed the results of CAM practitioners in IM in greater detail than the responses from Western providers.

One of the main motivations for providing IM care was that IM centers included providers from both Western and CAM fields. This was an interesting finding because previous research shows that many CAM providers do not want to work in IM because of fear that Western providers will delegitimize their treatments and will not work collaboratively. However, these reasons were not evident in participants’ responses. Instead, the ability to combine expertise, treatments, and insights into patient problems so that the best solution can be delivered influenced the CAM providers provide IM. Other factors that motivated CAM practitioners to integrate care were the clinical effectiveness of IM and previous exposure to IM. These other factors were novel findings that had not yet been discovered in previous research.

Despite having different medical roles, majority of CAM and Western practitioners were able to coordinate care effectively when they began providing IM and also currently. CAM
providers described that aligning under the same goals of the IM center and understanding how various expertise can improve care delivery allowed IM providers to set aside differences so that care could be well coordinated. Moreover, most of the CAM practitioners felt that their colleagues actually do not have different medical paradigms because they are able to unite under the same goal of IM. This is supported by how almost all of the CAM respondents agreed that the salient aspects of IM were important to their own practice. Even though the providers do have different expertise and roles, CAM providers view other providers more similarly rather than focusing on differences that can be divisionary.

The responses reflect a dramatic shift in how CAM providers view each other and IM. Typically, these practitioners hold false stereotypes and undermine each other’s approaches to care, thus creating barriers for integrating care. However, the responses show that these stereotypes and different medical paradigms do not usually hinder the center’s ability to deliver quality care. In fact, the responses show that CAM practitioners in the same IM settings actually value providers with different medical backgrounds and their care approaches highly. Therefore, CAM and Western providers are able to coordinate care effectively. This conclusion is supported by other significant findings which convey that majority of CAM participants find delivering IM enjoyable and all believe that it is a strength, instead of a weakness. Overall, the evidence shared from participants helps conclude that CAM providers using IM have a favorable view towards other practitioners, enjoy coordinating care with those who have different approaches to care, and believe this unique collaborative ability is a strength.

5.2. Implications

Although a majority of providers do not think differences in medical education, values and disease etiology hinder their ability to coordinate care, there were some CAM practitioners
who did. Their responses mentioned that Western providers would delegitimize their treatments and criticize their delivery of care. This reflects that staunch adherence to one’s medical paradigm can still function as a barrier to IM.

One method to overcome this barrier in the future is to increase the exposure to IM for future and current practitioners. Many responses shared how personally experiencing the clinical benefits of IM, becoming more informed about CAM modalities, and learning about IM increased one’s acceptance of IM within the study’s population. This is supported by research that shows how education about IM and exposure to IM is also associated with greater acceptance toward integrating care (Abbott et al. 2011; Hsiao et al. 2006; Reeves and Cheung 2014; Song et al. 2007). Encouraging greater awareness of IM to future and current medical professionals could reduce negative attitudes toward different medical practitioners in IM. More importantly, this could improve the coordination of care and emergence of IM.

Another method to overcome the divisiveness of different medical paradigms in IM is to encourage practitioners to unite under the goal of the IM center and view different medical approaches as tools to deliver better treatment solutions. By aligning under the mission of their IM center, CAM and Western providers can be able to focus less on their differences and more on the similar goal that they set out to achieve. CAM respondents shared how they could set aside their differences this way and coordinate care effectively. Furthermore, IM providers can deliver higher quality care if they can understand that combining their different expertise, insights, and treatments can generate better treatment solutions for their patients. By understanding how each practitioner can support one another with their unique roles, practitioners will be able to deliver care with improved outcomes - one of the reasons that IM care is enjoyable for CAM providers. When delivering IM care can be enjoyable with improved
outcomes, collective expertise, and the same vision, CAM and Western-based providers can overlook differences and coordinate quality care for their patients.

5.3. Limitations and Further Research

The greatest limitations of this thesis investigation were due to the small sample size. With only three Western medicine participants, the ability to compare responses between Western and CAM practitioners was not possible. As a result, it was difficult to generalize the responses and conclusions of the study. Also, responses from only one MD and two RNs are not enough to accurately describe how Western providers may generally view IM. This made their responses less significant as they could not be representative of Western providers using IM. Another limitation due to the small sample size was the inability to compare responses among different types of CAM providers. In reality, different CAM practitioners may have different views about care coordination or differences in medical paradigms depending on the types of providers they work with to integrate care. However, in this thesis, all types of CAM and Western providers were viewed equally. Overall, CAM responses were analyzed in greater depth than Western responses because the Western sample had too few participants in the study.

If I had more time for this thesis investigation, I would gather a larger sample that is more representative of practitioners in an IM center. This could be conducted by reaching out to more IM centers across the United States, instead of just three centers that are local in proximity. If a larger sample could be gathered, comparisons could be made across Western and CAM responses, and also among different practitioners within each of these fields. Additionally, issues regarding generalizability could be resolved. Lastly, responses concluded from the investigation would be more indicative of CAM and Western providers delivering integrative care.
There are also other areas of research that can investigated after this study. This was an exploratory study that gave many new answers not yet observed in the literature, but it also raised many new questions in a topic without much research. For instance, it would be interesting to compare the patient satisfaction scores between an IM center and also a conventional medical center or CAM practice. Conducting this research could give insights into how patient satisfaction between care approaches differs and what specific aspects of care lead to these differences. Another area that should be researched is the clinical outcomes from preventative health in an IM setting versus the preventative health in a CAM setting. Both of these medical approaches encourage healthy lifestyle choices and preventative medicine, but a comparison between outcomes could give information on how to improve preventative health in an era when chronic illnesses are more prevalent than acute illnesses. Lastly, investigation into the clinical effectiveness of integrative palliative care would have many ramifications. During the interviews at the Stram Center for Integrative Medicine, it was mentioned that many cancer patients receive IM. Some patients receive IM to complement their conventional care, but others only receive IM for end-of-life care. Conducting this research could show how effective IM could be in delivering palliative care. This research could also provide families of palliative care patients the best opportunities for their loved ones to experience the best quality of life in their late stage of illness. These examples of future research are just a few possibilities to better understand IM and provide the best care to patients.
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