

# Trials and tribulations on the road to implementing integrative medicine in a hospital setting

## ABSTRACT

### KEY WORDS

Sociological program evaluation, integrative medicine, sociology

*In this paper, results are reported from a five year qualitative study involving a stakeholder analysis of a hospital-based centre for integrative medicine. The objective of the study was to identify the barriers and the facilitators for creating integrative medicine in this setting. The study documented the timeline of the Centre from its very hopeful beginning to its demise. The paper focuses on the administrative implementation process, examining the original expectations in light of the organisational culture, business model, impact of policies and regulations, and the trade-offs made between the original goals and those attained within this environment. One of the most troubling aspects arising from this case study was that no corrective mechanism was in place for program design flexibility once previously created policies were deemed harmful to the Centre. When the major assumptions on which the Centre was founded, turned out to be false, there was no turning back and the Centre collapsed.*

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rationalistic quantitative Western scientific traditions. In contrast, complementary and alternative medicine (CAM) represents a loosely organised aggregation of heterogeneous practices based on global medical systems and philosophies that approach health and illness from an individualised but holistic perspective (Kaptchuk and Miller 2005; Coulter 2004). Despite these paradigmatic differences, this 'integration' has been occurring in some form for over a decade (Eisenberg 2006; Jonas 2005; Ruggie 2005; Coulter and Willis 2004; Singer and Fisher 2007; Cohen 2004; Collyer 2004; Barrett 2003; Dalen 1998). This case study examines an attempt to institutionalise this process of integration by establishing a hospital-based Integrative Medicine (IM) Centre.

## Introduction

An Integrative Medicine Centre represents two distinct medical systems and philosophies. Biomedicine, with its disease focus and fairly homogeneous, vertically organised hierarchy of specialists and generalists, traces its philosophical roots and practices to

## Definition of integrative medicine

While there is no agreement about what constitutes IM, most commentators agree it has something to do with bringing CAM into some form of relationship with biomedicine. An immediate difficulty is that there is no uniform definition of CAM (Coulter and Willis 2004), let alone a consensus of what constitutes

integration. The distinction between CAM and biomedicine is increasingly problematic (Coulter and Willis 2007). There is also increasing difficulty in naming the alternative to CAM. We concur with Wiseman (2004), who suggests that the term *biomedicine* is the least evaluative of the labels and does at least denote a medical paradigm within which the biological sciences are a core component and where explanations for disease and illness are predominantly biologically-based (Mead and Bower 2000). Further, the diversity of practices included under the rubric of CAM lessens its usefulness as an umbrella term. These practices range from very focused therapies to whole medical systems.

To call the combination of two paradigms 'integrative' is, as Coulter and Willis (2007) have noted, problematic:

*... the use of the term 'integrative' may bear more relation euphemistically to the term 'takeover' in much the same way as in the business world, the term 'merger' of two companies conceals the reality of takeover and on occasions hostile takeover at that.*

### **Institutional integration**

In the United States, institutional IM is being developed in a highly individualistic manner and a body of literature documenting attempts to establish integrative centres is growing (Barrett 2003; Weeks 2001; Muscat 2000; Moore 1997:114; Blanchet 1998).

In 2003, a national survey of 1,007 US hospitals documented that 16 percent provided IM and over one-quarter (26.7 percent) offered some form of CAM (Larson 2005). Novey (in Larson 2005), suggests the models of integration that have been implemented can be delineated into five types: a 'virtual' model (a clinic without walls); consultatory models (which rely on referrals from staff physicians to in-house CAM providers); primary care units integrating CAM and biomedicine; fitness or wellness centres; and expensive CAM services in a retreat-like environment.

Vohra *et al* (2005) studied nine IM programs in North America. Twelve key themes related to successful integration were identified. In contrast to the focus on implementation factors for success,

Barrett (2003) used a literature review to identify potential barriers and facilitators to the successful institutional integration of CAM. In the United Kingdom, the Prince of Wales brought together a steering committee and working groups to examine the issue of integrative health care (Dalen 1998). None of these studies, however, delineates what constitutes 'successful' integration.

### **Methods**

In order to examine how a Centre for Integrative Medicine (or IM Centre) fits into a larger medical centre and community of stakeholders, a case study methodology was utilised (Yin 1984). Case studies provide in-depth information about how programs work (or do not work) within the larger social and organisational contexts in which they are embedded (also Jinnett *et al* 2002).

We utilised both qualitative and quantitative data collection and analysis techniques. Most data came from structured and semi-structured interviews with six stakeholder groups:

- 1) key hospital administrators;
- 2) non-CAM clinicians within the hospital (attending physicians);
- 3) non-CAM clinicians in the community (private attendings);
- 4) CAM providers in the IM Centre;
- 5) CAM providers in the adjacent community; and
- 6) patients.

To complement our qualitative data, we collected quantitative data from patient files and structured patient questionnaires. Finally, to place our case study in a larger framework, we held a one-day workshop with key personnel from across the country who were directors of other IM programs (successful and unsuccessful).

### **Study setting**

The hospital-based, Integrative Medicine Medical Group (IMMG) was a multi-specialty practice delivering primarily out-patient medical care in a collaborative fashion and coordinates CAM with conventional Western medicine. The IM Centre was established by the hospital in the summer of 1998 to coordinate IM activities throughout the hospital's health system. It was located within a community-based academic medical centre with

the full services of a teaching hospital. The IM centre included two board-certified internists, an osteopath certified in family practice as well as geriatrics, two traditional Chinese medicine practitioners, a chiropractor and a massage therapist. Services offered at the centre included Western medical diagnosis and treatment, botanical medicine, nutritional counseling, mind-body interventions, acupuncture, Chinese herbal medicine, manual adjustments, craniosacral therapy, relaxation training, Tai Chi, limited homeopathy and massage therapy.

The centre ceased to exist as a formal entity during the case study, so this is a story both of creation and demise.

**Sampling**

The bulk of our data collection came from a stratified sample of stakeholder groups. The data from the stakeholders contributed both to our analysis of their beliefs, attitudes and behaviour, and also to our analysis of the relationships between the departments and other groups. In all the interviews, the ultimate focus was on the barriers to, and the factors contributing to, creating an IM Centre.

Although there are no strict rules for determining sample size for qualitative studies, they typically include 30 or fewer respondents (Patton 1990; Morse 1994). In our case, we conducted 17 individual interviews with providers and staff of the IM Centre and 40 with patients. In addition, we interviewed 21 administrators, medical directors and board members, 23 attending physicians and 21 community physicians with admitting rights. For the provider stakeholder group outside the IM Centre, we conducted 41 interviews of CAM community providers. We also interviewed eight respondents who were key CAM experts or donors. In addition, we tried to stratify informants across both mainstream medical and CAM specialties. The sample totals for all groups are shown in Table 1.

**Data collection techniques**

Data was collected using multiple methods (Miller and Crabtree 1992; Yin *et al* 1983), and then triangulated (Patton 1990; Tashakkori and Teddlie

Table 1: Stakeholder groups

STAKEHOLDER	n
CAM community providers	41
IM Centre patients	40
Attending clinicians	23
Community clinicians	21
IM Centre providers/staff	17
Administrators	16
CAM experts, donors, others	8
Board of Directors	5
Total participants	157

1998; Yin 1984). Data was collected by multiple investigators (Lincoln and Guba 1985; Patton 1990), and drawn from multiple points of view to reduce the influence on any single investigator (Edgerton and Langness 1974). We used six individual interviewers, all trained in qualitative methods. We also used quantitative data from patient records, patient intake surveys, and interviews of providers and patients (De Vries *et al* 1992).

The research team reviewed available documentary evidence relating to policies and procedures regarding the centre, for example, the business plan, organisational charts, administrative documents (memoranda of agreement, statements of standard operating procedure, policy pronouncements), proposals, reports, minutes of meetings, letters, and other written reports pertaining to the creation of the centre and its integration into the hospital and the adjacent community. We used semi-structured interviews with key informants covering the following topics:

- (1) historical factors surrounding the establishment of the centre;
- (2) existing policies with regard to the IM Centre and its integration within the hospital;
- (3) the nature and determinants of structural relationships between mainstream providers and the IM Centre providers;
- (4) the procedures used to refer patients to the IM Centre providers;
- (5) organisational and financial constraints that might contribute to the under-utilisation of the IM Centre providers; and

(6) characteristics of individual patients and providers that either facilitate or inhibit the use of the IM Centre providers.

Hospital staff reviewed patient records in the IM Centre from its inception to identify:

- (a) the referral source of the patient;
- (b) primary diagnosis;
- (c) providers seen; and
- (d) where (if anywhere) they were referred outside of the IM Centre.

To augment the patient data for sampling purposes, we mailed a survey to all patients of the IM Centre to gather data on the following topics: types of providers they visited and treatments they received at the IM Centre, how many times they visited and reasons they sought treatment, as well as demographic information. From their responses we purposely sampled 40 patients to interview. We also interviewed a sample of patients by phone, selecting individuals that represented the full range of presenting problems such as pain, symptoms/conditions/syndromes, general health/check-up and cancer patients seeking adjunctive treatment. We stratified this sample by high and low service utilisation. Patient interviews combined an open-ended set of questions and a closed-ended survey instrument (Bernard 2006; Spradley 1979; Becker 1958). At the end of the interview, we asked patients to complete a satisfaction questionnaire (Coulter *et al* 1994).

We used a semi-structured interview protocol when interviewing outside CAM providers. During the first part of these interviews, we explored CAM providers' attitudes, knowledge, and past experiences related to CAM in general. For CAM providers we were interested in the significance they give to CAM as part of the patient's care. We explored the linkages (if any) between these outside CAM providers and the IM Centre. We used the IM-32 scale that captures the providers' attitudes and opinions about 'integratedness' (Hsiao *et al* 2005).

Once our data analyses were near completion, we invited an expert panel of 12 members to review our preliminary results and give us feedback on these findings. We included a national representation of IM specialists and administrators, including several who had experience setting up similar integrative centres in hospital environments.

## Data management and retrieval

To help synthesize the large amount of qualitative data this effort yielded, we used computer software designed specifically for narrative interview and/or field notes (Fielding and Lee 1991; Pfaffenberger 1988). The software used on this project was *Atlas.Ti* (Muhr 1997).

The data from the abstracting of patient records, as well as all the survey data collected from patients and providers, was entered into a relational database, thus facilitating its input into statistical packages as needed. SAS software was used to clean and produce results (SAS 1999).

## Analysis

We used multiple techniques to analyse our diverse set of data. To analyse the key informant interviews (the bulk of our qualitative data), we used a multi-step analysis process. First, we coded the transcripts for specific time intervals to better capture how the IM Centre evolved. Second, we coded the transcripts for the kinds of stakeholders mentioned within the interviews. Third, we identified and coded 10 key overarching themes that we induced from the interviews themselves. To identify key themes, all team members read through a sample of the interviews and identified different thematic categories that appeared in the texts. Next, coders familiar with the interviews, read all the transcripts and marked all examples they found. We retrieved all marked segments for a given theme and sorted them into piles based on similarities (Lincoln and Guba 1985; Ryan and Bernard 2000). We came to team consensus as to what the key sub-themes were for each theme. Finally, we incorporated the sub-themes into our growing *Atlas.Ti* codebook and two team members applied the sub-themes to the previously marked text segments. Finally, we used the coded transcripts as the basis for our analysis and report writing.

The second step in our analysis was to examine how particular themes and sub-themes played out over time and across stakeholders with qualitative bivariate analysis.

We followed similar procedures with the patient interview data. For the structured section of the patient interviews, patient satisfaction, and provider integrated scale information, we entered

the quantitative data in a spreadsheet. We then used standard univariate and bivariate analysis techniques to examine the range, central tendency, and distribution of responses within and across types of respondents.

## Results

### *In the beginning*

The beginning of the story featured several major actors within the *Board of Directors* and the *Department of Medicine*. By 1996, members of the department were quite aware of the results of the study by Eisenberg *et al* (1993) on CAM use in the United States, which illuminated three major issues. First, many patients were using CAM; second, the public was spending significant amounts of money on CAM; third, many patients were not telling their physicians they were using CAM. By logical extension it meant many of the hospital patients, and possibly staff, were using CAM but not telling the hospital. For the patients, this raised the issue of the interactive effects that might occur between the CAM therapy and the hospital-provided care. It also meant there was a huge source of revenue which the hospital was not tapping into, and that opportunity existed for the hospital to provide a highly desired service for their patients and to profit from doing so. The board, for its part, had members who were already enthusiastic supporters of CAM.

The outcome was the establishment of a task force which undertook two endeavors. The first was to send a small group to visit existing IM Centres and/or CAM in hospitals. The second was to develop a business plan. The group considered three models for a possible centre, which at this time was called the 'Complementary Medicine Program'; to combine research, teaching and service in the university model; to partner with an existing CAM clinic; and to create a for-profit clinic within the institution. Initially they sought the second model.

There were two important drivers acting as facilitators here. From the board's point of view, the fact that the *Chair of the Department of Medicine* was initiating the program was significant. For many members of the board, even those who supported CAM, this fact alone assured

they would support the initiative. From the point of view of the staff of the institution (medical/health providers and administrators), the fact that the board was backing the initiative was important. For some it came to be seen as a board initiative, although this was more a perception than a reality in that the board did not actively sponsor or advocate for the centre. While they may have agreed with the initiative it was not something they strongly promoted.

*The background as we all know, was a growing body of experience that patients generally, and people in this community particularly, were increasing their use of complementary and alternative medicine ... So there was that experience. There was an obvious acknowledgement that almost none of those modalities was available at [the hospital]. Then there was the landmark study that came out in the New England Journal that had identified the percentage of patients who were seeing CAM type therapists, and not reporting to their primary care physicians and so forth. That was some background that was there [Administrator P12].*

### *The creation*

The hospital requires approval from the *Medical Executive Committee* (MEC) and the *Board of Directors* to establish a new program. This process involved developing a business plan that outlines the program's financial viability as a 'clinical' enterprise. Their approval, however, was not based solely on profitability. In fact, few new programs generated much profit. Many were underwritten by the *Board of Directors* to meet consumer demand. This program, in particular, had broad based support from its inception by the board, some of which was fostered by the wives of its board members.

While the board was mandated to set policy and fundraise, a board member could also advocate for a program and foster a positive outcome during the approval process. A positive climate for a new program can also be enhanced if the program can be positioned as serving the hospital's broad mandate of being at the forefront of innovation (leader of the pack).

*I think it's fair to say that it would be very unusual for the board to mandate the establishment of a program. We're trying to be responsive to the community's needs, and we should have systems in place to measure the community's needs, but not say, 'how about this or that?'*

[Board Member P22].

Within the context of hospital's faltering profits, the assumption that the centre would be a money-making venture drawing from a new revenue stream bolstered its approval.

### *The cultural context*

This institution held an ethos that validated a proactive stance towards exploring, developing and promoting novel medical programs, such as integrating an IM Centre into a hospital setting. This is expressed through a motto similar to 'leading the pack':

*We always like to think we're on the leading edge of medicine. We're very proud of [this hospital]. We felt if we could make it work here and do it in a way that was scientifically based, that would be a breakthrough. We could kind of lead the way, because we liked the idea. Maybe being from [this hospital] we think that way. Showing other people how to do it. We thought we had the ingredients to do it*

[Board Member P22].

Along with innovation, the hospital's organisational culture values intellectual openness, responsiveness to community needs, its community 'roots' and entrepreneurship. CAM touched upon each of these values. It required the hospital staff to be intellectually adventurous by being open to different medical models. It also fostered attentiveness to the perceived community needs of patients 'voting with their feet'. In addition, a willingness to integrate biomedicine with CAM, and potentially tap into a lucrative revenue source, was well suited to the institution's entrepreneurial focus.

The establishment of this centre however, presented moral and economic dilemmas for the hospital's executives who on the one hand saw an economic opportunity but on the other, may not have wanted the hospital to be associated with CAM. But given the reported high rates of CAM use, exploring CAM became scientifically and

economically attractive to the hospital's executives. Moreover, claiming to be investigating CAM scientifically would enable biomedical professionals to test the validity of some CAM approaches and justify its inclusion in the hospital. Many of the hospital staff felt the institution would be an appropriate test site for CAM and they would be capable of applying scientific methods to this field. In doing this research, they would be in a position to support or refute the claims made for CAM. In addition, providing CAM would enable the hospital to draw from this apparently vast, yet institutionally untapped, revenue stream.

The Task Force came to the conclusion that CAM alone would not be a program model that they would be willing to support, because they did not think they could compete with the various and numerous practitioners in nearby communities who focus on CAM. The end result of the Task Force site visits was a report supporting IM.

It was hoped that identifying a niche market with a 'sweet spot' – a model integrating CAM and biomedicine – would help the centre avoid the pitfalls that the Task Force had learned about during their site visits. Some programs were housed in substandard environments and treated as biomedicine's 'unwanted step-children'. For the Task Force, the 'going-in premise or belief' was that alternative medicine had its place, traditional medicine had its place, and they should be bought together in a way that enables movement of the patient from one modality to the other as seamlessly as possible.

### *The business plan and the model*

The proposed model would integrate the best of both medical paradigms, while ensuring that patients would receive this benefit within the safety net of a traditional and prestigious medical centre. A tri-partite of clinical, research and education design was finally proposed, with a research component that would test and advance CAM through an evidence-based approach. This would allow the hospital to patent and profit from some of its findings, while the teaching component would disseminate the research and clinical findings, and train future CAM/IM practitioners. This triumvirate would ensure that the centre would meet the institutional mandate of 'leading the pack'.

Even from the beginning, the administration recognised problems with this proposed model. Territorial issues are not unique to this centre and can be found whenever any innovative program threatens specialty barriers. The problem the administration saw with a new IM program is that it is very hard in the politics of the hierarchy of medical institutions to integrate one program into the numerous units across the hospital. As an integrative approach, they had to overcome the hurdles of territorial jurisdictional issues. Those involved in the centre's creation thought the integration could be achieved through patenting remedies, clinical work, publishing articles, and eventually serving an educational role in the institution. The latter would involve bringing change agents together to educate them.

This niche market approach, a 'blended model', it was thought, would be the most effective approach. It would foment cultural exchange and potential change for both biomedical and CAM/IM practitioners. However, to increase the appeal to hospital physicians, the exchange process would not include losing patients to the new program. Therefore, the initial proposed model defined centre staff as 'consultants' to whom in-house providers could refer patients knowing the IM Centre would 'return' the patients to the referring physician.

Three possible models were considered for the centre, which at this time was called the 'Complementary Medicine Program': 1) the university model that combines research, teaching and service; 2) partnering with an existing CAM clinic; and 3) a for-profit clinic within the institution.

The program designers operated under a set of beliefs that drove this initial venture. Among the various stakeholders, the key initial assumptions were as follows:

- there was already a patient demand for these services;
- there would be a high rate of referral to such a clinic;
- the venture would be profitable;
- because of the reputation of the institution, it would be successful;
- there would be considerable opposition from some of the medical staff;

- 'if we build it they will come': that is, the centre would generate its own demand for services.

The business plan was developed by the Task Force, reviewed by the board and the IM Centre was launched. But the model that was implemented was a for-profit clinic, set up as a separate entity from the hospital as a private corporation.

### *The change*

After the model for a proposed research-driven IM Centre was presented to the *Medical Executive Committee* (MEC), an important shift in emphasis occurred. Senior administrators focused on the clinical component rather than the research component, believing the former would serve as the financial 'engine', generating funds to support the research and education programs.

A major change in the model soon followed. Given the board's mission of protecting the hospital's limited seed funds, in contrast to the MEC, the hospital administration made it clear that it was critical for the clinical component be profit-generating.

The story of the 'morphing' of the business plan follows a circuitous path; one that had major ramifications for the final form the centre, as a significantly revised and modified business model was enacted. The realisation that the business objectives of the Task Force plan were not achievable began to emerge. Some of the administrators recognised it was going to take a long period of time to establish the IM Centre. They recognised IM providers could not treat as many patients as the Task Force originally projected. For example, an acupuncturist visit takes forty minutes, far longer than the traditional physician encounter:

*How many patients get a forty-minute visit in an outpatient facility? Doesn't happen. On the other hand you can't bill out as a surgical procedure. With even a minor surgery, you can get a big reimbursement. So you're kind of stuck in a lot of different ways* [Administrator P36].

### *The implementation - legal matters*

The IM Centre was set up within a foundation that existed within the hospital. The foundation provided a legal shelter from a state law called the

*Stark Regulations* by housing hospital-affiliated programs as private physician-owned corporations. The regulation originally drafted by California Representative, Pete Stark, is intended to ensure that physicians do not have a direct or indirect means to benefit financially from referring patients for services, procedures, prescriptions, supplies or equipment. It is, in essence, an 'anti-kickback rule'.

Initially, it was proposed that an IM program would be housed within the hospital's *Ambulatory Care Clinical Programs*. However, ultimately the centre was not established within the Medical Centre of the hospital's broader 'Health System'. Instead, it was made part of the 'Physician Delivery Network'.

The original plan was to establish the IM Centre as a cash-only business that would provide services for the out-patient program within the *Department of Medicine*. Subsequent decision-making regarding the administrative structure of the IM Centre was driven by a combination of regulatory constraints and potential incentives. Of the multi-level legal constraints, federal regulations regarding the corporate practice of medicine were the key factors in determining the initial administrative structure of the IM Centre.

As a consequence of the IM Centre being housed within the foundation, the IM Centre director was technically not hospital personnel.

*The director of the centre was in fact not employed by the hospital, but employed by the PC (private corporation), which was owned by two individuals, who owned the PC. The reason was that laws state that a hospital cannot employ a physician in the practice of medicine*

[IM Provider P11].

It put the centre legally at arm's length from the hospital.

In addition, there were considerable incentives to incorporate, such as creating a protective environment for innovation, and the anticipated financial remuneration for the corporation and the providers it contracted, such as above-scale salaries and bonuses tied to patient volume.

Additional legal constraints were associated with the decision to incorporate, including regulations regarding the sale of pharmaceuticals,

state-level billing codes, and hospital-level regulations mandating the acceptance of Medi-Cal and Medicare. The hospital, which does not have tax-exempt status, comprises three business units: the hospital, teaching and research, and medical delivery. The impact of legal constraints on the IM Centre's administrative structure was most central to what happened to it.

The foundation provided a shelter for the IM Centre from regulatory oversight in general, and more specifically, the *Stark Regulations*. The rationale for incorporating, was that the centre would have a kind of protective environment so the hospital did not have the burden of full bureaucratic regulation oversight. It meant the centre was not burdened too excessively by bureaucratic rules, by what could and could not be done in the hospital, such as following the rules for the joint accreditation groups for hospitals (JCAHO).

The normal process would be to develop a program and bring in full-time staff who are hired by the medical centre. The programs have the teaching, research, and clinical arms, and the patients, seen on medical centre property, are covered by medical centre insurance. Such a program would potentially fall under the MEC rules and regulations and oversight. However the model they chose was to create a physician-friendly professional corporation, a special corporation where the *Chief Medical Officer (CMO)* and the *Chief Financial Officer (CFO)* would be the owners.

#### *Financial incentives for incorporation*

In addition to the promise of autonomy and freedom from regulatory oversight, there were financial incentives to incorporate the IM Centre. As a private corporation (PC), it would provide the means to increase revenues and corporate salaries. The senior administration was attempting to demonstrate that the model they created was going to be able to work in an outpatient, clinical setting. They believed strongly that the model would work, and the outpatient clinical practice would not only be successful to cover its own cost, but would spin off profit to support the teaching and research initiative (components which would otherwise be unprofitable).



They also wanted to create incentives for the physicians to grow the practice by linking bonuses to the volume of patients seen. In the hospital setting, that strategy is not possible. By using this particular structure, the centre was not constrained by the hospital human resources policy about base salaries. There was a high market demand for the kind of providers they wanted to recruit, which pushed their salaries above the human resources base salaries for the hospital. Without paying these 'above base' salaries, they would not have been able to recruit for the centre.

The PC structure was attractive for several reasons. This structure did more than circumvent the *Stark Regulations*; it provided a strategic means to increase revenues and corporate salaries. From a risk-reduction vantage point, it would preclude hospital liability for CAM/IM services and any financial losses. It protected the PC from internal MEC oversight and hospital-wide salary caps, while providing shelter from the external regulations against the corporate practice of medicine. The PC model would also allow the centre to tie provider bonuses to patient volume. Finally, this 'physician friendly' corporation would have been able to offer stock options.

The assumption that the IM Centre would be extremely lucrative was a primary impetus to incorporate it as a separate entity, yet still within the administrative structure of the existing foundation:

*They expected that within a year, this thing would be minting money* [IM Provider P11].

Once the IM Centre was approved by the board, the foundation advanced a seed fund to set up a clinic. The centre therefore was structured as a private corporation under the hospital's foundation but legally distanced from the hospital. This varied considerably from the way the centre was initially conceived.

### *The aftermath*

The original plan was to have the centre provide CAM services as a cash-only outpatient facility, to avoid third party payment billing and reimbursement issues. However, because the PC was still within the umbrella of the medical system

(i.e. the foundation), the centre was subject to hospital-wide policies. As a result, the centre was required to hire the hospital's billing department to handle its accounts and to accept both public and private health insurance. Also, because of its relationship with the hospital, the centre needed to accept a mix of public and private third-party payments:

*The original model that [was] proposed was the model after [a local high-end clinic]. It's a cash on the barrel model, no insurances. [They] sell herbs and homeopathic products and everything else out of the office, which we weren't going to do, but it was going to be cash on the barrel. And then our CFO said, 'Oh, no you can't do that because hospital employees may want to use the services there, so you have to take Blue Cross and Prudent Buyer'* [Administrator P6].

Two years into the centre's existence, the financial losses were such that the hospital administration began the process of closing the centre and the corporation. The program was restructured within the *Department of Medicine* and ceased to exist as an independent centre at that time. The key factors that contributed to the centre's demise were legal, administrative, financial, location/market share, image, normative patient expectations, and medical as well as broader culture mores. In this paper we focus on the legal/administrative/financial issues.

As a PC, the centre was unable to use cost-shifting to absorb or buffer its losses. Such losses could have been anticipated given that most hospital-based IM Centres have not been big money makers. It appears that the initial internal Task Force overlooked the financial short-falls of the existing IM programs it visited, focusing instead on the studies documenting high rates of CAM use, which they failed to realise were not for the most part provider-mediated. Indeed there was a belated recognition that most of the hospital-based IM programs are in fact not making money:

*Ninety percent of all these medical centres were not making any money. I think it's very hard with insurance today to accept all insurances with big companies doing the billing who maybe don't know the specifics of the billing* [Hospital Provider P42].

Also, the systemic problem of successfully integrating a cash-only clinical model within existing medical systems' mixed payer reimbursement structure was not unique to this specific IM clinic. If a provider orders an MRI for headaches they will be able to get insurance reimbursement, but would not fare well with the patient if it was a cash for services procedure. If the CAM provider offered manipulation for headaches, there will be no reimbursement from insurance. So accepting insurance was problematic with current billing codes.

Trying to make the centre a cash-only venture also hurt it. Patients on Medicare were not willing or able to pay cash. If a service such as massage is available in physical therapy in the hospital and is covered by Medicare, the patient would not come to the centre and pay for the service themselves.

### *Problems in paradise*

While the centre's creators anticipated that incorporating the IM Centre would provide regulatory shelter and support an entrepreneurial corporate structure to increase physician incentives, it also brought extra costs, particularly for a start-up centre. It meant that the centre could not take advantage of the hospital's pre-existing structure and had to pay for items such as rented space, a billing service and extra insurance.

One important advantage the administration had in setting up the centre was that they could offer higher salaries to recruit providers to the centre. Yet this advantage was partly nullified because, as a PC, the centre was required to pay the hospital for its expensive space and required to use and pay for the hospital's internal billing services. In addition, although they were loosely housed within the umbrella of the hospital's medical system through the foundation, as a separate corporation they were not covered by the hospital's insurance policies. This meant the centre also needed to purchase separate plans to protect the providers and the PC owners.

Added to these unexpected start-up costs were the costs of the higher-than-market salaries and inflexible labour contracts for the allied health providers, who were guaranteed full salaries regardless of their patient load.

The global, internal regulations and bureaucratic mechanisms, such as billing procedures and the requirement to accept both public and private insurance, may have introduced insurmountable barriers to the centre's success.

The centre's services, particularly the lengthy in-take evaluation, further restricted patient volume. While the original business plan included the equivalent of five full-time providers seeing patients six days a week, the centre was instead top-heavy with physicians, and employed CAM providers, while the centre's patient base remained limited. Plus, it could not pursue one very lucrative revenue stream – the sale of herbs and pharmaceuticals – because of the hospital's structure. The constricted revenue stream resulting from the centre's low patient volume was compounded by its lack of spin-off income. The only means of creating this kind of 'high spark' income, herbs and pharmaceuticals, was moved to the hospital's pre-existing pharmacy department. This choked off the only 'high margin' income for the IM Centre, undermining its profitability.

Adding to the centre's limited means of generating profit, the original business plan, modelled on the findings from the Task Force site visits, which was founded upon a cash-only outpatient centre, was jettisoned. As an affiliate of the hospital, the PC was required to accept private health insurance.

The centre was also required by the hospital to accept Medicare and Medi-Cal, another low reimbursement payer source. In successful IM Centres, patients pay cash when services are rendered. This meant that the IM Centre billed Medicare and waited for payments. Also, the centre could only bill up to the amount Medicare would pay and then there was no guarantee Medicare would pay for the service.

Relying on the dominant payer pools of public and private insurance significantly decreased the viability of the centre. Its profit margin was already small and the lengthy and capitated reimbursement process for CAM/IM services further eroded profitability. The centre eventually tried to shore up the PC's growing losses by requiring cash payments from patients. However, this did not increase the centre's viability. Patients

were reluctant to pay cash for their care, indicating that the creators' hypothesised niche market was not on target. The patients expected the payment schedule to be like the rest of the hospital. Patients were accustomed to presenting their insurance card, perhaps making a small co-payment and then getting care. Being asked to pay out-of-pocket for services was unpopular among many patients:

*So who does the hospital end up with? They end up with all these people, this 30, 50, whatever percent of people who want to try alternative medicine in a safe environment, and yet they don't want to pay for it. That's who you're getting here. You're not bringing additional people to your hospital* [IM Provider P11].

Because of the small number of in-patient services that the centre provided, the insurance reimbursement was even more problematic. The patient in the hospital is not likely to have their wallet with them when services were being rendered and the services may not be covered by insurance since few CAM services are reimbursed. Even fewer in-patient services are covered by insurance companies.

Finally, because the corporation was established as an 'arms length' private corporation, it lacked mechanisms to funnel revenue back into the hospital, which might have helped its sustainability.

The business plan also created major – and unexpected – financial costs. These costs included not only the legal fees to create the centre as a separate corporation, but also spending to obtain a broad array of medical and corporate insurance. For example, hospital malpractice insurance, which covers its faculty, did not extend to the IM Centre; and because the IM Centre was 'a new concept', the malpractice insurance was high. In addition, because the centre was hiring providers from outside the hospital, they were required to purchase *tail* insurance to cover patients they had previously treated. Tail insurance is insurance to cover the period after a physician leaves his or her previous practice the insurance covers these patients, who may still pose liability issues. And once the PC owners discovered that they would be legally responsible for the PC's finances, they

required expensive Directors and Officers (DandO) insurance to protect themselves from financial losses. If these individuals had been hospital employees, they would have had malpractice insurance fully covered by the hospital.

The hospital's concerns about the centre's medical liability in general were heightened by the marginal position of CAM in Euro-American biomedical institutions. These concerns extended to the issue of dispensing herbs through the centre, which contributed to the decision to use the hospital's pharmacy for these prescriptions, even though the sale of herbs could have benefited the centre financially and might have made it a sustainable entity.

### *The business plan*

Along with the legal factors, the business plan, or lack thereof, had a tremendous impact on the centre. From the very start the business plan proved to be problematic. The most significant and perhaps fatal flaw of the business plan was that it was structured upon faulty premises and/or assumptions:

*Within the first 18 months it was [assumed that the centre was] going to be grossing a million and a half dollars. It just wasn't going to happen* [Administrator].

The other assumption was that they would get return on a visit. But they did not know how many patients they could run through the available space. The whole expectation that it would take less than two years to become very profitable, was not realistic.

The assumptions noted earlier in this report worked in combination with other faulty ideas about revenue: expected high patient volume (as based on reports of high levels of local CAM use); anticipated high levels of in-house referrals; strong revenues; a large population of CAM adherents willing to come to a hospital for their CAM care; and a single payer type that would be willing and able to pay for their visits with cash, regardless of future insurance reimbursement. These false assumptions led the Task Force to conclude there was a large, local medical niche market that could be tapped into by the hospital as a parallel revenue stream.

In this centre's business plan, this misinterpretation was further compounded by the attempt to emulate an existing local CAM model which catered to a single payer population of entertainment industry elites and other wealthy clients. Moreover, the business plan assumed and expected providers with this type of patient base would refer patients to this newly formed IM Centre. As a result, they failed to ground their plan with sound measures to ensure and grow a diversified patient and referral base internally or externally. Internally, a hospital-wide needs assessment was not conducted. There was no overarching coordination of efforts across departments to develop and nurture trust or, in turn, to develop and sustain consistent referral patterns.

For such a program to be successful they needed to determine they had a patient base or a referral base. They should also have determined if other similar programs were making money, researched the payer mix and services patients were paying for as well as what they were spending. None of this was researched. Moreover, the fledgling program failed to secure the kind of long-term financial support necessary to build its reputation, referral system and patient base. There was no long-term funding.

Rather than pursuing market research, the business plan assumed strong patient and provider referral bases and a single payer type that would meet their goals of maximising five full time employees including a director, two acupuncturists, a chiropractor and a massage therapist. Furthermore, the business model projected that the centre would provide services to patients seven hours a day, six days a week. It was also assumed that it would function at 50 percent capacity during the initial quarter, and up to 80 percent by the fourth quarter, and then 100 percent capacity within the following fifteen months. Their financial projections also assumed 'fairly brisk growth in year one and continued levels of high productivity throughout years 2 and 3', with projected payments of 60 percent fee-for-service at 6 months, 75 percent at 12 months, 80 percent at 24 months, and 85 percent at 36 months. In year two it was assumed that they would need to hire two additional part-time CAM

providers to meet 'increased patient volume'. The reality was very different: there was an inverse arc in fee-for-service payments, a reduction in staff, and a steady decline in growth and capacity.

Instead of a sound business model, the program had what amounted to an approach of 'build it and they will come', an attitude that was noted by mid-level management as the combined effects trickled down to the centre's front-line. From mid-level managers' perspectives, it was clear that the centre's business model lacked the basic framework it needed to succeed: a detailed strategic plan and a viable operating budget. The managers felt there was no strategic plan. Because of the centre's novel approach to health care, it was critical that its business model be founded on a clarity of vision outlined in a mission statement and supplemented by a detailed, workable operating budget.

A centre within the *Department of Medicine* might have been able to conceal its losses, which could have been absorbed in overhead costs, long enough to become a viable, recognised entity. The independent centre that was envisioned, which would have drawn from a broader patient base through a multiple hospital referral structure with a more robust payer mix, would have been held as a corporation by IM practitioners. These factors might have resulted in greater resilience over time with a broader revenue base, time to grow market share, marketable panache, and increased stakeholder stewardship.

### *The requiem*

Perhaps the greatest irony of this centre's failure is that one of the key factors that contributed to its demise was the unanticipated effect of incorporation:

*That was part of the mistake from the beginning. They made a huge mistake in the beginning. They set it up as a separate company, because they were afraid of a backlash ... and this was a way for certain individuals to separate themselves ... to protect themselves from the backlash. But there was no backlash* [Administrator P32].

In closing, it appears that multi-level legal constraints, as well as financial and practice-level incentives, drove the decision to establish the IM Centre as a private corporation. It may have also

been that this institution is very risk adverse because of its structure and reputation. However, because the decision-makers were unaware of the significant financial obligations that incorporation would entail, their attempts to deal with legal constraints and to create a protective and lucrative corporate entity, may have been the most significant barrier to their success:

*I suspect that we could have looked down the line and seen some of the practical clinical implications, bylaw implications and so forth, to anything around this topic [Administrator P12].*

## Discussion

This case study identified some key elements that might be considered necessary to successfully mount a hospital-based program in IM. The first is to establish a shared vision. As we have noted in this study, different visions lead to different models of IM, each with their own unique implications and outcomes. The established vision should be clearly articulated, made very public and be shared by the major stakeholders. This IM Centre suffered because the key planners failed to articulate a clear vision. Moreover, their vision changed over time and was neither widely shared internally by the various stakeholders or externally with the patients and community.

The IM clinic's vision also needs to be expressed in a mission statement. Unless the major stakeholders are all 'on the same page' with regard to the mission/vision, it is unlikely that a centre for IM could succeed. For a hospital-based IM clinic to be successful, the vision/mission should also harmonise with the broader mission of its host institution.

Part of the process of creating a vision includes examining the philosophical elements of IM. IM subscribes to a different paradigm of illness, treatment, healing and care than biomedicine, which gives rise to a different set of health practices and a different view of health and health care. Are these beliefs compatible with the beliefs held in the institution? Can they be made to be compatible? Can they co-exist without confusing the patients and causing conflict among the staff? To the extent IM involves bringing CAM providers into the institution it will be integrating a vitalistic paradigm

with biomedicine (a materialistic one). These are very significant philosophical paradigm differences. One of the barriers that this IM Clinic encountered was the inability to bridge these disparate paradigms, that is, to identify and articulate spheres of shared vision or paradigmatic overlaps.

A second element to successfully integrating IM within a biomedical environment involves identifying a market for such a centre within the institution and the communities it serves. Although in this case study the initiators established that there was a market for IM in the community, they never established whether that would translate into market share for this centre. While it may be the case that a centre will make a contribution that is not market driven such as providing a valued service which contributes to the retention of a client base, these approaches will lead to quite different strategic decisions in the centre's planning phase. But if the centre is expected to either make a profit or recover its costs, market research will be crucial. It is clear that no matter how prestigious the institution 'if you build it they will not necessarily come'.

A third element to successfully integrating IM in a hospital setting is the existence of strong advocates to launch a program within the host institution. Advocates must be perceived as credible and powerful. They may not have to do much promoting, but the very perception that they are advocating for the program can be a powerful incentive either for others to join the project or at the very least, not work to destroy it. The need for advocates occurs at many levels in an institution's hierarchy and may change at different points of the process. For an institution similar to this site having the *Board of Directors* on side and the leaders in administrative/medical staff on side ensured the launch of the program.

A fourth element to successfully integrating IM within a biomedical institution is the need for a realistic business plan. The plan needs to be tied to two important criteria; a specific market assessment of the clientele of this specific institution, and a full assessment of all costs that will be associated with the startup. The realism must also be applied to the time-frame in which the centre is expected to become self sustaining. It was clear that in this study no centre could have been profitable in the time-

frame allowed, given the costs and lack of a clientele. Successfully launching and maintaining an IM clinic within a hospital requires widespread examination of the assumptions on which the business plan is based. However, the business plan also needs to be flexible. Circumstances change and the business plan should also change. In this case study, the business plan was unrealistic, but because it was not re-examined during crucial phases of the IM's start-up, it lagged behind what was happening on the ground. By the time the business plan was changed, the deficit was already enough to bring an end to the clinic. Part of the business plan must also be focused on what services can be billed to insurance companies and what type of practitioners can bill for them. It is also clear that start-up funds are a crucial part of the finances and need to be in place for a sufficient time period to allow the centre to survive. The fact that so many of these IM centres have been established through philanthropy is indicative of this fact.

A fifth element of IM's success in a hospital setting is that a centre will raise numerous legal issues. Credentialing of providers and ensuring they are covered by malpractice insurance can be extremely complicated. Determining the legal entity under which the clinic will operate under proved in this case to be the most important decision made by its planners in this case study and one with significant unforeseen consequences which led to its demise. In one sense the legal possibilities will help shape what kind of IM centre can be constructed. To this extent it may lead to quite drastic changes in the vision, because of the attendant constraints upon what will then be legally permissible.

The final required element is that until all the aforementioned issues have been addressed and resolved it would be premature to actually design or construct a centre. The resolution of these issues will dictate the implementation of the centre as opposed to what the institution might want the centre to be. A centre that is constructed for a non-existent clientele is very unlikely to survive. It is somewhat difficult to envision a centre with a broad range of CAM practitioners if legally they cannot practice in the institution, cannot be covered by

malpractice insurance and cannot bill for their services under the existing insurance schemes.

## Conclusion

This case study can best be described, sociologically, as a study of unintended consequences. Given all the barriers we identified, it was not surprising the IM Centre did not survive. It was a high-risk venture that pursued a high-risk strategy. The risks may not have been that obvious to the planners at the time. In retrospect, the centre was expected to do too much, too fast. In addition to rapidly becoming financially viable, the centre was also expected to establish and sustain education and research components. Such goals may have been overly ambitious, especially in light of the fact that this was the first program of integration in the hospital. Important, and somewhat surprising, are the results that the centre's creators and participants did achieve. They managed to take a vision, create a centre in a highly bureaucratic (and somewhat skeptical) environment, hire CAM providers, open for business, develop a clientele, and provide services with which clients (for the most part) were satisfied. The centre and its outreach efforts also promoted the integration of CAM and biomedicine and various CAM modalities are still being practiced in this institution today.

The study raises some significant challenges for the sociological study of IM. The first is a very descriptive challenge. We have so few descriptive accounts that to use the label 'integrative medicine' to characterise programs or to use it as an analytic concept are problematic. We simply do not know enough about what is being done within institutions like this across the US to enable us to collectively term them IM. It may be that at the moment the best we can do is identify various exemplars all of which its proponents consider IM. The site studied here is clearly a hospital-based, physician-based model. Other hospitals have opted for nurse-based models. A third option might be CAM-based (that is the providers are CAM providers who are neither doctors nor nurses).

To the extent that IM may be seen as a way of organising health care, that is, is a particular organisational structure, the sort of organisational sociological questions that must be asked are:

- 1) What model of IM is being implemented? Is it a distributive model whereby CAM services are spread throughout the institution? Is it a consultative model wherein patients are referred for consults but returned to the division from which they came?
- 2) Is it a stand-alone clinic offering primary care? Is it a specialty clinic? Is it a virtual clinic?
- 3) Is it a treatment clinic, a research institute, an educational program or some combination of these three components?
- 4) Is it therapy-based (i.e. mind – body therapy; herbal therapies), disease-based (i.e. chronic illness), adjunctive therapy (i.e. for cancer patients) or more focused on symptoms (i.e. pain clinic) or some combination of these foci?
- 5) What professions, practices, and providers have been appointed?
- 6) Do Western trained biomedical providers provide the oversight and are they the dominant profession in the centre?
- 7) Who is the service primarily for? The worried well who have resources? The under-served populations? The very sick who are undergoing other conventional treatments? Persons who are already patients in the institution? A whole new population?

The broader sociological question is, does IM constitute a new form of medicine? Does it lead, as many of its proponents claim, to a transformation of biomedicine, or as one proponent claims ‘returns to medicine its soul’? And of course, the ultimate medical sociological question, does this form of medicine get better health outcomes for the patients?

At the moment with regard to IM, we are left very much like Lewis Carroll’s Alice when arguing semantics with Humpty Dumpty in *Through the Looking Glass*:

‘... the question is’ said Alice, ‘can one word mean so many things?’

‘The question is’, said Humpty Dumpty, ‘which is to be master – that’s all – however I can manage the whole lot of them! Impenetrability! That’s what I say’.

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