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Challenging integration: clinicians' perspectives of communicating collaboration in a center for integrative medicine

Patricia Geist-Martin[a], Beth J. Bollinger[b], Kelsey N. Wiechert[c], Brielle Plump[d] and Barbara F. Sharf[e]

[a]School of Communication, San Diego State University; [b]School of Communication, University of Washington; [c]ValueSelling Associates; [d]Code for America; [e]Independent Scholar & Professor Emerita.

ABSTRACT

A shift has occurred in the provision of health care to include a focus not just on biology and disease but also on the whole person, preventative care, and an array of healing modalities based on systems of beliefs and values not typically included within biomedical practice. This approach to health care, termed integrative medicine (IM), blends biomedicine with a broader understanding of patients and their illnesses, including elements of mind, body, and spirit that may be contributing to an ailment. While the use of integrative medicine has increased and centers for integrative medicine have proliferated within conventional health care organizations, distinct tensions arise from this amalgamation. The tensions between IM and biomedical clinicians often center on their differing training and philosophies, as well as on a larger system of health care that privileges biomedicine. As a result, this research is designed to explore the challenges IM clinicians face in collaborating with conventional practitioners to provide patient care. Analysis of interviews with 14 clinicians at one center for integrative medicine revealed four specific challenges they face in their attempt to co-practice IM with conventional medicine. The four challenges include (a) challenges to collaboration, (b) challenges to legitimacy, (c) challenges to consistency, and (d) challenges to unification. Future research should investigate the ways in which these challenges can be addressed so that collaboration throughout the system is facilitated. The professional training of clinicians, the structuring and institutionalization of integrative medicine, and enhanced systems for communicating patient information all play a significant role in this transformation.

In its most basic form, modern biomedicine is considered "an elaborate system of specialized knowledge, technical procedures, and rules of behavior" (Starr, 1982, p. 3). Biomedicine places emphasis on curing diseases observed in the body from a natural science perspective, such as biology, chemistry, or physiology (Keshet, Ben-Arye, & Schiff, 2013). The predominant health care model in the United States therefore is based on diagnosis and treatment of disease (du Pré, 2010; Sharf & Vanderford, 2003). As a result, this model offers a causal explanation for an abnormal physical state (Tyreman, 2006), and treats disease primarily through technology, medication, and procedures (Ho & Bylund, 2008).

Within the past few decades, a shift has occurred in the provision of health care to include a focus not just on biology and disease but also on the whole person, preventative care, and an array of healing modalities outside the biomedical repertoire (Keshet, Ben-Arye, & Schiff, 2012). This approach to health care, termed integrative medicine (IM), seeks to blend biomedicine with a broader understanding of the nature of illness, healing and wellness (The Bravewell Foundation, 2013), through which clinicians evaluate the patient's life, including mind, body, and spirit, that may be contributing to an ailment.

Although public acceptance of IM has grown, skepticism and marginalization held by conventional clinicians and administrators translates to challenges in efforts to incorporate and institutionalize IM into the biomedical models of care that dominate most health care systems. In order to understand and investigate some of these challenges, this research is designed as a qualitative study of one long-standing, widely acknowledged IM center, which includes interviews with center clinicians to discover their perspectives on collaborating with clinicians external to the center in order to provide care to their patients. We begin by offering an overview of IM, then turn to a description of the methods we used for this study. Next, we offer the results of this investigation, and close with a discussion of these results.

Integrative medicine (IM): mind, body, and spirit

It is important to understand how IM has developed in order to elucidate the challenges it faces today, as it is now practiced and institutionalized in more and more hospitals and medical centers. Historically, IM has evolved from definitions of care that are referred to as unconventional, alternative, or complementary therapies (Geist-Martin, Sharf, & Jeha, 2008), often with pejorative inflections based on comparisons with

CONTACT Patricia Geist-Martin pgeist@sdsu.edu School of Communication, San Diego State University, 5500 Campanile Drive, San Diego, CA 92182-4560.

biomedicine (Schreiber, 2005). Complementary and alternative medicine (CAM) is the overall term used to refer to "diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine" (National Center for Complementary and Alternative Medicine [NCCAM], 2012). Unconventional therapy has been defined as "medical practices that are not in conformity with the standards of the medical community" (Eisenberg et al., 1993, p. 246). The term "alternative medicine," referring to methods of healing that are distinct from biomedicine, originally was applied to therapies that had not been scientifically researched and approved by professional associations, such as meditation, prayer, or yoga (Schreiber, 2005). Complementary modalities are similar to what are called unconventional and alternative therapies, except intended to accompany and enhance, rather than remain apart from, biomedicine (du Pré, 2010).

IM has grown to be the preferred terminology for describing health care that incorporates the philosophies and practices of both biomedicine and complementary therapies. As Baer (2004) indicates, "*integrative medicine* refers to the efforts on the part of conventional physicians to blend biomedical and CAM therapies or the collaborative efforts on the part of biomedical physicians and CAM practitioners to address health care needs of specific patients" (p. xiv). Essentially, IM emphasizes patient-centeredness and a holistic approach to assessing and caring for patients' health problems, as well as concern for prevention and maintenance of well-being. Proponents of IM emphasize that it is inquiry driven, open to new paradigms of knowing, and confirmed by scientific investigation. IM models of care have now been instituted in small independent clinics and larger health care systems (du Pré, 2010; Keshet et al., 2013).

The notion of integration as used in U.S. health care is complex, layered with a variety of meanings (Sharf, Geist-Martin, Cosgriff-Hernandez, & Moore, 2012). A partial understanding of this semantic complexity includes at least three points. First, integration of biomedical and complementary education, beliefs and values, culture, and technical practice occurs within individual key personnel, such as integrative physicians, nurses, dentists, and pharmacists. For example, IM physicians are typically board-certified doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) with medical specialties such as general internal medicine, cardiology, or oncology, plus they have additional training and expertise in a complementary specialty such as acupuncture, plant-based nutrition, or stress reduction. This dual training and proficiency result in knowledge of biomedical assumptions and perspectives, along with a much broader vision of health and healing. Because of their dual credentials and ability to speak in common with biomedical colleagues, these clinicians often provide leadership for centers of integrative medicine.

Second, IM centers incorporate an array of experts who participate in patient care and education. Depending on their needs, patients/clients typically begin with a medical consultation, and then may be referred to one or more other therapists and other classes available within the center. Referrals among staff, shared record-keeping, patient consultations and conferences, and staff meetings are examples of how internal integration within such centers may occur on a regular basis. Quality of patient care depends on how well these communicative opportunities are enacted. Unfamiliarity with the expertise of other staff, scheduling conflicts, and locational difficulties are frequent constraints on internal integration.

Third, external integration deals with how well IM centers are able to communicate in productive ways with key external agents and organizations, which may include the public at large, the immediate local community, and/or external clinicians. Within large health care systems, the biomedical practitioners in more traditional clinical departments may be the most important external community—and often, the most resistant. Symbolic communication forms such as naming and spatial location, as well as organizational and interpersonal outreach, are ways in which external integration has been accomplished.

This study is designed to explore the challenges IM clinicians face in collaborating with conventional practitioners to provide patient care. With the rise of IM, there has been an awareness of the collaboration needed to bridge the contrasting philosophies and practices of IM and biomedicine (Keshet et al., 2012, 2013). As IM has grown in acceptance, so too has there been a growth in small and large centers for IM (Sharf, Geist-Martin, & Moore, 2012; Wieland, Manheimer, & Berman, 2011). Scholars write of various IM centers (Ho & Bylund, 2008; Keshet et al., 2013), but currently there is no comprehensive list of centers located in the United States or elsewhere. It is clear that centers for IM exist within university medical centers, larger health care systems, and smaller fee-for-service centers across the nation (Ho, D'Agostino, Yadegar, Burke, & Bylund, 2012; Sharf et al., 2012).

Collaboration between IM and biomedical clinicians within facilities is an ideal that does not always occur easily. How communication facilitates or restricts collaboration among clinicians is worthy of investigation, not only because of the history that separates biomedicine and complementary therapies, but also because of a history of professional training that leads some clinicians to be opposed to IM and others to be in favor of this trend in medicine.

Tensions affecting clinical collaborations between IM & biomedicine

Although the care models of IM and biomedicine differ, they are both focused on patient well-being—and for this reason many clinicians of both orientations are willing to cooperate in the best interests of the patient (Chung, Ma, Hong, & Griffiths, 2012; Hollenberg & Bourgeault, 2011; Narahari & Kanjarpane, 2013; Sharf et al., 2012). This collaboration of health care models holds great potential for patients; however, tensions exist within many health care systems that threaten the efficacy or even the possibility of such partnerships.

As patients choose to embrace both approaches to health care, one struggle they face is discussing their use of different therapies with each respective clinician. Research indicates that the coordination of information between IM and biomedical clinicians about their patients does not occur frequently, if at all (Gaboury, Lapierre, Boon, & Moher, 2011; Narahari &

Kanjarpane, 2013), leaving patients to incorporate the advice received from each health care practice on their own.

In addition to the coordination of information and advice that occurs in individual patient–practitioner encounters, a second tension is problematic at the organizational level of IM centers. Very few models exist with strategies for structuring and instituting collaboration between biomedical and IM care units (Gaboury et al., 2011). Resistance to cooperation also emanates among clinicians with differing philosophies of what health and healing mean. Rather than working together to improve patient outcomes, biomedical practitioners may view IM, in some cases, as a "strange" philosophy and in other cases as eccentric, even bizarre. With this mindset, difficult and even tense communication between IM and biomedicine clinicians may occur. IMs' philosophy and incorporation of therapies emphasizing spiritual, psychological, and social influences on wellness and illness remain outside the realm of biomedicine (Kligler et al., 2004; Snyderman & Weil, 2002).

Unfortunately, research is often written from the perspective of one health paradigm and its benefits alone, rather than the interactions and outcomes that occur when they collaborate together. Dividing rather than integrating these two health care models in scholarship has the potential to separate these philosophies of care even further in functional treatment situations (Hollenberg & Bourgeault, 2011)—a third tension.

The tensions health care systems face in facilitating collaboration between IM and biomedicine are not unlike the challenge that any organization faces initiating and sustaining collaboration among a range of professionals with differing philosophies. In the next subsection, we offer a brief discussion of research that focuses on collaboration and teamwork within the health care arena.

Teamwork and collaboration

Patients seek both biomedical and IM treatments and expect collaboration among their clinicians. This movement toward integration has caused many scholars to study the role of teamwork and collaboration in health care (Gaboury et al., 2011; Rose, 2011; VanWormer, Lindquist, Robiner, & Finkelstein, 2012). Up to this point, research on collaboration, specifically in health care systems, tends to focus on methods that create teamwork and joint goals (Rose, 2011), rather than on the communication utilized to accomplish integration. Scholars continually identify the opportunities for collaboration, but not necessarily the specific tools or obstacles that need to be addressed in order to achieve successful, collaborative health care systems.

Investigations of cross-discipline collaboration have found that communication is central to alleviating barriers and producing high-quality interactions between those from different backgrounds (VanWormer et al., 2012). However, communication barriers occur due to the quality and quantity of communication (Conn, Reeves, Dainty, Kenaszchuk, & Zwarenstein, 2012). The process of blending these differing communication perspectives in order to benefit a patient has rarely been researched. More often, research reveals that biomedical clinicians do not accept IM, and that "multiple communication failures" require negotiation at multiple levels by a variety of stakeholders (Cohen, 2004; Coulter, Hilton, Ryan, Ellison, & Rhodes, 2008). Interestingly, some health care systems advertise and market IM to their patients but fail to take the needed steps to ensure IM is supported and integrated within the system (Sharf et al., 2012).

Even though the collaboration between biomedical and IM clinicians is severely limited, relationships and listening still seem to be what patients want to gain from their health provider relationships (Geist-Martin et al., 2008). Patients want providers who will listen to their health issues, as well as work from biomedical and IM perspectives. It has been noted that "better organizational integration" (Chung et al., 2012, p. 1) is needed in order to address challenges that come along with health care that is being integrated by hospitals and patients alike.

Constraints on collaboration

There are numerous constraints placed on collaborative health care systems as they communicate to construct integration. One particular constraint is establishing regular and systematic collaboration "across the different modalities so that the clinical group brings together all perspectives on behalf of the patient" (Sharf et al., 2012, p. 135). Often, patients are placed in the position to create collaboration by being the go-between in the communication among their different providers—it is not something providers seek out on their own.

A second constraint arises in the differences in desires to share ideas across varied practitioner paradigms (Hollenberg & Bourgeault, 2011). Since biomedical and IM health care systems can be vastly different and IM is still relatively growing, there has been significantly less time for constructing collaborative environments and the accompanying communication competencies for successful collaboration among biomedical and IM clinicians. Working from such different perspectives of health and treatment causes tension in communication; biomedical clinicians may resist opportunities to communicate within a system of IM that is so different from their preferred treatment for patients.

A third constraint is that little is known about the practice of collaborative methods or organizational structures of IM (Gaboury et al., 2011). Teamwork is essential to patient–provider relationships and patient care; however, the lack of research conducted on biomedical and IM teamwork is substantial. Discovering methods of coordinating collaboration between two varied health care structures is essential to integrate the best care plans possible for patients who may benefit from IM treatments but are never referred to IM by their biomedical doctor because of communicative collaboration issues.

These three constraints need to be addressed if effective and satisfying collaboration is to occur for IM providers with administrators and providers in "traditional" departments. Thus, we see challenges in this internal-versus-external collaboration/communication integration. It is apparent that IM "requires the collaboration of multiple disciplines and team members with diverse backgrounds [and teamwork] should comprise physicians and scientists working together" (Narahari & Kanjarpane, 2013, p. 695). Bringing multiple backgrounds and expertise together for a common goal of

healing a patient takes work and effort. Discovering the challenges that may occur during this coordination process is crucial to understanding what practical steps can be taken to facilitate and institute collaboration among providers to enhance the care provided patients. The study of collaboration is a study of communication: understanding the perspectives of providers as they communicate in ways that enhance or restrict collaboration. We learn the challenges that clinicians describe as they work with one another to diagnose and treat patients. As a result, this case study asks the following question:

RQ_1: What communication challenges do IM clinicians face in collaborating to provide patient care?

Discovering the challenges providers face in coordinating patient care has the potential to illuminate best practices for provider collaboration within health care settings. Interrogating the role of communication will begin to bridge the gap in collaboration research and offer avenues for enhancing patient–provider and provider–provider interactions in centers for IM.

Methodology

One of the best ways to explore the communicative challenges that clinicians face in coordinating care is to locate our research in one medical context. The larger project, begun over a year and a half ago, draws on ethnographic methods that are ideal for accomplishing this research in that the goal of this type of research is to "examine people's actions" (Tracy, 2013, p. 22). While our methods included participant observation for the larger study, this research focused analysis on interviews with health care providers. Through interviewing the people who perform these actions, we gain access to the communicative interaction of participants and their perceptions of these interactions. In the following sections we offer descriptions of (a) the context of the study, (b) the research team, (c) the design of the study, (d) the methods of data collection, and (e) the data analysis and representation decisions.

Context

The research is located in Stevenson Integrative Medicine Center (SIMC), established in 1999 as a stand-alone facility, in a health care system that includes four acute-care hospitals on five campuses, a network of clinics, and more than 2,600 affiliated physicians. SIMC houses approximately 20 providers, six of whom are doctors of medicine (MDs), and 14 of whom are nurses, most of whom have overlapping titles as IM providers (e.g., acupuncture, nutrition, biofeedback, guided imagery, healing touch, and hypnosis), or instructors of SIMC classes (e.g., yoga, meditation, vegetarian cooking, qigong, and tai chi). SIMC offers services to more than 2,500 patients monthly, people who either are referred to the center by physicians in the larger health care system or seek out the center because of what they have learned from friends or family. The care provided by SIMC is based on a "whole person" approach to health and wellness and is guided by the philosophy that "healing starts from within."

In this research, we use the phrase "the System" to refer to the larger health care system within which SIMC functions. All the interviews, with two exceptions, were conducted with individuals who are employed and practice within SIMC, also referred to here as "the Center."

Research team

The "we" used throughout this article refers to the research team composed of all five co-authors. Three of us are in the same locale and correspond regularly through e-mail and conference calls with the other two co-authors. Both of the other two co-authors have invested time at the research site, participating in the research or conducting interviews with participants. One of our participants, Dr. Rose, was a member of our research team, both as our key informant and in the critical insights she provided throughout the research process, in recorded and unrecorded interviews. While we offered her co-authorship in the paper, this was not possible because it would have compromised efforts to keep the site anonymous.

Design

The study is designed to explore the perspectives of providers about their actions and interactions to collaborate in the provision of health care. This study focuses primarily on the perspectives of clinicians at a center for IM and their views on the challenges they have faced in providing care. Specifically, this study is foundational for a number of reasons: (a) It offers the specific vocabulary that the providers use to account for the challenges they face, both inside their Center and in communicating with others outside of the Center; (b) it provides background on issues that we are only beginning to understand; and (c) it offers access to information about past events and issues that will help to frame our next study (Tracy, 2013).

Data collection

The research began in February 2012, continues, and has included written field notes of our participant observation at the Center and public events sponsored or attended by clinicians from the Center. Our research included touring the facility, sitting in on two meetings, attending four classes, and observing interaction in the waiting rooms. This information, while not part of our analysis in this study, served the important function of providing a background and foundation from which to develop our interview guide, conduct our interviews, and analyze the transcripts. However, for this study, the primary form of data collection focused on the interviewing of clinicians and administrators inside the Center. The next two subsections describe this method in more detail.

Interviewing

The purpose of the interviews was to gain the perspectives of clinicians about the functioning and value of the Center. In addition, our aim was to gain insight into each clinician—how their life, education, and career path brought them to the

Center. We created a universal interview guide for clinicians, but this guide was adapted for each clinician based on any administrative position they served within the Center and what they may have insight about that others may not (see the appendix).

In total, we conducted 17 interviews, 13 of which were audio-recorded and transcribed verbatim, and extensive field notes were written for the remaining four interviews. The four interviews that were not recorded were conducted with the institutional review board (IRB) manager, a senior analyst of the patient experience, and two with the key informant as we were negotiating the procedures for arranging and conducting subsequent interviews. All three participants agreed that we could use these notes, but preferred that we not tape-record and transcribe the interviews.

Interviews were arranged via e-mail and conducted on site at the Center or in one of the other facilities that are part of the larger health care System. Participants signed consent forms and offered suggestions for others to be interviewed, creating a snowball sample.

Participants included six medical doctors (four males and two females), two registered nurses (females), two staff/administrators (one male and one female), and two IM providers (two females). The ethnicity of our sample is diverse, with countries of origin that include in addition to the U.S., Cambodia, Germany, India, and Italy. The medical doctors, nurses, and providers each utilize some combination of different IM modalities, including meditation, acupuncture, tai chi/qi gong, hypnosis, healing touch, lifestyle change, and herbal/dietary supplementation.

Data analysis and representation

Analysis of data occurred through five phases. Phase One of our analysis began with all members of the team reading and rereading the transcriptions. Phase Two of our analysis involved each member of the team taking notes about patterns that he or she discovered in the transcripts. Phase Three of our analysis involved a series of dialogues (in person and in conference calls) for narrowing down and reaching agreement on a set of patterns that became our initial discoveries in the data. We were seeing patterns in how clinicians described their philosophies and what they see as the overriding foundation of the Center. Specifically, clinicians described their goals at Stevenson as providing health care and a Center that focuses on (a) health care, not disease care; (b) optimal health as the foundation for optimal living; (c) patient needs over financial gain; (d) understanding and healing; (e) prevention of disease; (f) integration as a "thought strength"; and; (g) humanistic teamwork.

In Phase Four of our analysis, we dialogued about what these patterns revealed in terms of addressing our research question. Specifically, we wanted to know what the data revealed about the communication challenges clinicians face in coordinating patient care and how they see these challenges affecting the collaboration they engage in to provide the best patient care. In Phase Five of our analysis, we reviewed the data coded into the seven patterns already described and narrowed our data set by locating four patterns in how clinicians describe their efforts to accomplish these goals. In their efforts to accomplish the Center's goals, clinicians face communicative challenges providing IM as they (a) engage in teamwork to provide integrative health care (challenges to collaboration); (b) demonstrate the value of IM within the larger health care System and public arena (challenges to legitimacy); (c) recognize the need for more extensive, systematic, patient satisfaction feedback (challenges to consistency); and (d) institute a system of open, unified communication within the Center and the health care System at large (challenges to unification).

The presentation of the results of our investigation is organized into subsections offering evidence for each of the four challenges. These challenges are interrelated and concurrent, yet we present them here in a sequence based on the prevalence of the challenge in the narratives of clinicians. Throughout the presentation of the results, we weave in words, phrases, and sentences in quotation marks, quoted directly from the interview data. Dr. Rose as our key informant and Dr. Moretti as the co-founder and director of the Center were interviewed two or more times and thus offer more insight than other participants. Throughout the results, the name of the Center has been changed to protect its identity and often we refer to it as the Center and the larger hospital system as the System.

The four challenges to integrating medicine

Discovering the challenges providers face in coordinating patient care has the potential to illuminate opportunities for improvement within health care settings. While these challenges can be seen as roadblocks, in dialoguing about challenges clinicians offered their understandings of the ideals that are worth striving for and why they remain dedicated to IM.

Challenges to collaboration

Challenges to collaboration occur when parts of the whole System do not work together to accomplish the Center's goals. Collaboration is both an ideal that the clinicians aim to achieve and a significant challenge to the clinicians' communication with one another. Researcher Eysenbach (2008) defines collaboration as connecting groups of people together; collaboration involves teamwork, assessment of both patients' and staff desires, and whole-person orientation (Bagley, 2005; Bauer-Wu, Ruggie, & Russell, 2009). In this sense, clinician communication occurs among clinical and administrative staff within the Center, as well as with others in the health care System, in ways that invite increased knowledge and expertise into their organization and their provision of care. This, however, is not always the reality. The specific challenges to collaboration include differing views on how to spend time and money concerning patients (economic issues) and opposing views on the best practices for treating patients (cooperative issues). All 10 of the staff clinicians interviewed in this study mentioned collaboration as a challenge that must be addressed.

The clinical staff members in this study view collaboration as a way to support health, not just treat illness, with a focus on incorporating a myriad of treatment modalities into the health care they provide patients. Clinicians describe

ideal collaboration as "holistic" and "integrating many specialties," meaning it should occur both between clinicians and other clinicians, and between clinicians and patients. In fact, most of the clinicians originally entered the field of IM because they aspired to include a more holistic approach with their biomedical approaches. Through IM, their treatment focuses on an overall healthy lifestyle where "pieces of the puzzle" would unify clinicians in a collaborative environment. Also significant in achieving collaboration is the mutual agreement and understanding of the financial piece of health care—that is, focusing attention on how money is spent in the Stevenson system and how much time is spent treating patients. The Center clinicians seek understanding of a patient's history, lifestyle, and health, which requires additional financial and time expenditures beyond the typical medical visit. In describing a typical patient visit under Stevenson's philosophy, one clinician stated, "That's not health care. It's disease care."

But the Center clinicians want to achieve a collaboration that extends beyond patient–provider communication to provider–provider communication. While these two types of collaboration share similar roots, they have integral differences. The goal for both types is to work together to identify problems and find solutions as a team, to truly hear one another and synthesize ideas, but they approach this same goal in different ways. Provider–patient collaboration works backward to discuss a patient's symptoms and find the root of the issue. There is an intimate dependency on one another; the patient wants to see the provider as reliable, and the provider wants to be seen as a reliable and trustworthy; the provider needs to know everything about this patient's lifestyle to assess him or her holistically. Together, they dig deep into symptoms and causes of the patient's conditions. Provider–provider collaboration, however, works forward to heal the root of the patient's condition, its branches, and its leaves. Each provider is a clinical expert, and therefore has less dependency on the other. Ideally, their two expert minds allow them to dig deep into a wider range of options for the patient, because both providers have their own sets of applicable knowledge.

Often, however, communicating the legitimacy of each provider's knowledge and communicating the legitimacy of their treatment ideas prove difficult, making collaboration challenging (especially if one is integrative by title and the other is more specialized). In both provider–patient and provider–provider relationships, trust is key, but dependencies are different. We see both types of collaboration (and the challenges to them) in cooperative and economic issues at the Center.

Cooperative issues

One of the most significant challenges to collaboration is the resistance from other specialties to bridge the practices of IM. Rather than operating from an illness model, the clinicians' goal is to function under a health model where the philosophy is optimal health as a foundation for optimal living. In order to achieve this, clinicians need expertise from an array of specialties to treat the whole body, not just one piece of it.

In describing the collaboration that needs to occur in order to maintain a healthy body, one clinician explains that patients have to convince the hospital System that treatment from the Center is the right thing for them. One clinician describes it this way:

> Oh, there's plenty of resistance from within. A lot of my patients say, "I really have to work hard to get to you even from within the Stevenson family." So even though there are, you know, doctors who know about our existence there and they know kind of what we do, only sometimes they'll refer on their own. Like with these structures that I'm talking about —they will refer, it's like they've kind of lost it with the patient. They're done. They're done and they're like okay let's just send to integrative medicine because I don't know what else to do with you and others they're more resistant to sending because they feel like there's still more that they could do. But the patient's like no, I don't want to have medications, I want to have these other alternatives and they're like, no, no, you don't need to go over there but they kept on persisting with it. It took them multiple visits with their primary care doctors to get them to be referred over to us. (Rose, Interview 3)

This account illustrates that although the clinicians are all part of the same organization, there are times when the pieces work against each other, making collaboration impossible. Even within the same hospital, outside clinicians do not refer patients to clinicians at the Center, preventing inter-System collaboration from happening. Center clinicians perceive that other specialties look down upon IM, the clinicians, and/or their treatment modalities, only sending patients their way if they have no other options. Yet the challenges to collaboration go beyond cooperative issues, to economic issues too. As Dr. Rose pointed out, collaboration is not desired by the System; collaboration is the last resort.

Economic issues

One clinician claims that it is simply "naive" to think that a health model focused on collaboration would work at all when the System is driven not by patient needs, but by financial gain. The clinician recalls the ideals the clinicians had originally set out to achieve:

> We were extremely naïve at the time because it never occurred to me that here we were talking about health and lifestyle change and wellness, and we were trying to put a model that focused on that in a System that makes all its money on diseases. (Moretti, Interview 1)

While the clinicians speak of caring for the patients as a whole —their biological, emotional, and spiritual health—the System's goal seems to be quite the opposite: to care for one aspect of health at a time in order to keep the patients ("customers") coming back for more. Treating patients holistically would work against the System's financial plan. While the clinicians' bottom line is health, they perceive that the System's bottom line is money, restricting the care they can offer the patient. One clinician explains the "business" of hospitals:

> Everybody here knows that we feel like we got a target on our backs. You know, that integrative medicine has not been producing tons of money and stuff. … I don't know how much you know about medicine and business of medicine. But seeing patients is not what makes money for the hospital. It's driving the procedures and stuff, which is second opinion. … So these

> scanners here, if they're busy then we're making money. (Ghanem, Interview 2)

The clinician's account illustrates the fundamental difference in the Center's and System's philosophies: Health and a desire to heal drive the clinicians to continue practicing medicine, but the clinicians perceive money is the System's primary motivation.

Also inherent in the System, yet counterintuitive to the collaboration the Center seeks, is the frequency with which clinicians see their patients. While the System emphasizes the practice of brief visits with patients that minimize face time, the collaborative approach the clinicians see as imperative requires working with patients on a regular basis to promote overall health. Another clinician explains:

> You know, 10-minute visits, 15-minute visits. And it's ludicrous to me as someone trained in family medicine to say, "'Okay, you're supposed to be the quarterback of this patient's team. You're supposed to coordinate their care, oversee their continuity of care, manage all of their chronic diseases, take care of all their preventive needs in a span of once-a-year 45-minute annual visits, and then in between have a 10, 15-minute visit." Whereas as a specialist, you get to have 60 minutes for an initial consultation, 30 minutes for follow-up visits, and they don't restrict how many 30-minute follow-up visits each patient can get. (Rose, Interview 6)

While IM seeks more time with patients to design a collaborative approach to health care, the System works against this collaboration by enforcing strict appointment times and a protocol that discourages any collaborative communication from taking place. In addition to the challenges in collaboration, clinicians face challenges in establishing their legitimacy and credibility.

Challenges to legitimacy

Legitimacy is established when individuals communicate credibility, integrity, and trustworthiness. Kreuter and McClure (2004) characterize credibility with two dimensions: expertise and trustworthiness. They assert that these two attributes comprise clinician credibility and therefore, practice credibility. Apker, Propp, Zabava Ford, and Hofmeister (2006) similarly depict credibility as trustworthy and straightforward communication between clinicians and patients, as well as with colleagues. This type of interaction involves confronting conflicts that occur and creating an environment of respect. Further, the clinicians conceptualize credibility as "mutual respect" between themselves and their colleagues, approbation from the System and other specialties, and "validity as a practice." The System built the Center with this ideal in mind, in an attempt to "create a place of understanding and healing." The Center clinicians entered into the field of IM because they saw a need for something beyond exclusive, conventional biomedicine that was not meeting patients' needs. With this in mind, they conceived an institution where "technology meets patient care," and where both patients and clinicians alike were validated for their health concerns and methods. However, legitimacy arose as an issue for seven of the clinicians interviewed.

While the clinicians seek to communicate "Center legitimacy" to patients and other employees within the System, their communication remains restricted by misunderstanding, ignorance, and lack of support from outsiders. Communicating legitimacy means creating credence around IM and delivering a message of reliability and authenticity (Eysenbach, 2008). Although the clinicians aim to communicate legitimacy and credibility, their attempts are thwarted by outside limitations. One such limitation is the demand for evidence-based research. Such evidence does exist for IM, but it is limited and not well publicized within the System or sought out by clinicians who are skeptical of IM. Of the 10 interviews that took place, six mentioned legitimacy as a challenge. Specifically, they find challenges to establishing legitimacy with issues in "illegitimacy" and issues in "detraction."

Illegitimacy issues

After years of dealing with the lack of support and respect from the System, one clinician views the contention as rooted in rigid belief. Because the belief is so rooted and widespread, other practitioners within the System naturally hold the same belief of IM. The clinician indicates:

> It's not that they're feeling hurt for business, because their numbers are fine. It's not like, "Gosh, are you stealing my patients?" No, it's not about that kind of competition. Their perception from how I perceive it is they're not done medically believing their way is the only right way, and if you deviate from that way, you're harming patients. So my answer to that question is there's a whole lot of gray area in endocrinology but they would not perceive it as gray. They perceive it as black and white. If this, then that. They're very protocol driven. Well it's this whole perception of real medicine is clean. It's cut and dry. It's not fluffy. It's not touchy feely. It's not uncertain at all, no. There's absolute certainty. (Rose, Interview 6)

The preceding narrative describes the overall type of communication that occurs within the System: one in which Center clinicians are "looked down upon" and "invalidated by others in the System." The System in place abrogates their legitimacy in medicine, and the clinicians perceive that others in the System similarly invalidate their practice in multiple ways.

Another clinician acknowledges that IM "just lacks the scientific evidence to support it," but looks forward to the day when her colleagues realize what she and the other clinicians already understand: IM is about holistic health and living. While other specialties invalidate the clinicians' work, the clinicians are working from a long-standing tradition with a history that speaks for itself. "Every other global healing tradition says to prevent disease, right? IM does precisely that —it prevents" (Moretti, Interview 1). Elaborating on this idea, this clinician states:

> We have to recognize that there are global healing traditions in the world, right? All these global healing traditions are called: traditional Chinese medicine, Ayurvedic medicine, homeopathy, naturopathy, allopathic medicine, which is what I was trained to do with medical school. So all of these global healing traditions have value. (Moretti, Interview 1)

Although the clinicians readily admit that all of the specialties have a place in health, there are other clinicians who continue to discredit their work, ignoring centuries of evidence. Beyond feeling invalidated as a practice, the clinicians also deal with "detractors" and "naysayers" from within the System on a regular basis.

Detraction issues

Detractive communication poses a challenge to the Center building legitimacy and credibility. Other specialties and clinicians discredit the Center's achievements and "actively speak out against" them. The System at large seems to be the "source of it all." One clinician describes the difficulty in not being recognized for his accomplishments as a practitioner simply because he chooses to practices IM. In reflecting upon his interest in connecting the worlds of traditional medicine and IM when he entered the field, the clinician remembers being teased for it. He states:

> I was the first to kind of bridge the gap between cardiology and integrative—I mean I was teased by my group. "Grass pusher," you know, "herbal freak." You know, all that stuff. That was fine because I always considered myself very strong in medicine, and I could outdo any procedure that anybody there ever could do. So I could hang in their field as far as being a cardiologist but yet bring my thought strength from an integrative perspective, and so that's how I kind of bridge it. (Ghanem, Interview #1)

As this account indicates, the clinicians face a significant challenge in communicating legitimacy because there are outsiders who discredit their work and disrespect them. This working against others—specifically against the clinicians—is precisely what prevents the Center from moving forward in building legitimacy and achieving a health-centered model of medicine.

Similarly, one clinician's efforts to offer treatment to her patients have been particularly dismissed by others in the System. She perceives it as the lack of respect from other specialties and an unwillingness to cooperate. The clinician describes the situation in this way:

> The department head alleges that there are internists, other primary care physicians who come to him and said, "Gosh, do you know what she is doing? It seems a little off base." He's had to respond like, "Yeah, I kind of know what she's doing. I disagree with what she is doing." And he'll just give his perspective like that, and that's probably what instigated that first one-on-one meeting with me. (Rose, Interview 6)

This account brings up many issues, the lack of legitimacy, or "recognition from the System," being the most prominent. It is clear that internal disagreement among clinicians at the Center and clinicians from other specialties results in tensions that question the Center's methods and legitimacy as a health care practice. The perceived lack of legitimacy and "detraction" surrounding the Center cultivate "feelings of mistrust" in the Center and top-down communication, both of which contribute further to the challenges to legitimacy. Additionally, the Center faces challenges in maintaining consistency.

Challenges to consistency

Similarly, the Center faces challenges in establishing consistency. Consistency is created for clinicians and patients when there is an established accord, a general sense of congruity in the daily operations of an organization; Kreuter and McClure (2004) describe it as a likeness and understanding from one aspect of the environment to the next. It contributes to the general trust and dependability of individuals in the institution, and without it, they experience "mistrust and anxiety" and feeling "never sure what's going to happen next." In fact, six clinicians mentioned consistency as a current challenge. The clinicians do, however, have an idea of the role they would like consistency to play in the Center. Ideally, the clinicians envision the System as utilizing open communication, accurate documentation of care, regular feedback, and timely appointments. In turn, all of these would contribute not only to stronger consistency, but also to building legitimacy and collaboration. The challenges to consistency in this way lie within documentation and feedback issues.

Documentation issues

The current method for keeping record of patients' care is "spotty at best" and unfortunately only symptomatic of the problem at large. The System is restrictive in many ways, and its lack of collecting data is just one of them. In describing her frustration with the current state of documenting records, one clinician explains:

> I wish we had somebody tracking the data for every new person that signed up in the Stevenson System because of the Stevenson Center for Integrative Medicine. I wish we tracked that. Do you know how many people said, "I've changed my insurance to be your patient, I've changed my insurance to come and see you"? I wish we had data for every referral this Center gave to a specialist across the parking lot. (Moretti, Interview 1)

The clinician's explanation speaks to the lack of consistency in gathering data for record keeping. While the clinician believes there are clear cases that prove the Center is a big draw for patients to the System, there are no hard data to back it up, as the System has no consistent means for keeping record of patients' motivations to visit. Further, because the System lacks a means for accurate documentation, the Center continues to be discredited, ignored as a legitimate asset for treating and bringing new patients into the System.

In fact, being "ignored" is one of the biggest obstacles to consistent documentation overall. One clinician explains:

> We used to have a marketing department that was dedicated specifically to us. I don't know exactly if we still have one or if it's just become more centralized or whatnot. It used to be that the person in marketing used to come to our division meetings and kind of assess our needs and figure out how we can disseminate information to the people. Because there are still plenty of physicians within the Stevenson System—even ones that have been here for more than a decade—who still don't quite know that we exist or what we do, these kinds of things. So there's still a lot of ignorance that exists even within Stevenson. (Rose, Interview 3)

This clinician's description exposes how the System creates an environment of ignorance and confusion—by lacking consistent documentation—to "keep people in the dark." The clinician, who has worked at the Center for years, is still unsure

about the processes for patient documentation and disseminating information. Amid all the confusion one thing is clear: Purposefully or not, the System maintains distance from the Center and patients, and ineffective documentation sustains that distance and lack of accountability. According to another clinician, the System seems to have no problem keeping track of its own records, however, particularly when financial matters are concerned. The clinician explains:

> We have to do all these things so that's all being tracked very closely because Stevenson gets bonuses if we are meeting certain benchmarks. And so they are really strict about enforcing that. … The administration shows a lot of financials that just don't make sense, and it just—it was just very tough. Our meetings with them were really more defensive where we're just trying to justify our existence. (Ghanem, Interview 2)

Interestingly, this account displays how documentation does not seem to be an issue for the System when keeping records that benefit the System financially. The Center's challenge to be consistent in documentation is evident in the feedback it receives from the System as well.

Feedback issues

Furthermore, clinicians at the Center receive no consistent, continuous, or substantial feedback from patients or the System. They have no way of ascertaining long-term treatment effectiveness or patient satisfaction. Ideally, the clinicians would like to obtain information on patient satisfaction, the effectiveness of treatment, and "overall, how the Center is doing." Feedback on how to improve is essential to the Center's success, especially given the clinicians' future goals in IM. Due to the lack of instruments to measure patient satisfaction and the lack of consistent feedback from the System, the clinicians specifically, and the Center generally, are restricted in their efforts to move forward in reaching their goals.

The clinicians would ideally employ questionnaires that they design with each and every patient who receives care at the Center, to include patient satisfaction, use of services, and demographic information. At present, a standard survey is sent out by the System without any adaptation for the particular unit seeking specialized knowledge of how well it is providing care. Specifically tailored feedback on the care that each clinician is providing would enhance clinicians' communicative competencies and the expertise they could offer to clinicians outside the Center. Unfortunately, due to the lack of consistency in receiving such feedback, the clinicians are restricted in their efforts to achieve these ideals. A clinician explains the inadequacy of the present feedback System in place:

> We have been so limited in receiving any feedback from those questionnaires. They were used once before to try and help bring up the level of morale to say, "Well look, most of our docs are getting accolades from their patients," and just little snippets here. … However, it is not something that has been standardized in any way. There's been one time in the seven years that I've worked here that I have specifically received any [supervisor] feedback, and it's because I requested it. Otherwise, there's been nothing. (Rose, Interview 5)

A System that prides itself on practices that are "cutting-edge" and "innovative" seemingly fails to achieve basic, consistent communication within the Center and the System at large. Offering feedback to a clinician once in 7 years—only after the clinician requested it—hardly seems the mark of a leading System, and it holds back the Center as well. The feedback issue is a challenge for all medical providers, but it is especially essential for the IM Center for developing consistent and continuous collaboration internally and externally with other biomedical providers. In many ways, the challenges to consistency set the stage for the challenges to unification.

Challenges to unification

The fourth challenge that the Center faces is being the sum of many moving parts, which results, in limitations in unifying their efforts. Unification is established by creating internal agreement and focus, an overarching congruity and consonance among clinicians and patients; it is created by perpetual rules and norms and the achievement of desired outcomes (Berry, 2007; Irving & Dickson, 2004). Without it, "disconnectedness" arises, as well as a general "sense of confusion" for individuals in the Center. The clinicians envision unification in the Center as a feeling of connection between clinicians and patients, a natural flow of space, and a continuous momentum in moving forward with IM. However, many clinicians noted challenges in receiving feedback and felt that unification was restricted by minimal dialogue with referring physicians. While the clinicians at the Center value the space dedicated to IM, the geographic positioning of the Center as separate from the System as a whole creates provider–provider communication constraints.

One clinician explains:

> I remember years ago when we were being accused of taking people's patients. I said to the docs, "Make sure you dictate everything you do. Send the notes back to the referring physician. Thank them for their consultation. Dictate the exact acupuncture treatment so that when people were looking on the medical record, they see, 'Oh, this patient was treated with acupuncture. He got better. Hey, maybe I should tell somebody else about acupuncture.'" You know, let the communication be open. I think that that is really important. (Moretti, Interview 2, p. 17)

Dr. Moretti's account sheds light on the current challenges to unification for the Center within the Stevenson System. Physicians at the Center express concern over accusations for taking other doctors' patients, and the lack of unification in communication—through doctor's notes, electronic medical records (EMR), dictations—prevents open, coherent communication from occurring.

Clinicians within the System, outside of the Center, often fail to communicate vital information to the clinicians within the Center, offering little to no information in the process of referral—a practice that hurts both the clinicians and the patients. While the electronic medical record is a device that seemingly can bridge the communication gap, there consistently is a lack of unification in this form of communication. One provider describes it this way:

> I would say that there are two camps. There are the people who are more flexible and who are able to tolerate the tediousness of this new electronic medical record and are consistent with it. And then there are the people who absolutely will not touch it, and will continue to stay with the phone dictations and not order anything through the electronic medical record. And then there is probably a third camp where it's intermittently documented. (Rose, Interview 3)

It is clear from the clinician's account that there is no continuous form of communication that bridges the provider–provider communication gap in the System. And as one of the providers suggested, there are such constraints on time that it is impossible to take the time needed to construct this unification. The lack of unification in such a crucial aspect of communication prevents the Center from functioning properly. Without full knowledge of patients' medical records and needs, the Center clinicians cannot properly access the materials they need or serve patients. In addition to the constraints upon communication, structural limitations hamper unification.

The results of this research demonstrate that clinicians perceive their challenges to communication as collaboration, legitimacy, consistency, and unification, which are integral to the clinicians' philosophy of health and care and what they envision as the ideal for providing care to their patients. Analysis of the data and presentation of these results offer some understanding of how these communication challenges have evolved. In the final section of this article, we offer a discussion of the conclusions, theoretical implications, practical implications, limitations, and directions for future research that can be derived from these findings.

Discussion

This research stemmed from our interest in organizational communication in the integrative health care setting. In this study, the findings reveal that the clinicians of SIMC report communicative challenges in collaboration, legitimacy, consistency, and unification. Although the clinicians largely envision a medical practice that utilizes collaboration in their communication and care for patients, it remains a challenge they have not yet overcome, particularly in regard to economic and cooperative issues. We next offer conclusions that we have drawn from these results as well as theoretical and practical implications. We close with limitations and directions for future research.

Conclusions

Revealed within the experiences of the clinicians at Stevenson is a passion for IM, which drives their efforts to work through the challenges that constrain their provision of health care. One very important conclusion can be drawn from this research: All four challenges emanate, in part, from a lack of support from upper level hospital administration. This research shows that the voices of all clinicians describe a persistent difficulty in gaining support from upper level administration. When the Center was founded more than 15 years ago, the president of the health care system was in support of its creation. That support, even then, was limited in funding the Center; however, it did provide the momentum for the founders to seek private donors needed to set its wheels in motion. The interview data reveal that clinicians seek collaboration with administration in the decisions they make for the provision of care, but face resistance in terms of questioning the time they spend with patients and the preventative care they provide, which does not fit well with the disease model under which the System operates.

Additionally, differences in the priorities for administrators and clinicians result in the administrators prioritizing disease treatment and making financial gain, while clinicians prioritize treating the whole person and preventing health concerns. This tension constrains the support that others offer the Center, particularly by the administration; the Center's legitimacy is challenged, and the unification and consistency in referring and treating the patient are interrupted.

Rather than collaborating as a team, IM clinicians, administrators, and clinicians from other parts of the System become divided over philosophies and the bottom line, which significantly stunts productivity across silos. Inherent in this phenomenon is in-group and out-group division. Group members are divided over goal-oriented outlooks, thus causing all members to question what group reigns supreme and which groups are considered to have value.

A second significant conclusion that can be drawn from this research is that the challenges to collaboration emerge because the IM clinic is looking to alter not just the philosophy of biomedicine, but also the practices that are embedded within it: that is, the business tactics of biomedicine, the referral processes, the silo style of communication, and the short length of patient visits. Our interviewees reveal that disrupting philosophy and practice are both necessary for IM to work (Ho & Bylund, 2008). More importantly, this research illustrates that the collaborative efforts integral to IM are not just between providers and patients, but also among providers. The real issue at hand is that the IM clinic in this study is trying to institute a different form of medicine, which requires a different form of communication on various fronts: (a) Legitimacy is about competing philosophies of medicine/science/health; (b) collaboration and consistency both seem to be about the systemic operations and how the practice of biomedicine doesn't fit well with the ideology of IM, let alone contribute to collaboration; and (c) unification is a basic challenge of engaging in everyday communication tasks to create collaboration and finding ways to address the external/individual resistance to these tasks (which in practice have nothing to do with biomedicine or competition within philosophies). Instead, there is a kind of institutional indolence occurring that is worth further exploration. Following from these conclusions are theoretical and practical implications of this research.

Theoretical and practical implications

Research on collaboration suggests that teamwork and interdisciplinary approaches are the best methods to facilitate

communication in the provision of health care (Van Liew, 2012). Our results reveal that while clinicians desire teamwork and a collaborative approach to health care, this is rarely the approach that is put into practice. Rather, communication, and thus collaboration are stunted by the four challenges (e.g., challenges to credibility, legitimacy, and unification). Previous research reveals that the practice of collaboration is not working well in medical settings and that many challenges exist in the efforts to facilitate integration (Coulter et al., 2008; Kaptchuk & Miller, 2005; Mizrachi, Shuval, & Gross, 2005; Wiese, Oster, & Pincombe, 2010). Our results build upon these findings, and more research is needed to understand what steps can be taken to facilitate collaboration between hospital administrators and clinicians because of their greatly divergent priorities. As one provider indicated, if financial goals and healing goals coincide, then performance medicine is paid for. Future research can support both conventional and IM efforts, and can work toward creating a communication method that bridges all stakeholder goals.

One theoretical implication of these results is to consider the tension between administrator support and clinician interpretation in more depth. One way this can be explored is through the study of dialectic tensions. For example, the results reveal that inherent in the dialectic tensions of integration is a tension that Baxter and Simon (1993) describe as equality and inequality. One goal of the clinicians is mentioned in examples by Ghanem when he says, "We got a target on our backs; [the view is] that IM hasn't been producing tons on money and stuff," and by Rose when she says, "[The System's] way is the only right way." This goal displays how the clinicians desire to be on the same playing field as the administrators, to be seen as equals in their medical and professional decision making, in hopes of achieving collaboration. Administrator emphasis on financial issues relegates the IM clinicians to a different playing field, one where they must engage in a continuous process of communicating to justify the care provided and the cost expenditures for that care. Simultaneously, another dialectic tension of stability and change occurs as administrators and biomedical clinicians prefer the consistency of a disease model, while IM providers continuously adapt to patients based on a personalized holistic care model. Clinicians expressed frustration over differing philosophies used by the System and the IM providers. Because they have similar goals (i.e., treating a patient), they need to find a strategy to have both parties meet in the center for their shared goal. Their differing approaches to health care lead in part to the communication challenges we have identified, as well as preventing the Center and the System from seeing eye-to-eye in treating patients. As one provider suggested, it would be ideal if billing and health outcomes went hand-in-hand, not just billing and coding of care provided.

Understanding the dialectic tensions illuminates possibilities for practical applications in IM centers. Continuity and increased quality of communication between administrators and clinicians would ease the tension of equality and inequality and would elucidate potential changes that collaboration could offer while maintaining financial stability and viability of change. Monthly discussions that invite both administrators and clinicians to share their outlooks on the current arrangement of the System and the Center could produce suggested changes in the functioning and future growth of the Center. If education in the business of health focused more on health outcomes than on disease treatment or patient fees, at least some of these dialectic tensions would be resolved. Most importantly, a critical symbolic shift must occur where a space is opened for dialogue among all providers and administrators within the System that focuses on the relevance and value of integrative medicine for patient care (Willard, 2005). The Center has made progress on this front with acupuncture, which is now a moneymaking modality. The plan is to work with one modality at a time, and to methodologically move it from the red to the black and have it become a lasting modality utilized in the center.

Limitations and directions for future research

In the process of conducting this research, we have learned a great deal that has helped us to understand what we do not yet know about communication within the IM space. We have gained great insight from IM clinicians about their philosophies and medical practices. At the same time, we have learned about the challenges these clinicians face as they navigate their interactions with other clinicians and administrators in the System. What we do not know—knowledge that is critical to understanding the workings of collaboration within the System—is the perceptions that others within the System (such as providers with other specialties and patients) have about collaboration with the Center. We learned from our interviews that there are clinicians who support the Center's mission by referring their patients, and there are clinicians who are naysayers, unsupportive by not referring their patients, even communicating disparagingly about the Center. Without the input from these naysayers, we cannot know definitively what forms of communication are being attended to or ignored.[1] Future research needs to explore the wide range of perceptions of clinicians and administrators outside of the Center to discover the complexity and specificity of their perceptions. Even more, by facilitating opportunities for others to gain exposure to the Center and its mission, these others too may envision a place for themselves and their work as aligned with that mission.

One other avenue for future research that emanates from our conclusions is the exploration of the integrative medical center as a discursive field (Mizrachi et al., 2005) where the boundary work between biomedicine and integrative medicine occurs. What is unspoken, but worth examining, is the valued forms of communication across and between the symbolic and real boundaries between biomedicine and integrative medicine. Instead of an oppositional model or even an integration model, the ideology could be a pluralistic model that "recognizes unbridgeable epistemological differences in

[1]We attempted to include such outsiders in the interview sample, but despite many efforts, we could not enlist them to participate.

the methods of developing medical knowledge and validating treatments, but acknowledges that both mainstream medicine and CAM can offer clinically valuable treatment options for patients in the light of informed choices based on their preferences and values" (Kaptchuk & Miller, 2005, p. 288). Investigating the notion of an unspoken communicative ideology that is being enacted but not openly discussed may offer a more complete understanding of what is foundational to the challenges described in our findings.

Closing

The findings of this study offer insight about communication and collaboration in one IM center. The four fundamental challenges to clinician communication (collaboration, legitimacy, consistency, and unification) demonstrate the need for change to occur. The stigma surrounding IM must be changed, through interaction, education, and outcomes-based research (Cohen, Hrbek, Davis, Schachter, & Eisenberg, 2005), in order for a healthy and effective collaborative environment to exist. The tension between IM and biomedicine philosophies is one that has the potential for change, but needs more research to evaluate where and how change from the inside out can happen. These changes are substantial, but if achieved, they have the potential to dramatically increase effective collaboration and communication between IM and biomedical clinicians—and therefore, the health and wellness of the patients who visit them, which, ultimately, is the goal of all working within the System.

In the end, what is needed are grassroots efforts to focus on patient satisfaction with health outcomes, the satisfaction of physicians/clinicians, and a reimbursement system that is connected to the value of health care, not just disease care. As it stands, the unresponsiveness of the System's clinicians and administrators reifies these challenges. What is needed to enhance legitimacy is a focus on patient satisfaction, not just in terms of what occurs in patients' interactions with providers during appointments, but patients' satisfaction with their health outcomes and their sense of power in improving their quality of life.

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Appendix: interview with clinicians at simc

Thank you so much for meeting with us. Would you mind if we recorded so that we can focus on the conversation, rather than taking prolific notes?

We know that you are aware that our research is focusing on the ways that providers in Centers of Integrative Medicine communicate with one another to accomplish collaboration, coordination, and integration.

Along with our colleague Dr. Barbara Sharf, we have engaged in informational interviews at other Centers of Integrative Medicine. Over the past 8 months, we have conducted many interviews with the Stevenson staff, and learned a lot about the background of its establishment. Today, we would like to learn more about the path that led you here, and your experiences and perspectives as one of the Center's initial physicians. So we would like to begin by asking:

(1) Tell us how you became involved in integrative medicine, focusing on some events that were instrumental in leading you down this path.
(2) Can you tell us more about you see your specialty fitting with the center?
(3) What do you see as the vision for the Center?
(4) What do you see as some of the most important goals for accomplishing that vision?
(5) Can you tell me a story of an event or incident that best represents the effective coordination of services at the Center or effective collaboration among the providers at the Center?
(6) Can you tell me a story of an event or incident that best represents something that complicates or impedes collaboration or coordination among providers?
(7) What would you describe as the single most important factor that has facilitated the existence and growth of the Center within the larger Stevenson System? What factor has restricted the existence or growth?
(8) If you were to offer one piece of advice to the incoming Director, what would it be?

Is there anything we have not asked about, that you believe is important for us to know?

As we move forward in our research, what advice would you offer us in terms of who we should interview and what we should observe or investigate to understand communication, collaboration, and coordinating integrative medicine at the Center?

We would like to set up second round interviews with all the Center's physicians in the new year; is email the best way to coordinate with you?

Thank you so much for your time.