Dr Jennifer Hunter **explains the considerations to make when planning to run a clinic with complementary medicine services.**

# Establishing an integrative practice

Jennifer Hunter, BMed, MScPH, is a practising integrative GP

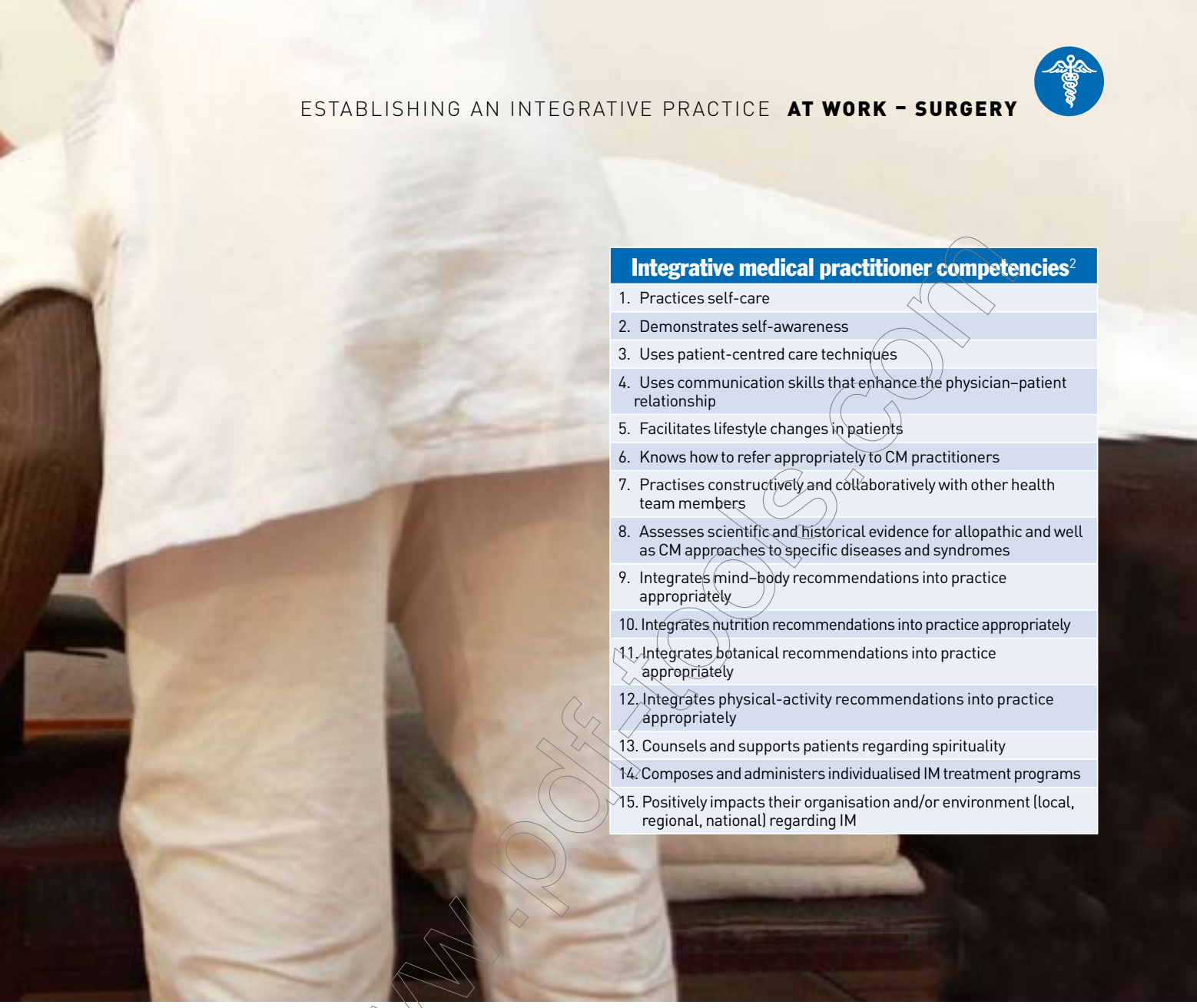
The Editor thanks Joachim Fluhrer, MBBS, ND, FACNEM, and Penny Caldicott, BMed, FRACGP, both integrative GPs, for their kind assistance in the peer review of this article

Although complementary medicine (CM) enjoys increasing popularity and demand from the Australian public, there are still relatively few integrative medicine (IM) clinics in operation.[3,4] Patients who use CM express the desire for their doctors to know about it and to recommend and integrate CM with their clinical management.[5] This paper aims to present the main factors for consideration when establishing an IM clinic.

The increasing use of the term 'integrative' as opposed to CM implies increasing acceptance by mainstream medicine of TCAM, along with the desire to create dialogue and even combine the two therapeutic approaches.[5] Bell argues that 'combination medicine' is not necessarily integrative. Rather, IM is patient-centred, focusing on wellness and healing of the whole person (bio-psycho-socio-spiritual dimensions).[6] The patient-centred model appears most likely to support truly IM for the benefit of patients rather than therapists or industry [see 'The patient-centred model of care' diagram, p 24].[7–10]

## The integrative practice

The IM debate is further extended by what constitutes an IM clinic. Two types of IM clinic locations are reported in the literature: clinics operating in the hospital setting and those in primary care. Health-service models include clinics that simply house healthcare practitioners from both camps, through to clinics that truly integrate patient care.[11–13] Boon et al extends this to propose a continuum of seven team-oriented healthcare practices: parallel, consultative, collaborative, coordinated, multidisciplinary, interdisciplinary and integrative.[14]



## Integrative medical practitioner competencies[2]

1. Practices self-care
2. Demonstrates self-awareness
3. Uses patient-centred care techniques
4. Uses communication skills that enhance the physician–patient relationship
5. Facilitates lifestyle changes in patients
6. Knows how to refer appropriately to CM practitioners
7. Practises constructively and collaboratively with other health team members
8. Assesses scientific and historical evidence for allopathic and well as CM approaches to specific diseases and syndromes
9. Integrates mind–body recommendations into practice appropriately
10. Integrates nutrition recommendations into practice appropriately
11. Integrates botanical recommendations into practice appropriately
12. Integrates physical-activity recommendations into practice appropriately
13. Counsels and supports patients regarding spirituality
14. Composes and administers individualised IM treatment programs
15. Positively impacts their organisation and/or environment (local, regional, national) regarding IM

The challenge of providing IM in the primary healthcare setting is highlighted in a series of interviews with GPs and naturopaths working in shared premises in NSW [see also *JCM* 2008;7(5):10]. Patients received a combination of CM and conventional medical treatment. GPs tended to dominate the diagnostic process and operate as the primary healthcare provider. However, where the GP had undertaken CM training, there was more integration of CM diagnosis into the overall management process. In these cases, the CM practitioner was also operating as a primary healthcare provider.[3]

Other research confirms the significant impact that medical practitioners' attitudes and knowledge of CM have on the style of IM practised.[15] There is still a tendency for orthodox medicine to dominate. This is often achieved by controlling patient care and using biomedical language as the main form of communication.[16] The proposed 'new therapeutic triangle' of doctor, CM practitioner and patient[17] [see p 26]; and the pressure to only include evidence-based CM[18] further demonstrates the tendency to subsume CM 'into' orthodox medicine rather than integrate the two as equal partners.

## Success factors for IM clinics[1]

- Open-mindedness of administrators and an open-minded culture within the institution /clinic
- Credible 'champions' to conceive, advocate and manifest the IM clinic
- High competency of CM and mainstream healthcare practitioners
- Finding the right fit of practitioners and staff
- Effective communication and trust between practitioners
- Appropriate physical space to house the clinic
- Economically sustainable environment
- Ability to match the unique needs of the community and market

Although there are only a handful of evaluations of IM clinics reported in the literature, the success factors found for an IM clinic are reasonably consistent [see 'Success factors for IM clinics' table].[1] How the clinic operates and the style of IM it practises will reflect its philosophy and values, structure, process and outcomes goals.[19] Answering these questions, along with developing a mission statement, is perhaps the first and most important step towards setting up an IM clinic or expanding a pre-existing practice.

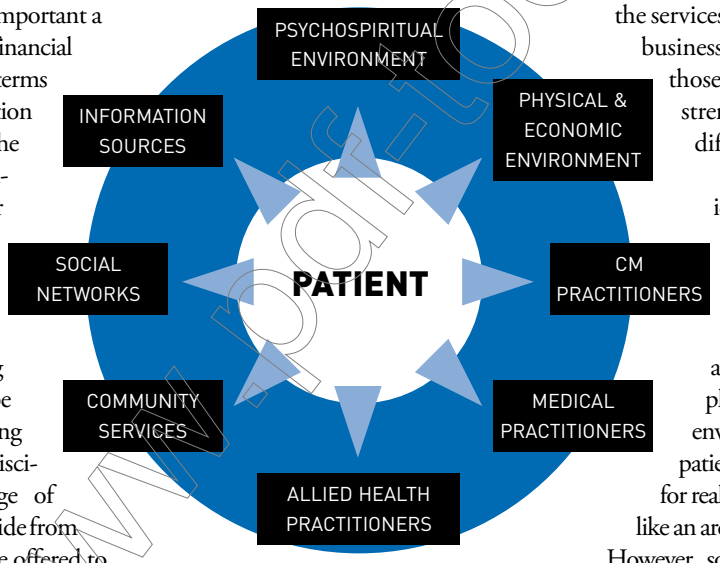
## The integrative team

Finding the right administration staff and health practitioners is key to the success of the clinic. Although not essential, it helps if the administration staffs are familiar with both orthodox and CM. A sound business plan will help determine how many and what type of personnel are needed, how important a pre-existing client base is to the financial viability of the clinic and the terms of agreement for remuneration of services and dispensing. The combination of different practitioners is limitless. Consider combing a range of orthodox medical and allied health practitioners with a variety of CM practitioners.

The practitioners' training and competency will need to be assessed. Variations in training and accreditation between disciplines adds to the challenge of building a reputable team.[20] Aside from affecting the quality of the care offered to patients, the calibre of the team members will also influence their ability to integrate. Team building, effective communication, systems for cross-referrals and generating trust between practitioners continually feature in the literature as important characteristics of a successful IM team.[1,11,17] This is a challenge for both orthodox and CM practitioners who generally receive neither education nor training about how to achieve such objectives and integrate their different languages, constructs and models of health.[2,10,21–24] In the private setting, where practitioners' incomes are based on a fee for service, there may be further constraints on time and finances, which can negatively impact on team-building exercises and other formal strategies to enhance communication and case conferencing.

IM teams with medical practitioners who have experience and training in CM enhance the capacity of the team to practise true IM.[3] However, finding these medical practitioners can prove to be a significant challenge [see 'Integrative medical practitioner competencies' table].[2] A similar set of competencies could be used for assessing appropriate CM and allied-health practitioners.

**The patient-centred model of care**




▲ This model focuses on the patient and their access to resources to help reach self-defined goals for health and well-being

## Planning

Healthcare practitioners receive little, if any, training in how to run a successful and efficient clinical practice. A survey of 578 Australian GPs found dermatology, CM, psychiatry, and business and practice management as the highest-ranking unmet learning needs.[25] Many of the practical and logistical challenges are the same for setting up any clinic, be it integrative or not. Unfortunately, there is no tried and tested business model or 'one size fits all' IM clinic. The advice therefore is to employ the services of an appropriately qualified business consultant and to consult those with expertise to identify the strengths and weaknesses of their different approaches.

A business plan is a document identifying the objectives and strategies for meeting the clinic's objectives. It should clearly outline all the key facts, such as the mission statement, activities of the clinic, financial plan, branding and marketing, environment and competition, patients/clients and the resources for realising the plan.[26] This may seem like an arduous and unnecessary process. However, sound business planning is the key to creating a clinic that serves both the patients who use the clinic and the staff and practitioners who work there.

When deciding on a location for the clinic, local information is required to estimate unmet needs and potential demand. Information about local demographics (such as sex, age, socioeconomics, multiculturalism) and epidemiology can be obtained from the Australian Bureau of Statistics and Public Health Units.[27] Market research must also include information about pre-existing primary and secondary health services, ancillary health and CM practitioners and practices, pharmacies and health-food stores. This will also help inform other decisions such as whether to include a supplements and herbal dispensary.

The physical aspects of the building should complement the style and philosophy of the clinic and be able to accommodate the different types of practitioners. A space for meetings and seminars

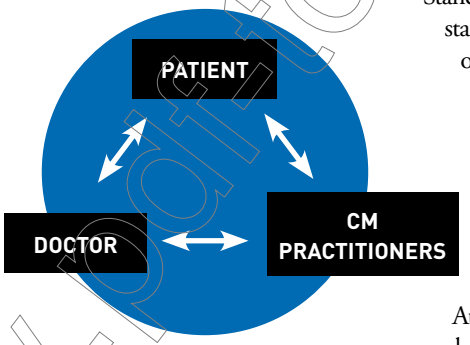
will help foster the growth of the IM team and community outreach; this could be a dedicated space such as a staff room, or a clever after-hour's conversion of the waiting room.

## Dispensary

Although it is commonplace for CM practitioners to dispense and make profit from natural therapies, the question of whether doctors should dispense medications, be they natural or pharmaceutical, is open for debate [see *JCM* 2005;5(4):37–41]. Dispensing of pharmaceuticals by doctors is legal but uncommon. Many argue that it is not good clinical practice due to the potential conflict of interest. The AMA position is that 'Doctors should not dispense pharmaceuticals, etc. for material gain unless there is no reasonable alternative'.[28] This year, the AMA further clarified its definition of medicine to include OTC and CMs.[29]

One advantage of dispensing CMs on site is that the practitioner is able to prevent brand substitution and monitor compliance. Brand substitution will become a bigger issue as practitioners begin to prescribe more natural therapies with product specific evidence. Even if the local health-food store or pharmacy stocks this product, there is no guarantee that the prescribed product will not be substituted. Even if a prescription is written (with or without repeats), there is no statutory requirement for the dispensing shop to comply.

**The new therapeutic triangle**[17]




▲ Generally the doctor maintains the role as gatekeeper to other health services

## Administration

Streamlined systems for appointments and billings; telephones, emails and other messaging; follow-ups and recalls; and stocking and cleaning the rooms and dispensary will ensure the smooth day-to-day running of the clinic. The innovative use of technology can improve efficiency.[30]

Record keeping is an important part of high-quality clinical practice and an essential medicolegal requirement. Practice management and clinical software programs available in Australia are not designed to accommodate IM. Englin reviews the criteria for practice management software for use in mainstream general practice.[31] This software would still require modification and is not ideal (e.g. the need to manually enter a large number of CM therapies into the recipe section of the drug database).

Whether a computerised or paper-based system is chosen, careful consideration is required to determine who, what and how clinical information is recorded. Some IM clinics in Australia share all patient records, as would be done in the hospital or general-practice setting. Others keep medical, psychology and/or CM records separately. The clinic and practitioners should check with their medicolegal insurers before making a decision. Whatever the decision, the policy on information sharing and cross-referrals between the practitioners must be clear and consistent. Patients must be informed and give consent.

## Accreditation

There is no recognised process for credentialling IM clinics here in Australia or internationally.[32] Given the small numbers and heterogeneity of IM clinics, it is not surprising that an agreed standard has not been established.

If the IM clinic is in the primary-care setting and GPs are part of the team, then the practice should at least consider formal accreditation through either AGPAL or GPA ACCREDITATION plus. The 'RACGP Standards for General Practices' set the standards for this process. This document outlines the requirements for practice services; rights and needs of patients; safety, quality improvement and education; practice management and physical requirements.[33]

## Education and research

Given the paucity of IM training in Australia, all IM clinics are an important educational and capacity-building resource for undergraduate students, healthcare practitioners and the public. In response to competency[15] [see 'Integrative medical practitioner competencies' table][2], actively participating in education and research will support both the clinic and its community.

## Over-servicing

When conceptualising your ideal IM clinic, it is easy to be carried away with grand ideas of comprehensively evaluating the patient and providing a complete integrative healthcare plan. The reality, however, may be a complicated model which is time-consuming and expensive. It may confuse the patient due to information overload and conflicting advice from different practitioners. This is not to say that patients are unable to recall and follow a complex integrated treatment plan[13], rather there is a risk of patients failing to find value in the program. Using the patient-centred model of care can help guide the provision of healthcare appropriate to the patient's self-defined needs rather than the practitioner and clinic's agenda [see 'The new therapeutic triangle' figure, above].

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IM clinics are still in the minority. As more clinics establish themselves, there is urgent need and scope to evaluate them for the benefit of patients and practitioners and for health-services planning.

Given the newness of this type of healthcare provision, perhaps the most important aspect of establishing an IM clinic is for all members of the team to share a vision. Coupled with strong leadership and a united team, it will sustain the momentum through the challenges of planning, setting up, staffing, operating and building a strong client base. The potential rewards for patients, practitioners and the community are well worth the effort. ◗

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NEWS
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# Eat alkaline for longevity

Today's Western diet is high in acid-producing foods inappropriate for optimal acid–base status and may be resulting in ageing effects, such as bone and muscle breakdown, a visiting US renal specialist told practitioners and researchers recently.

At the Blackmores Research Symposium in Sydney in October, Assoc Prof Lynda Frassetto, of the University of California's Division of Nephrology, explained some of her investigations into the long-term effects of dietary acid-base balance on human physiology.

In healthy people, body pH is maintained at 7.35–7.45, a slightly alkaline state. As dietary acid load increased, blood and urine pH decreased and more acid is retained in the body at steady state. However, as we age, the kidneys struggle to eliminate the acid and more is retained. Base, measured as bicarbonate in plasma, tended to be excreted as we age. High salt intake also resulted in a more acidic balance, added Prof Frassetto.

This resulted in a chronic, low-grade metabolic acidosis, which made the kidneys create and excrete more ammonia, increased the risk of kidney stones, lowered bone mineral density and catabolised protein from muscle. This could lead to renal hypertrophy, hyperplasia and dysfunction, Prof Frassetto warned.

Other metabolic effects were suppressed human growth hormone secretion, decreased insulin-like growth factor and thyroid hormone in plasma, increased glucocorticoid production and suppressed activation of vitamin D.

Prof Frassetto said that our adoption of an agricultural-based diet ~10,000 years ago meant crossing from systemic net base production to net acid production, contributing to the many chronic age-related 'lifestyle' diseases we now see.

However, Prof Frassetto showed that this imbalance could be corrected by replacing grain-based foods and beans with more fruit, vegetables and nuts without reducing intake of meat or dairy products.

If alkali supplementation were to be used, Prof Frassetto recommended potassium-based bicarbonate or citrate over sodium, i.e 1–2mmol/kg/day in divided doses. ■