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EDITORIAL

Integrative practice

In May 2004 the *International Symposium on the Science of Touch* (ISST) in Montreal, Canada, focused on themes of integration and research. In a closed panel format, in which various experts were offered the chance to present their experience and vision of integration, several presentations were particularly memorable.

Phuc Felix Nguyen-Tan an expert in radio-oncology (particularly involving the throat and neck) in Montreal, described his experience of creating, from the personnel at his disposal in a regular, critical care, medical setting, an integrated team, in which complementary therapeutic approaches, including massage, are offered to the distressed and seriously unwell patients. Results in terms of reduced medication usage, improved function (for example in swallowing), and length of hospital stay, are remarkable, and suggest that were such teams widely available in such settings patient well-being would improve dramatically, along with cost reductions of major proportions. Readers may recall the article by Dudley et al. (2003) suggesting that a single post-operative massage reduced both medication and hospital stay in women following hysterectomy.)

David Eisenberg MD, of the Osher Institute, Harvard Medical School, described the integrated care team that he had supervised the creation of, utilising funds provided by a US Government agency (NCCAM—National Council for Complementary & Alternative Medicine). The integrated care team comprises medical personnel (internist, rheumatologist, neurologist and orthopaedic surgeon), as well as a nurse practitioner, occupational therapist, physiotherapist, chiropractor, massage therapist, acupuncturist, mental health expert, exercise physiologist, pharmacist and nutritionist. Over a period of eight months, one day per week has been devoted to team building incorporating didactic presentations by all members of the team; treatment of all other members by each discipline; and a gradual arrival at a point where there is a complete trust and understanding of what each member of the team has to offer. Patients with low back pain problems have also been seen by the team, and a pilot study (focusing on this problem only at this stage) is shortly to be underway. This will be followed by a multicentre trials. Back pain has been selected as Dr. Eisenberg (a major researcher into complementary health care in the USA—see Eisenberg, 1998) because research (Luo, 2004) has identified its overall cost to the US economy to be almost 1 percent of the GDP of the Unites States, approximately $190 billion annually, both in direct medical costs (about $90 billion) and in lost productivity, social security costs etc.

If this 'team' approach can be shown to have the potential to reduce costs, and offer good outcomes, the hope is that agencies and insurance companies would see the logic of funding such teams nationwide, potentially with a focus toward other health conditions than back pain. Migraine, for example, costs $14 billion annually in the USA, of which only $1 billion is in direct medical costs with the rest in lost production and employer's expenses (Hu, 1999).

The model described by the editor of JBMT as his contribution to the Montreal panel discussion, covered both the experience of the School of Integrated Health (University of Westminster), and the Marylebone Health Centre, London, which has a dedicated CP (complementary practioner) team comprising osteopaths, acupuncturist, naturopath, homeopath, massage therapist and counsellors, working with the GPs, in that practice.

The nearly 20 years of team building in the 'Marylebone experiment' has been described by Peters et al. (2002).

This integration model represents the antithesis of 'bolt-on' approaches, where there is little actual interaction between mainstream and complementary practitioners, merely a 'sort of' collaboration. A truly integrative approach involves multi-professional interaction, patient-informed choice and a commitment to developing reflective practice. It requires an ethos in which CAM and mainstream learn about, and question, each other's perspectives and methods, and where issues of authority

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are addressed non-confrontationally. In current settings the GP needs to remain the gate-keeper for obvious legal reasons, however the objective should be a change of the way medicine is practiced, through collaboration and enhanced health care, involving modification of clinical thinking and management approaches, by both GPs and CPs.

From the perspective of GPs, questions requiring answers might include:

- Are previously unmet needs likely to be met through integration of CPs into a practice?
- Which CT methods/individuals are most relevant to patient needs?

Over time this might require audit of different disciplines relative to different patient groups and conditions

Reflective practice of CPs requires the development of systems for data collection and consistent methods for reporting outcomes.

Certainly there needs to be an ability to think contextually by all parties to collaborative integration, as well as a putting aside of egos, and a willingness and try to understand the semantics, jargon, beliefs and objectives of models of care that are foreign to current ways of understanding the body.

It is necessary to accept that many mainstream and CAM practitioners are probably incapable of working together, either because they are unwilling to consider doing so, or lack the necessary collaborative tools or perspectives.

There was much more at ISST, however hopefully this brief outline of one aspect offers a sense of the excitement and expectation that emerged. The organizers, particularly Real Gaboriault Ph.D., deserve thanks for their foresight and effort in creating the opportunity.

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