A preliminary investigation into the attitudes and practices of New Zealand osteopaths in relation to the health care system: does the future hold a greater degree of integration into the biomedical system?

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A research project submitted in partial requirement for the degree of Master of Osteopathy, UNITEC Institute of Technology 2011.
Declaration

Name of candidate: Lily Rose

This Thesis/Dissertation/Research Project entitled

‘A preliminary investigation into the attitudes and practices of New Zealand osteopaths in relation to the health care system: does the future hold a greater degree of integration into the biomedical system?’ is submitted in partial fulfilment for the requirements for the Unitec degree of Master of osteopathy

Candidate’s declaration

I confirm that:

- This Thesis/Dissertation/Research Project represents my own work;
- Research for this work has been conducted in accordance with the Unitec Research Ethics Committee Policy and Procedures, and has fulfilled any requirements set for this project by the Unitec Research Ethics Committee.

Research Ethics Committee Approval Number: 2009. 1025

Candidate Signature: .................................................. Date: ......................

Student number: 1270929
Abstract

Background:

Complementary and alternative medicine (CAM) is said to be currently integrated in an ad hoc fashion in New Zealand, with patients choosing CAM as part of their health care and practitioners referring patients to each other. In New Zealand, the Ministerial Advisory Committee of Complementary and Alternative Health (MACCAH) recommended that if specific CAM modalities can contribute to New Zealand’s health strategies, are cost effective and have proof of efficacy, further integration should be encouraged. Osteopaths in New Zealand come under the umbrella of CAM. However, little is known of the practices, attitudes and opinions of New Zealand osteopaths in relation to the general health care system. This study investigates the phenomenon of further integration of osteopaths into the biomedical system.

Methods: A qualitative interpretive descriptive study was undertaken. Two focus groups of six purposively selected osteopaths provided the data. The inductive analysis approach identified core statements that described practitioners’ experiences, practices and opinions of the biomedical system.

Results: Three key themes were identified ‘Interactions in the biomedical system’, ‘Integrity: ‘being true to yourself” and ‘Integration’. For each theme three subthemes emerged respectively: ‘The role of osteopaths’, ‘Relationship with the other health care professionals’, ‘Promoting osteopathy’; ‘Defining osteopathy’, ‘Fitting into the biomedical system’ and ‘Securing a place in the biomedical system’; ‘Opinions on models of integration’; ‘Expanding the role of osteopathy’ and ‘Concluding thoughts’. The overarching theme, ‘towards integration’, reveals osteopaths opinions on prerequisites for further integration which emerged from the data.
Conclusions: Osteopathy has the potential to expand its role in the general health care system and contribute to New Zealand health strategies. However, osteopaths do not appear to be well integrated in the current ad hoc model of integration, which may also diminish their ability to practice in accordance with the osteopathic philosophy of holism. Not being well distinguished from other physical therapies and known in the general health care system is a major issue for osteopathy and seems to be an important factor for the lack of integration. Defining osteopathy, a strategic marketing plan and research into efficacy, safety and expansion of the role of osteopathy, are required to support further integration in the general health care system.

Keywords: Complementary and alternative medicines, integrative medicine, inter-professional collaboration, integrated health care, inter-professional relationship, primary health care.
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Glossary

‘Academic group’ pertains to this study only and refers to one of the focus groups which was composed of Unitec lecturers and tutors, who were also practising clinically at the time of the focus group sessions.

Accident Compensation Commission (ACC). ACC is New Zealand’s accident compensation scheme since 1974, with a ‘no fault’ policy for personal injury. It provides comprehensive, no-fault personal injury cover for all New Zealand residents and visitors to New Zealand.

Allied Health Professional Forum (AHPAF) The Allied Health Professional Associations’ Forum (AHPAF) is an informal grouping of professional associations which work together to promote and support allied health professionals. AHPAF is the recognised connected voice of allied health professionals, advancing their common interests. Currently 20 allied health professional associations are members of AHPAF.

An anti-colonial perspective a view from the standpoint of the marginalised. In integrative medicine, as discussed by Holland and Muzzin (2010), from a complementary and alternative medicine perspective, with biomedicine in ‘the ruling position’.

Best practice is an idea that asserts that there is a technique, method, process, activity, incentive or reward that is more effective delivering a particular outcome than any other technique, method, process, etc.
The idea is that with proper processes, checks, and testing, a desired outcome can be delivered with fewer problems and unforeseen complications.

**Biomedicine**

the employing of the principles of biology, biochemistry, physiology, and other basic sciences to solve problems in clinical medicine. Biomedicine predominantly provides health care in Western countries and is therefore deemed mainstream medicine in those countries.

**Complementary and Alternative Medicine (CAM)**

Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities, and practices, and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-identified by their users as preventing or treating illness or promoting health and well being.

**Centres of Integrative Medicine**

1. Clinics were medically trained physicians, who have one or more qualifications in CAM modalities provide services using one or more health care approaches; 2. Clinics were biomedical and CAM practitioners share premises, patients and other facilities; 3. Both 1 and 2 combined

‘Clinician only’

pertains to this study osteopaths from the pool of practitioners currently registered with the osteopathic Council of New Zealand and practising but not holding an academic role
Community services

(In this text) pertaining to New Zealand, part of primary health sector, services include district nursing, a number of specialist nursing services e.g. gerontology, incontinence; physiotherapy; occupational therapy, Needs Assessment Service Co-ordination (NASC).

Dual training

Biomedical practitioner trained in both the biomedical and one or more CAM modalities.

Doctors of osteopathy (DO)

In the United States of America osteopathy has long been a speciality of mainstream medicine with osteopaths undertaking the same education as medical doctors (MDs), but studying osteopathy as an elective module. After graduation doctors with this elective can choose to practise as DO or MD

GP integration index

A tool for measuring how well general practitioners are integrated into the general health care system; developed in Australia by Southern et.al 2002.

Health care system

1. services put in place by governments to provide health care needs; 2. a method of treatments.

The health maintenance organizations (HMO)

is a type of management care organisation that provides a form of health care coverage in the United States that is fulfilled through hospitals, doctors, and other providers with which the HMO has a contract. An HMO covers only care rendered by those doctors and other professionals who have agreed to treat patients in accordance with the HMO’s guidelines and restrictions in exchange for a steady stream of customers. Similar to PHO in New Zealand.
The Health Practitioners Competency Assurance

(HPCA) The Health Practitioners Competence Assurance Act 2003 (HPCAA) provides a framework for the regulation of health practitioners in order to protect the public where there is a risk of harm from the practice of the profession.

Holistic 1. Analysing whole system of beliefs, characterised by the view that a whole system of beliefs must be analysed, rather than simply its individual components. 2. Considering all factors when treating illness, taking into account all of somebody’s physical, mental, and social conditions in the treatment of illness.

Interdisciplinary teamwork A health care approach where patients are central to treatment planning and are discussed by the different modalities involved, e.g. doctors, nurses, physiotherapists etc.

MACCAH Ministerial Advisory Committee of Complementary and Alternative Medicine.

Mainstream medicine the predominant medical health care practised in a country, pertaining to biomedicine in Western countries.

Miri miri Maori for massage and may be part of the traditional Maori health care approach

United States National Center for Complementary and Alternative Medicine

(NCCAM), The National Center for Complementary and Alternative Medicine (NCCAM) is the USA Federal Government’s lead agency for scientific research on the
diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine.

Primary Health Organisation (PHO)

Primary health organisations (PHOs) are funded by district health boards to support the provision of essential primary health care services through general practices to those people who are enrolled with the PHO. The aim is to ensure GP services are better linked with other primary health services (such as allied health services) to ensure a seamless continuum of care, in particular to better manage long term conditions.

Primary care physicians (PCP)

the same as general practitioner (GP)

Primary Health Care Strategy 2001

Launched in 2001 by the Ministry of Health, the New Zealand Health Strategy sets out principles, goals and objectives for the health system and these have guided the development of the Primary Health Care Strategy. Six key directions for primary health care will achieve this vision: work with local communities and enrolled populations; identify and remove health inequalities; offer access to comprehensive services to improve, maintain and restore people’s health; co-ordinate care across service areas; develop the primary health care workforce; continuously improve quality using good information.

Primary health care sector

Primary care is the term for the health services by providers who act as the principal point of consultation for patients within a health care system.
<table>
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<th>Rongoa</th>
<th>Maori for herbal medicines and may be part of the traditional Maori health approach</th>
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<td>Sample size</td>
<td>Number of people participating in a research.</td>
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Chapter One-Introduction

Introduction

The issue of integration is an important one for both health professionals and the Ministry of Health (MoH). “MACCAH (Ministerial Advisory Committee of Complementary and Alternative Health) notes that currently integration occurs in New Zealand on an ad hoc bases and mainly in the primary sector” (MACCAH, 2004, p 41). In their recommendations to the Ministry of Health, the MACCAH further points out that New Zealand’s future health care system in an aging population and increase of chronic diseases, requires a multifaceted approach of treatment options, to meet the populations’ health needs. They therefore suggest further investigations into greater integration of suitable CAM modalities that can or have potential to contribute to New Zealand’s health care strategy, are cost effective and have evidence of efficacy.

Osteopathy is one of many CAM modalities in New Zealand. A five year double degree of bachelor of health science and masters of osteopathy provides practitioners with a good grounding in biomedical science and skills to be competent osteopaths. The lengthy educational process requires a strong personal and financial commitment and sacrifice. In the environment of the future outlined above, it is important for osteopaths as health care providers to express their position of their role in the general health care system and future developments of integration into the biomedical system. There is no current research on how osteopaths practice and what their experiences are working in the biomedical or general health care system, neither is it known what their opinions and attitudes might be about a future integration.

The research described in this dissertation is an interpretive descriptive study that explores the current experiences and practices of osteopaths which shape their attitudes and opinions in relation to the biomedical system. It provides a first time view of how osteopaths interact
with other health care professionals; difficulties they face working in a medical paradigm different to their own and what opinions osteopaths have concerning further integration into the biomedical system.

This chapter presents definitions of biomedicine and CAM, and includes a brief discussion on the complex issues surrounding these terms. An explanation of how the interest to study this topic evolved is followed by the rational for, and aims of the study. The chapter concludes with a summary and outline of other chapters that follow in this dissertation.

**Background**

The 1978 World Health Organisation (WHO, 2010a) conference at Alma Ata heralded the beginnings of fundamental changes to primary health care systems of participating countries including New Zealand’s. Health care, it was agreed, is a fundamental human right and is more than just the absence of disease, but constitutes physical, emotional and social well being. It was declared that while it is the duty and responsibility of individuals to participate in their health care, primary health care is the source for promotion, preventive, curative and rehabilitative health services. Governments were to make changes to the primary health care sector to provide a more equitable, geographical and economically accessible primary health care system. One of the ways to achieve these gaols, it was stipulated, is through cooperation between health care practitioners by integrating health care through appropriate referral systems and support of each other (WHO, 2010a). Although the declaration originally addressed biomedical practitioners, New Zealand’s Ministry of Health sought advice on integrating CAM in early 2000. Osteopaths are primary health care providers and may therefore be affected by current policies and future primary health care reforms.

Increased demands by consumers of CAM in the past three decades (Barrett, 2003) and a global growing shortage of health professionals (Smith, 2008) may give further impetus to governments to consider integration of CAM. Research studies from the United States of America, Canada, UK and Australia confirm a trend of CAM integration into biomedicine.
However, there is a scarcity of studies into CAM practitioners’ view points of integration and none to date about the opinion of osteopaths’ on integration of osteopathy into the biomedical or general health care system.

According to Winnick (2005), biomedicine has been the dominant health care system in the western world marginalising CAM. The author maintains that despite the historically antagonistic relationship between the biomedical profession and CAM, the biomedical profession is now showing changes in attitudes and an increased interest in CAM integration. Studies and opinions on integration are very varied; some forms of CAM integrations considered in literature do not always include CAM practitioners, which is of worrying concern for CAM practitioners. Osteopathy is one of a number of CAM modalities. These new developments in health care are of urgent importance to osteopaths, as they may be required to take a stand on what their role and contribution is to general health care. This research is a preliminary investigation into the experiences and practices of osteopaths in relation to the general health care system and informs the reader of what osteopaths perceive their role in the biomedical system to be. It also explores what models of integration osteopaths believe are appropriate and what prerequisites are necessary for integration to happen.

**Defining complementary and alternative medicine (CAM) and biomedicine**

The following terms have been used throughout this thesis and require clarification, namely “complementary and alternative medicine” (CAM) and “biomedicine”. The definition of integration and its derivatives are closely related to models of integration, and are deal with in detail in chapter two, the literature review.
**Complementary and alternative medicine**

In the main, in literature, CAM is not particularly differentiated as different modalities, but is used in the sense of not being biomedicine or mainstream. For the ease of reading, CAM is used in this study with the latter sentiment, unless where studies referred to specific CAM modalities; these will be named accordingly.

Defining complementary and alternative medicine (CAM) is controversial and complex (Leckridge, 2004). Complementary and alternative medicine are heterogeneous terms both having in common the need for a third form of medicine (Kaptchuk & Miller, 2005). Complementary, according to the New Zealand Oxford Dictionary means “making something complete; add what is lacking” (2002, p 153), in this context, to the hegemonic medicine or mainstream medicine. In his address to the American Senate Committee on Health, Education, Labour, and Pension, Mehmet Oz, M.D. (2009), Vice-Chair and Professor of Surgery Columbia University proclaims:

> Conventional medicine alone could not offer the robust, holistic approach that our patients deserved. We started a centre where we paid salaries of complementary and alternative medical (CAM) practitioners to offer free services to all of our heart surgery patients (p. 1 of 3).

Oz further advised the Senate to incorporate CAM into the conventional health care economy. This testimony demonstrates how the biomedical approach may lack components of health care that CAM can offer, thus complementing biomedicine.

Alternative medicine, on the other hand is defined as “offering a different approach from the conventional or established one” (New Zealand Oxford Dictionary, 2002, p 20), and is exchangeable in its use with terms like “unconventional “and “unorthodox” (Dew, 2003). Examples of alternative medicines are Traditional Chinese Medicine (TCM) (Parker, 2003), Homeopathy and Ayurveda (Kaptchuk & Miller, 2005).

The World Health Organisation (WHO) defines CAM as a broad set of health practices that are not part of a country’s own tradition, or not integrated into its dominant health care system.
(WHO, 2002). In New Zealand Maori medicine could be said to be the country’s own tradition and is a vital part of ‘whanau ora’ (family health and well being), at least to Maori (Quinn, 2005). Maori medicine clinics, according to Quinn, can be accessed by all New Zealanders, and is a government funded part of the primary sector. Yet Maori medicine incorporates rongoa (herbal medicines), mirimiri (massage) and karakia (spiritual prayers) (Quinn, 2005), which are commonly identified as practiced by CAM. Thus by the WHO definition of CAM, Maori medicine find itself in the ‘twilight zone’ of health systems, being neither CAM nor dominant.

Far from identifying what precisely CAM might be, with its numerous different modalities, the United States National Centre for Complementary and Alternative Medicine (NCCAM), defines CAM as: “a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine” (Johnson, Priestley, Porter & Petrillo, 2010, p. 167). It informs what it is not, namely conventional and further complicates the issue by including products, such as vitamins and minerals, which are also prescribed by doctors of conventional medicine (Dew, 2003). This further raises the question: does this make these doctors conventional and CAM practitioners at the same time?

The following definition of CAM has been adopted from the Ministry Advisory Committee on Complementary and Alternative Health (MACCAH, 2004) is the most appropriate for this study and is thus the working definition in this dissertation:

Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities, and practices, and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-identified by their users as preventing or treating illness or promoting health and well being (p. 1).

Further, the advisory committee notes that CAM is an “umbrella term” for different modalities which can be put into several categories: “Mind, Body, Spirit Interventions; Biological Based
therapies; Manipulative and body-based therapies; and Energy Therapies” (MACCAH, 2004, p. 1). These modalities further distinguish themselves by their individual epistemologies and by their founders (Kaptchuk, & Miller, 2005). Thus the above discussion demonstrates the controversy of using CAM as collective term when in fact it has a complex meaning.

Osteopathy is placed under the CAM category of ‘manipulative and body-based therapies’, thus seen as part of CAM, except for the United States of America, where doctor of osteopathy is considered part of conventional medicine (Johnson et.al., 2010). CAM and osteopathy have been treated as comparable in much of the literature informing this study.

**Biomedicine**

The term ‘biomedicine and biomedical model are synonymous, according to Germov (2005) and are defined as:

The conventional approach to medicine in Western societies, based on the diagnosis and explanation of illness as a malfunction of the human body's biological mechanisms. This approach underpins most health professions and health services, which focus on treating individuals, and generally ignores the social origins of illness and its prevention (p. 8).

The definition of biomedicine is far less complicated. In the literature the meaning of biomedicine and mainstream is interchangeable (Kaptchuk & Miller, 2005). Mainstream medicine is deemed to be the dominant form of health care delivery, and is said to be based on evidence-based medicine, using randomized controlled trials as its gold standard method (Kaptchuk & Miller, 2005). In the context of this research, biomedicine refers to mainstream medical practice, as taken from MACCAH (2004) and represents the health care systems widely employed by governments of Europe, the United States, Australia and New Zealand (Leckridge, 2004).
Why study this topic of further integration of osteopaths into the biomedical health care system?

This author has qualifications in naturopathy, acupuncture and nursing, with special interest in gerontology, before studying osteopathy. Gerontology nurses working in hospitals refer and liaise with community services in the primary health care setting as an essential part of ‘older people’s health’ care management. Community services include district nurses; specialist nurses, for instance, continence nurses, gerontology and oncology nurses, as well as occupational therapists (OT), physiotherapists (PT) and needs assessment service coordinator (NASC). The question whether osteopaths refer patients to and liaise with community services to make these services available to their patients, thus arose.

Liaising with other health care professionals and using health care services, in the general health care system, may not only enhance a holistic approach to osteopathy beyond the consultation room, but also raises the profile of osteopaths in the general health care system as they become known. Informal talks with community health service nurses and dialogue with a number of osteopaths, including lecturers at Unitec and clinical practitioners in private practice, about triaging and patient referrals, revealed that osteopaths are not amongst referring health care practitioners, even where this option is available to them.

A literature search on referring habits discovered an Australian study by Southern, Young, Dunt, Appleby, and Batterham, (2002). The authors found that referring patients to other health practitioners and services was one of a number of measures of integration into the general health care system. A New Zealand study by Taylor (2003) found that General Practitioners, in Whanganui, referred patients to CAM practitioners. Only chiropractors were included as manual therapists, and no osteopaths were represented in the study. Although this implies that there is contact between medical and CAM practitioners it does not convey if CAM practitioners refer or initiate liaison with GPs or other health care professionals. Anecdotally osteopaths refer their patients to general practitioners and hospital emergency departments when diagnostic findings and treatment needs exceed osteopathic scope of practice.
Further exploration of research studies on interactions of CAM practitioners, revealed a move towards integration of CAM modalities into the general health care system. However, there are no studies on how osteopaths interact with other health care professionals or the general health care system in New Zealand. It is not known what their experiences are with other health care practitioners or if efforts to develop collegial relationship are made. What difficulties, if any, they might experience practising osteopathy in a biomedical dominant health care system? It is not known how osteopaths’ experiences in the general health care system influences their practice, attitudes and opinions about the general health care system, or their views on further integration into the biomedical system.

Rationale for the study

An integrated primary health care system is said to provide more geographically and economically accessible and equitable health care (King, 2001). The New Zealand government acknowledges the right of patients to choose their preferred health care practitioner and therefore consider the need to make them available (MACCAH, 2004). A lack of integration may be one factor that affects accessibility and affordability of osteopathic services to the wider population in general and the lower socio-economic population in particular. Learning about the views osteopaths have about integration with the biomedical system, could be a helpful step towards accessibility and affordability of osteopathic treatment for patients.

As the next chapter will show, CAM integration into the biomedical health care system has been a global research topic for the last decade and may have great implications on the way osteopaths practice and deliver their services. Therefore it is important for osteopaths to put their professional perspective on integration forward.

This study is important because it will present an initial view point osteopaths have on the topic of integration to those who may be interested, for example the Ministry of Health and other stake holders, such as the Osteopathic Council of New Zealand (OCNZ), the
Osteopathic Society of New Zealand (OSNZ), the osteopathic profession and education institute. This research delivers a basis for further studies to establish a model for “best practice for integration” (MACCAH, 2004), thus contributing to future guidelines on osteopathy, and other CAM modalities, integrating into the health care system.

**Aims of this study**

The aim of this study is:

- To explore the experiences osteopaths have with other health care professionals and with the biomedical system.
- To investigate how the experiences osteopaths have in the biomedical system influence the way they practice as health care providers, their attitudes and opinion towards further integration into the biomedical system.

**Summary**

This first chapter gave a brief background for this research, how the idea for this study evolved and its importance. For the purpose of this dissertation CAM is defined as ‘a diverse set of holistic health care modalities, not part of the dominant or biomedical model.’ Biomedicine is synonymous with the general health care system, as it is the predominant health care system in the western world including New Zealand. The definition of integration is the subject of chapter two, the literature review, where the relationship between defining integration and its derivatives and models of integration found in research studies and opinion papers are discussed. Chapter three explains the method and methodology used in this study including discussion of ethical considerations and actions taken throughout this research to ensure credibility or rigor. Chapter four details the presentation of the data and data analysis. Chapter five ‘discussion’ compares and contrasts the data findings with other studies on this
topic found in literature. Chapter six concludes the theses with a description of the limitations of this study and recommendations for future research.
Chapter Two-Literature Review

Introduction

This literature review explores research studies and opinion papers on the subject of complementary and alternative medicine (CAM) integration into the general or biomedical health care system. It appears that most studies to date are written from a biomedical perspective, with the exception of one medical anthropological study by Hollenberg and Muzzin (2010), which gives a contrary view of CAM integration.

A general background begins with an overview of why CAM integration is a noteworthy issue in general health care, including the controversy and associated problems surrounding it. Reasons for why CAM should be integrated into the biomedical health care system are also given. Three models of integration that emerged from the literature, which are linked to the different ways of how integration is defined, will be discussed. The first model is the integrated health care model, which excludes CAM modalities and pertains to the biomedical health care system only. The second is the integrative medicine model, a newly developed concept of biomedical practitioners expanding their scope of practice into CAM. The third model involves CAM practitioners and ranges from an ad hoc model of integration, the current modus operandi of CAM, to a patient centred health care involving CAM and biomedical practitioners. Lastly, barriers of integration are explored.

Background

Biomedicine is recognised as the predominant health care system in the western world, with numerous complementary and alternative medicines (CAM) existing to a greater or lesser degree on the fringe (Leckridge, 2004; Maizes, Rakel & Niemiec, 2009). Although marginalised (Winnick, 2005), an ever growing public use of CAM services has made CAM a
multi-million dollar industry, despite little support from governments. The increasing demand for CAM on the one hand and the inability of biomedicine to deal with the ever rising numbers of chronic diseases on the other hand, are factors thought to have led to the need for change, with the possibility of a new health care system emerging (Baer & Davis-Floyd, 2005; Mizrachi, Shuval & Gross, 2005). This new health care system is not just undergoing reform but is said to be on the verge of a paradigm shift, with a restructure including CAM into the biomedical system, which is the subject of this literature review (Sundberg, Halpin, Warenmark & Falkenberg, 2007; Weil, 2000).

While academics and theorists are pondering the pros and cons of integration, clinicians from the biomedical and CAM fields are taking action to integrate. For example, CAM modules are being included in biomedical training programmes; selected CAM therapies are offered in hospitals and included in biomedical research; insurance plans and governments are supporting CAM practice and education respectively (Sundberg, 2007). The question of integration of CAM into the biomedical system is no longer an academic exercise, but a fast developing reality.

Still, much controversy and debate about integration can be found in the literature. Rees and Weil (2001) maintain that integrative medicine is the incorporation of acceptable parts of CAM into orthodox medicine health care delivery and treatment plans. In contrast Gamst, Haahr, Kristoffersen and Launso (2006) reject integrative medicine as a model of integration, because CAM practitioners are not included. CAM practitioners themselves emphasise that integrative medicine is what CAM does (Hollenberg, & Muzzin, 2010). Bell et al. (2002), on the other hand, state that integrative medicine is not CAM as it does not incorporate both CAM and biomedicine. While, Maize et al. (2009) postulate that integrative medicine is the best form of health care system, as long as the integrity of each system is not altered. Hollenberg and Muzzin (2010), propose a rather sinister motive for integration being instigated by biomedicine, with a detrimental outcome of further marginalizing CAM. The above are examples of opinions and definitions, which partially but poignantly reflect the complexity of the issue of integration discussed in literature and thus highlight the difficulty of the realisation of integration of CAM into biomedicine.
This literature review presents some of the historical background, research and opinions on the changes happening in the biomedical healthcare systems around the world including New Zealand in relation to CAM integration. It provides the background to the importance of investigating how osteopaths practise in the general health care system and their attitudes towards increasing their relationship with the general health system.

**Reasons to integrate CAM**

*Increased demand for CAM*

The increased use of CAM is given as the major reason for integration of CAM into the biomedical health care system by commentators and researchers on this matter (Coulter & Wills, 2007). Rising figures of CAM use from late 1970 to date are testimony to its increased demand: a reported 33% of Americans used CAM services in 1992, increasing to 42% by 1998 and to 62% by 2002 (Barrett, 2003; Frenkel & Borkan, 2003; Johnson, Priestley, Porter & Petrillo, 2010). In the UK 46.6% of the population used CAM therapies in 2004; while in Australia 48.5% of the population used CAM in 1993 (Cohen, Penman, Pirotta & Da Costa, 2005), with figures rising to 50% recorded in the year 2000 (Chrystal, Allan, Forgeson & Isaacs, 2003). In 2002/2003 the annual use of CAM in New Zealand was acknowledged by 25% of adults (MACCAH, 2004).

The umbrella term CAM, which stands for many different modalities, also includes over-the-counter remedies, thus CAM uses range from self-administered remedies to patients choice of CAM practitioners, separate from or additional to their biomedical health care. Nahin, Pontzer, and Chesney, 2005, point out that the increase of CAM was not necessarily recorded in the visits to CAM practitioners but in the self-administration of vitamins and minerals. Barrett (2003) also draws attention to the fact that the number of visits per patient to their CAM practitioner is greater than that to their general practitioner. Hence the above figures may be difficult to discern and may therefore be distorted. On the other hand, in their literature review on increased use of CAM, Coulter and Wills (2007) assert that expenditure
of US$21.3 billion in the United States and Aus$ 2.3 billion per annum in 2000, an increase of 62% since 1997, leaves no doubt of the increasing trend for CAM demand. On the contrary they advise that due to patients’ reluctance to disclose CAM use, studies may give an underestimation of the figures. Furthermore, added to these figures are the home remedies, which they say have never been included in any research. On any account there is no doubt that despite its marginalised position in the biomedical system, CAM is a formidable player in the marketplace of health care.

**Accessibility of CAM**

CAM is thought to be most suited for involvement in chronic disease health care. Chronic disease has become a growing concern in health care with ineffective biomedical treatments leading to increasing health costs (Maizes, Rakel, & Niemiec, 2009). Often afflicting lower socio-economic groups, it may be that chronic disease with loss of income exacerbates further decline in socio-economic status (Anderson, 1999; Hollenberg, 2007). While predominantly used by the poor as health care in underdeveloped countries, CAM is largely privately funded in the industrialized western countries; ‘user pays’ ironically makes it unavailable to the lower socio-economic groups (Coulter & Wills, 2007).

CAM’s inaccessibility to those who cannot afford it raises the question of whether public funding should pay for CAM services and whether it should be integrated into the general health care system. The answer to this question is as complex as defining CAM. Public funding of CAM is problematic, because the broad term CAM does not distinguish the largely different modalities and neither does it shed light on whether they have an academic grounding such as is required in biomedicine. Qualifications in CAM may vary from tertiary education in human health sciences to those earned in weekend courses (MACCAH, 2004). Some modalities like chiropractic and osteopathy are known to have comprehensive education, as required by their regulatory bodies.

Nevertheless, it was the increased demand for CAM that led to the health maintenance organizations (HMO) in the United States to incorporate CAM in their coverage of health care services (Nahin et al., 2005; Meenan & Vuckovic, 2004) and persuaded others, including
the United Kingdom, Australia and the New Zealand Ministry of Health, to start investigating CAM integration into the biomedical system (MACCAH, 2004). In view of this, an investigation into how osteopaths’ experiences and practice in the general health care system may reveal their opinions and attitudes in relation to an increased relationship with biomedicine. Thus this study not only provides an opportunity for the osteopathic profession to express their perception of a greater integration, but it also offers preliminary data and recommendations for further research projects.

**Other reasons for integrating CAM**

The increased use of CAM services and CAM products can potentially pose a danger to people’s health when conflicting with biomedical pharmaceutical treatments. Winslow and Shapiro (2002) point out that biomedical practitioners’ attitude towards CAM services may act as a deterrent for patients to disclose CAM usage. Furthermore biomedical practitioners’ lack of knowledge about CAM modalities scope of practice impairs their ability to give educated advice to patients or make informed decisions when referring patients to CAM. Conversely, Ernst’s (2009) critique of CAM, claims CAM practitioners practice of discouraging patients to use biomedicines, for example vaccinations, is misguided at best and dangerous at worst. Greater integration of biomedicine and CAM may be a way of eliminating ill informed and dangerous practices.

**Model one: ‘Integrated health care’ in New Zealand**

In New Zealand, the goal of an integrated health care system first arose with the Social Security Act of 1939, when the care and welfare of its citizens was accepted as a national responsibility, but this pertains to the biomedical health care system. Historically, integration implementation has been encouraged under Labour Party governance but hampered by both National Party governments and the powerful General Medical Society, who advocate privatised health care (Gauld, 2001). In September 1978, with the ‘declaration of Alma Ata’, a new approach, named ‘integrated health care’, was initiated by the World Health Organisation and agreed to by participating governments, including New Zealand, (WHO,
New Zealand took action to further integrate its health care system, to achieve a more geographically and economically accessible and equitable health care system, also taking bio-psycho-social factors into account when dealing with individual health care delivery (MACCAH, 2004). The New Zealand ‘Primary Health Care Strategy 2001’, gave particular consideration to the integration of the primary sector (King, 2001). One reason for this is that primary health care providers are usually the first level of care sought by patients. In this context it can be said that some CAM providers, like osteopaths, are also primary health providers, therefore changes pertaining to this sector may affect how osteopaths practise.

**Paramedical health professionals in the integrated health care model**

Integrated health care is a patient-centred approach, bringing doctors, nurses, physiotherapists and other paramedical practitioners together, working as a multidisciplinary team, with a common goal to improve and maintain health, including considerations of the bio-psycho-social sphere of the individual patient. The European Health Care Office, which is a branch of the WHO for Integrated Health Care Services, defines integrated health care as: “a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care rehabilitation and health promotion. Integration is a means to improve the services in relation to access, quality, user satisfaction and efficiency” (Groene & Garcia-Barbero, 2001, p. 7).

Multidisciplinary approaches can be observed in public hospitals and primary sectors, such as community health services, in New Zealand. With the changes to the health care sector, physiotherapists perceived the opportunity to integrate into the primary health sector, to provide rehabilitation and services for those with disabilities and chronic health problems (Nicholls & Larmer, 2005). Similarly, nurse practitioners identify a position for themselves in primary care as an independent practitioner who can lighten the load of general practitioners (Carr, Armstrong, Hancock & Bethea, 2002).

However, health care professionals, such as physiotherapists and nurse practitioners, are struggling to integrate into the health care system as autonomous health care providers. Both
Stewart and Haswell (2007) and Main, Dunn and Kendall (2007) point out that biomedical practitioners pose a barrier to integration, as they hold a “position of power in primary care as providers, employers and managers” (Main, Dunn & Kendall, 2007). Freidson states (as cited in Main et al., 2007, p. 486): “the medical profession has furthermore secured the authority to define the tasks and boundaries of other paramedical professions such as nursing”. A further hindrance to integration was identified as GPs failing to familiarise themselves with and lacking understanding of the scope of practise of these professionals (Carr et al., 2002; Main et al., 2007; Nicholls et al., 2005).

**Characteristics of integrated biomedical health professionals**

In an attempt to accomplish better integrated health care in Australia, Southern, Young, Dunt, Appleby, and Batterham, (2002) developed the “GP integration index” to measure how well GPs are integrated into the health care system. The data were generated in a qualitative study, using focus groups of 122 participants from all over Australia including GPs and paramedical health care professionals. The index measures the GP’s ‘characteristics’ and activities of patient care revealing the degree of integration into the health care system. Dunt et al.’s, (2006) main findings on the application of the index were that a lesser degree of integration was associated with lack of knowledge of local services, for example community services, and other health practitioners, including their scope of practise, liaising, communicating and referring patients to them.

Until biomedical practitioners in the tertiary and primary care settings improve on the identified shortcomings, especially knowledge of scope of practice, paramedical practitioners will not be able to work autonomously and patient care delivery may not be optimal. Integration of CAM practitioners, including osteopaths, may face similar problems. Although Dunt et al.’s (2006) study is not concerned with integration of osteopaths or CAM practitioners, characteristics and activities of patient care on the one hand and a lack of knowledge of the above-mentioned areas on the other will be of interest because they may also be indicators of integration for osteopaths into the biomedical system.
Currently in New Zealand a project to pioneer a ‘Shared Care Planning and Management System’ is part of a strategic trial of ‘integrated health clusters’ in Christchurch. With the advances of software, the internet and broadband, multidisciplinary teamwork in primary health care and secondary settings are sharing patient information and improving communication between health care practitioners. This pilot study is currently being conducted within the Canterbury District Health Board region and is an example of ‘integrated health care’ within the biomedical setting in New Zealand, improving on the above-mentioned problems; however it excludes CAM providers (Scope Health, 2010). Still, it is feasible that the above examples of multidisciplinary teams, of the different health care systems could work together by using the ‘Shared Care Planning and Management System’ software, thus expanding the multidisciplinary team approach to an interdisciplinary one of CAM and biomedical practitioners. Such sharing of patient information and services would benefit patients and health practitioners, including osteopaths, in delivering holistic health care beyond the consultation room.

**CAM and the integrated health care model**

Although the biomedical model of ‘integrated health care’ as described above does not include CAM or osteopathy in New Zealand, there are CAM clinic centres to be found, where multiple diverse modalities are co-located. An example of this type of ‘integrated health care’ in the CAM field has been advertised on the website of an osteopathic clinic in Wellington (City Osteopaths, 2010). The site offers a number of CAM practitioners of different modalities and their services, but it excludes biomedical practitioners. This integrated health model differs from the biomedical model above, where doctors and nurses and paramedical health professionals share the same basis of health care approach, whereas each CAM modality is autonomous with its own philosophical, epistemological, practical differences and different founders (Kaptchuck & Millar, 2005). It is not known to what extent the various practitioners work as a multidisciplinary team, that is sharing patient information and case conferencing, or how they perceive their integrated health care. Neither is it clear if CAM practitioners, in an integrated health care clinic, are inclined to exclude certain other CAM modalities, distinguishing them from their own by level of training, for
example. Further studies into existing CAM ‘integrated health care’ may provide insight into a workable integration model for CAM and biomedicine. Investigating osteopathic practise and opinion in relation to other health care professionals in the general health care system, including shared patient care, is one of the aims of this research and may include experiences of relationships with other CAM practitioners.

**Model two: ‘the integrated medicine’ model**

**CAM as a form of biomedical treatment**

Rees and Weil (2001) use integrated medicine and “integrative medicine” interchangeably defining it as “practising medicine in a way that selectively incorporates elements of complementary and alternative medicine into comprehensive treatment plans alongside solidly orthodox methods of diagnosis and treatment” (p. 119). Complementary and alternative medicine, as perceived by biomedicine and others, may range from the use of vitamins, minerals and herbal products, to practitioners taking all domains of body, mind and soul into consideration, to spiritual healing. The phenomena of rising CAM demand and realisation of limitations of biomedicine, has led some biomedical practitioners to include CAM into their repertoire of treatment options; this may vary from prescribing vitamins and herbs to giving acupuncture and other CAM treatments (Leckridge, 2004; Maize et al., 2009; Oz, 2009).

Leckridge (2004) refers to the incorporation of CAM by biomedical practitioners as the ‘assimilation model’. He points out the problem with this model is the danger that unqualified people, who are not educated in CAM, are practicing. Gamst, Haahr, Kristoffersen and Launso (2006) maintain that some biomedical practitioners attend short weekend courses in CAM skills, for example acupuncture, with a focus on symptomatic relief. This over simplification underestimates the complexity of some CAM modalities and may deprive the patient of the quality care they can expect to receive from formally taught CAM
practitioners. Gamst et al. (2006), reject this model of ‘integrative medicine’ as a model of integration because CAM practitioners are not included.

**CAM a biomedical elective module**

Frenkel and Borkan (2003) suggest CAM modalities should be included in the curriculum of biomedicine. In the last decade evidence based aspects of complementary medicine have been included in mainstream medical practise and taught in medical schools. Furthermore a new type of medical practitioner with dual training in CAM subjects and biomedicine, known as ‘integrative medicine physician’ has emerged and Centres of Integrative Medicine in the United States of America offer integrative medicine care (Ben-Arye, 2008; Hollenberg & Muzzin, 2010; Kligler et al., 2007; Maizes, Schnider & Bell, 2002). These courses offered CAM subjects to biomedical or mainstream practitioners, including nurse practitioners, in the United States of America, but excluded CAM practitioners or educators (Arizona Centre for Integrative Medicine, n.d.). The term CAM, according to Kligler et al. (2007) has been widely replaced by "Integrative Medicine" (IM), which is defined as "healing-oriented medicine that takes account of the whole person (body, mind, and spirit), including all aspects of their lifestyle. It emphasizes the therapeutic relationship and makes use of all appropriate therapies, both conventional and alternative” (p. 2 of 11). Researchers like Kligler et al. (2007) are developing and trialling competency tools for IM practise as a biomedical modality. This demonstrates that advances of IM are no longer experimental but are already happening and becoming embedded into the biomedical system.

Osteopathy or osteopathic medicine as it is know in the United States of America, has the same licensing privileges as biomedicine since 1961, with an enlarged scope of practice, including surgery and obstetrics in some states, but with a predominant application in primary care (Baer & Davis-Floyd, 2005; Gervitz, 2009). Doctors of osteopathy (DO) undertake equivalent education in human health sciences as medical doctors (MDs), but with a central focus on osteopathy (Gervitz, 2009). Gervitz alerts that “if osteopathic medicine wishes to maintain its independence (from biomedicine), it will need ...to produce physicians who believe they are (and are perceived by others to be) not only “qualified” but “different” in the way they practice medicine” (2009,p 706).
Arguments against biomedical use of CAM

In their discussion paper Kaptchuck and Millar (2005) critique this integrative medicine model and warn that there would be a loss of the essence of what both CAM and biomedicine are offering in a diverse health care system. They question how integrative medicine physicians can possibly practise ‘evidence based medicine’, the hallmark of biomedicine, and at the same time prescribe CAM, which is still largely disapproved of by biomedicine because of lack of evidence for efficacy. Caspi, Bell, Rychener, Gaudet and Weil (2000), refer to CAM and biomedicine as “two camps” that speak different languages and have little knowledge about how the other works. Hence, it is difficult to comprehend how two fundamentally different systems of health care can simultaneously be incorporated without compromising one or the other.

Medical anthropologists Hollenberg and Muzzin (2010), refer to the IM physician model as assimilation and appropriation of CAM. They observe that such actions are used in colonisation and maintain that the anti-colonial perspective is the often invisible view of the marginalised. In their qualitative study the authors express an anti-colonial view. They attribute the historical relationship between biomedicine and CAM as the reason for the advent of IM physicians and the increasing interest by biomedicine in merging CAM into the biomedical system. They base their findings on two other qualitative studies, done by Hollenberg (2006, 2007) and their conclusions on sociology theory and analysis. The view of these authors is that biomedicine aims to ‘assimilate’ and ‘appropriate’ CAM.

‘Appropriation’ means that aspects of a CAM modality are taken and changed into a ‘new’ approach to become a scope or tool of biomedicine but essential parts are left out of the original modality, thus devaluing it as an alternative health care system. For example, Traditional Chinese Medicine (TCM) and acupuncture were changed to Western Acupuncture, abandoning the theoretical knowledge of TCM and concept of Qi energy. TCM gives theoretical guidance to the technique of dry needling in Chinese acupuncture, making it a comprehensive health care approach including herbal medicine, diet and life style counselling, addressing body, mind and spirit of the patient. Thus Chinese acupuncture is diminished in Western acupuncture to applying dry needling technique only. ‘Assimilation’ is when
biomedicine practitioners reinterpret a given CAM modality with their own logic and reasoning of their biomedical paradigm. For example, Qi energy theory becomes ‘release of endorphin relieving pain’ in the biomedical paradigm, thus replacing a foreign concept of TCM with a hegemonic biomedical one of endorphins.

Similarly replacing the term CAM with ‘integrative medicine’, as mentioned above (Kligler et al., 2007), not only ignores that the term CAM embraces many independent and essentially different modalities of alternative and complementary medicine, but also may be an example of the diminution of CAM as biomedicine makes it part of its own paradigm. The reality of these examples comes alive with a statement expressing the attitude of IM physicians “I think there won’t be this distinction any more, there’ll be just the right way to practise [IM]” (Hollenberg & Muzzin, 2010, p. 50) an integrated medicine, as the authors note, excluding CAM practitioners. It is also of interest to note that the director of the National Centre of Complementary and Alternative Medicine (NCCAM, 2010) Josephine P. Briggs, is a biomedical practitioner, and not, as one might expect a CAM practitioner.

However, it could be argued that biomedicine is not alone in appropriating and assimilating aspects of other modalities. For example, osteopathy, outside of the USA, has integrated biomedical aspects into the curriculum of osteopathic studies. At Unitec New Zealand, osteopathy has incorporated human health science subjects including pathology (Unitec New Zealand, n.d.). In the UK and Australia, osteopaths are investigating prescription rights for osteopaths (Grundy & Vogel, 2005). Further the integration of other CAM modalities into osteopathy in not a new concept to osteopathy. Naturopathy was part of the osteopathic diploma at the British School of Osteopathy before regulation and using Western Medical Acupuncture and Related Needling Techniques for those trained in it, is within the scope of practise of osteopathy in New Zealand (OCNZ, n.d.). Still, osteopathy is not the predominant health care system and so is distinguishable from the motivations attributed to biomedicine practising other modalities, as proposed by Hollenberg and Muzzin (2010). However, what this may suggest is that there are possible other motives rather than merger, for adopting aspects of other modalities. Maizes, Schneider, Bell and, Weil (2002) suggest dissatisfaction with the biomedical health care system, as it fails to deliver expected outcomes
despite advancements in technology, to be a reason for integrating the best of CAM in order to improve their own health care service.

Research into why osteopaths, and perhaps other CAM modalities, have chosen to adopt aspects of other health care approaches, although not the scope of this study, may give insight into the relationship between different health paradigms and practitioners opinions on how to best deliver health care in the best interest of the patient.

**IM practitioners as mediators between CAM and biomedicine**

Integrated medicine physicians may be able to offer a link between biomedicine and CAM, given their knowledge of both health paradigms. Ben–Arye (2008) investigated a mediator role, of integration in primary care, of dual trained, integrative medicine physicians. This Israeli quantitative study, used questionnaires in which 333 primary care physicians (PCP) and 241 CAM practitioners, of whom 31 were integrative medicine (IM) physicians, participated. The author found that IM physicians supported integration similarly to CAM, in the areas of greater collaboration in clinical practise, increase in combined scientific research and medical education, when compared with primary care physicians. However, IM practitioners displayed a closer alliance with their primary care physician colleges than CAM practitioners, in that they supported a dominant, physician led teamwork approach in integrated clinics, while CAM practitioners supported a co-directed model. Further they perceived their role to deliver CAM services in an integrated primary setting as more appropriate than delivery by CAM. The author, a physician himself and stakeholder at the clinic from where the study participants were recruited may have a bias when suggesting that insurance cover, cost to patients and increased insight of IM physicians into CAM limitations may be a reason for the result of IM physicians’ opinions. Furthermore, from this study’s findings it is difficult to generalise to other IM physicians, because of the small sample size of 31 and the position these IM physicians and PCP are holding as triage managers for CAM services, at the clinics shared by CAM practitioners, which may be unique. Whatever the reasons, IM practitioners in this study did not offer an equitable solution for CAM integration,
but suggests a risk that CAM practitioners maybe further marginalized in a model where biomedical practitioners practise CAM.

Contrary to another Israeli study investigating barriers of integration of CAM into hospitals, one medical doctor, dual trained in acupuncture, was advocating for gaining acceptance of alternative treatments. This dual–trained doctor acted as a mediator between the acupuncturists, the Traditional Chinese Medicine practitioners and the biomedical doctors and patients participating in the study (Mizrachi et al., 2005). As above it is difficult to generalise from one study as to the role IM doctors may play in integration. But what was revealed in this study was that recommendation by a medical doctor and trust in the doctor’s judgement was enough of a criterion for accepting to trial acupuncture as an alternative medicine in the hospital. However, the social, professional and special position of the CAM practitioners, in regards to patient care, was clearly secondary to the medical and paramedical professionals and without acupuncture epistemological integration. Further studies on opinions of IM physicians on CAM integrations may shed more light on attitudes of CAM integration and IM physicians’ role within it.

**CAM and biomedical practitioners’ opinion on IM**

One exploratory study by Hsiao et al. (2006), of biomedical and CAM providers’ opinion on integrated medicine, yielded a range from approval to disapproval of IM in both camps. CAM providers were found to be more in favour, open minded and displaying a positive view of integrative medicine compared to biomedical practitioners. Integrated medicine was defined as understanding the whole person, body, mind, spirit, and environment, and health and disease is only one aspect of holistic health. Younger biomedical practitioners were more supportive of IM than older practitioners. The young practitioners’ endorsement was thought to be due to greater exposure to CAM during their training. CAM practitioners with strong beliefs in their modality but also realising its limitations were also more likely to back IM. On the whole CAM practitioners thought practising CAM and biomedicine concurrently was conflicting, while dual-practitioners in acupuncture and biomedicine believed they could ‘harmonise’ the two paradigms and were able to use both of them at the same time in their practise of health delivery. Biomedical practitioners dubious of IM admitted lack of
understanding of IM, whereas CAM practitioners with the same sentiments towards IM feared merger of CAM into biomedicine.

**Model three: Integrative medicine, ad hoc and patient-centred interdisciplinary approach**

Bell et al. (2002), maintain that, while interpretation of integrative medicine like the earlier one described by Rees and Weil (2001) is common, its proper meaning is as follows: “integrative medicine is a comprehensive, primary care system that emphasizes wellness and healing of the whole person (bio-psycho-socio-spiritual dimensions) as a major goal, above and beyond suppression of a specific somatic disease” (p. 133). Although CAM practitioners claim that what they practise is integrative medicine (Hollenberg & Muzzin, 2010), Bell et al. argue that ‘integrative medicine’ is not CAM as it does not incorporate both CAM and biomedicine.

However, for CAM in general and osteopaths in particular to survive within the health care system, they need to work autonomously in a holistic way and maintain their own identity (Hollenberg & Muzzin, 2010). Bell et al.’s (2002) definition of integrative medicine is congruent with the General Systems Theory, which underpins parts of osteopathic philosophy. The General Systems Theory portrays the individual as having several aspects that are described as “domains” consisting of body, mind, emotion and spirit, psycho-social and socio-economic factors. Living systems have their own reality and are part of larger systems, all in need of consideration by practitioners of the osteopathic health delivery system (Sprenger, 2005). In their opinion paper, Kaptchuk and Miller (2005) suggest that integrative medicine can best exist in a co-operative way with the biomedical system without merging into another system, as this may compromise the epistemology of CAM modalities. They called this a “pluralism model”. In agreement with Kaptchuk and Miller, Gamst et al. (2006) put forward two versions of the co-operation, which are somewhat different from each other: one, is the ad hoc model, where practitioners of a rich diversity of therapeutic systems refer patients to each other and two, more an interdisciplinary approach, where there is cooperation,
interaction and partnership with the patient, in a patient-centred and health practitioners team approach from both paradigms.

**The ad hoc model of integration**

Although marginalised (Winnick, 2005), it could be said that CAM practitioners are already integrated into the biomedical system in this ad hoc manner, working autonomously within the biomedical system. For example, patients choose CAM practitioners as their health care providers along with biomedical treatment in the primary sector, but also in hospitals, for instance, as an adjunct in cancer care (MACCAH, 2004). The Ministry Advisory Committee of Complementary and Alternative Health (2004), report that some District Health Boards have changed their policies, to allow the inclusion of CAM, if desired or requested by the patient. Furthermore, patients use over the counter CAM products, such as vitamins, minerals and herbs, integrating CAM treatment by themselves as part of their health care management. Leach (2008) narrates her participation as an osteopath in caring for a patient with gastric cancer. Chrystal, Allan, Forgeson, and Issacs (2003) give an account of CAM care in regional cancer treatment centres around New Zealand. Although the latter-named studies are individual qualitative studies, they tell of an apparent trend of increasing CAM treatments within the biomedical system. Further quantitative studies may illuminate the extent of this development.

**The patient-centred, interdisciplinary approach model**

Calling it a ‘patient–centred’ model, in their study of CAM integration into biomedicine Frenkel and Borkan (2003), suggest that GPs should advise and decide with the patient what CAM modality and which practitioners to use for treatment, with the diagnosis made by the GP. Furthermore, the GP should monitor progress and efficacy of the given treatment and decide on the length of the treatment, thus claiming diagnosis and treatment as a biomedical practitioner’s domain. Taking a less paternal perspective, Leckridge (2004) maintains that a ‘patient centred model’ should be about the patient’s safety and CAM health professions and medicines should be regulated, like doctors, nurses, allied health and other paramedical professions.
Osteopathy is one of the CAM professions regulated by the Health Professional Competency Assurance Act 2003 (HPCA Act 2003) in New Zealand, which enables governments to protect the general public by ensuring competent and fit-to-practise health practitioners. The criteria for regulating a health profession are ‘the risk of harm’ that may be caused to the consumers of their services, and ‘public interest’ (Ministry of Health, 2010). The Osteopathic Council of New Zealand (OCNZ) acts as the regulatory authority for osteopaths. It determines osteopathic scope of practise, holds a register of osteopathic practitioners, issues annual practising certificates and oversees that competency requirements are met and more (OCNZ, n.d.). However, only few CAM modalities are regulated, which results in a great variety of CAM health care on offer, by a broad range of health care providers who have unknown levels of education or training. Furthermore, the decision to access their services is left in the hands of the (presumably unaware) consumers (O’Brien, 2004; Parker, 2003), thus safe use of CAM is not assured.

Other examples of ‘the patient–centred models’ have been explored in literature where biomedical practitioners and CAM practitioners work together for the common good of patients. A pilot study conducted in the UK reported by Emanuel (1999), where GPs were referring their patients to osteopaths and other CAM practitioners with whom they shared premises, revealed a measure of success. When CAM and biomedical practitioners worked together a decrease in referrals to the orthopaedic outpatients clinic reduced costs and over servicing. However, this only happened when GPs showed strong interest in osteopathic treatment methods and had developed good communication with the osteopath. Likewise findings were made in a study by Haahr and Launso (2006), who give details of CAM use for Multiple Sclerosis (MS) in co-operation with biomedical practitioners in a Swedish study. Research done in Canada by Hollenberg (2006) produced similar results. In this study CAM practitioners were found to have benefited by increased income, due to patient referrals between CAM practitioners and elevation in status due to the association with biomedical practitioners. However, it was found that GPs in general dominated patient care and the running of the practise, a trend also observed in other studies (Emanuel, 1999; Frenkel & Borkan, 2003; Ben-Arye, Frenkel, Klein, & Scharf, 2008).
Grace and Higgs (2010) maintain that their exploration of Australian patient-centred interdisciplinary clinics revealed participating GPs to be the gate keepers and primary health care providers. They reported that this arrangement was agreeable to all patients, biomedical and most CAM practitioners. Even the Australian government, they claimed, supported such clinics, as it appeared to be the safest option of providing CAM services. The CAM modalities included homeopathy, naturopathy, herbalism, nutrition. The authors asserted that CAM practitioners admitted a lack of knowledge in diagnostic skills. At the same time they conveyed that biomedical practitioners participating in the research, all of who are dual trained, had trust in CAM and equally accepted experiential evidence as evidence based medicine.

A recent Canadian study by Gaboury, Bujold, Boon, and Moher (2009), explored the experiences of 21 biomedical and CAM practitioners from five integrative health care clinics. All of the clinics involved were led by biomedical practitioners, with the exception of one, which had a shared management arrangement. In contrast to the other studies, the authors explain that a downward expression of power from biomedical practitioners to CAM correlated with education and legitimacy status, through professional body regulation and/or formal professional organization. For example, chiropractors and naturopaths appeared to have a more equal relationship with biomedical practitioners than massage therapists, reporting no conflicts when making treatment plans for shared patients, while the latter depended more on biomedical practitioners’ respect for them and referrals of clients. It appears that belonging to a professional, government regulated body gave CAM health practitioners more credibility and seemingly instilled more trust in their abilities than modalities without need of regulation. Another difference from above named studies was that no financial gains were reported the members of the integrated interdisciplinary clinics. On the contrary discussing patients, reading colleagues reports and patients’ files required extra unpaid time. The State health plan, the authors pointed out, did not remunerate or subsidize CAM, making decisions for biomedical practitioners to refer patients to CAM difficult. Furthermore, in Canada the professional body of biomedical practitioners, the College of Physicians and Surgeons, deems interdisciplinary shared practices with sharing of patient information illegal. Patients of such clinics are required to give written consent to overcome
this restriction. These difficulties may not be the same in other countries where legal requirements differ.

Nevertheless, it is interesting to note that despite the greater efforts required in the combined clinics compared to solo practices, most practitioners expressed a preference and great commitment to their interdisciplinary work arrangement. Practitioners from both paradigms conveyed enjoyment of social interactions, an increase of knowledge, benefits of immediate feedback, advantages to patients and exposure to a greater mix of patients. Further details in relation to perceived obstacles to integrations will be discussed later under ‘barriers to integration’.

Shared practices are not common phenomena in New Zealand; however, GPs do refer patients to CAM practitioners. According to Barrett (2003), a 1994 USA surveys of general practitioners’ attitude to CAM proved to be favourable with 60% recommending and referring to CAM practitioners. A New Zealand study in Whanganui found that 80% of 25 participating GPs refer and liaise with CAM practitioners (Taylor, 2003). Although not without its difficulties, the interdisciplinary model may be the most appropriate model to be developed into the least contentious model for integration of osteopathy and other CAM into the biomedical system, as it allows autonomy to be retained. Further studies on the relationship between biomedical and CAM practitioners in relation to shared patient care and pilot studies of interdisciplinary teams in New Zealand, may be a way forward in developing agreeable ways of integration of both paradigms. One area in need of being explored is barriers preventing integration, which will be discussed next.

**Barriers to integration**

**Biomedical attitude**

Despite CAM’s incorporation by biomedical practitioners as part of their treatment, attitudes within biomedicine still vary greatly from country to country and between individual practitioners, from prohibiting biomedical and CAM association to an openness and
embracement of CAM (Ernst, 2009; Garboury et. al., 2009). In Winnick’s (2005) literature review of medical journals from 1965-1999, the historical development of the relationship between biomedicine and CAM provides an explanation for the change from animosity to integration and may offer reasons for the differences in attitudes of biomedical practitioners towards CAM. The author gives an account of how biomedicine and CAM polarized, with biomedicine taking a leading and dominant position in health care. Winnick discovered a pattern of CAM appearance in medical journals from initial obscurity of no mention of CAM, to scorning and degrading of CAM, to an increase of published articles discussing integration of CAM and making it a part of biomedicine. This trend, the author asserts coincides with the growing popularity of CAM. Winnick maintains that biomedical attitudes of embracing CAM as their own secures biomedicine’s dominance of the health care system. This mode of integration and interest in CAM may be a deterrent for CAM practitioners to consider integration into the biomedical model; for fear that the essence of their modality may be lost (Kaptchuck & Millar, 2005). Earlier cited studies of interdisciplinary clinics reveal GPs’ tendency to leadership in mixed settings to be at times problematic, with downward power directed at CAM. Thus biomedical dominance in the health care system may pose as one of the most significant barriers for CAM integration.

**Lack of research**

Although not well founded, during its earlier part of medical history when using chemicals like mercury as medicines, biomedicine claims to be scientific in its approach, and argues that it is now guided in its treatments by evidence based medicine. As the predominant health care system in the West, biomedicine expects CAM to work by the same standards. Lacking the financial resources and support enjoyed by biomedicine, CAM has struggled for years to undertake research to provide scientific evidence of efficacy and safety for its treatments (MACCAH, 2004). External factors such as funding are a consideration of the Ministry of Health and need to be addressed. However, this is by no means a simple issue with questions of who will provide funding and how, to be answered (MACCAH, 2004; Nahin et al., 2005). Additionally, controversy over what constitutes evidence and what does not further fuels the debates (Kaptchuck and Millar, 2005). CAM argue from its paradigm view point with
concepts foreign, not understood and in some cases not measurable by biomedical scientific tools or methods; for example, homeopathy or Traditional Chinese Medicine theory. Unless biomedicine and CAM find a way of gaining an understanding about each other’s paradigms, trust in the efficacy and safety of CAM may remain a barrier to integration in the absence of research evidence.

**Communication and Language**

According to Winslow and Shapiro (2002), a significant number of biomedical practitioners appear to have difficulty communicating with their patients about CAM, due to the lack of knowledge of CAM scope of practise. Dunt et al. (2006) named unawareness of the scope of practice of other health care practitioners is one of the indicators of lack of integration. The different terminologies used by the numerous CAM modalities in contrast of biomedicine pose further problems in understanding and dealings between practitioners from the different paradigms (Caspi et al., 2000).

Anderson (1999) undertook a pilot study involving a panel of an orthopaedic specialist, a psychologist, a Traditional Chinese Medicine practitioner from China, and a body therapist. Each participant discussed their diagnosis and treatment of a shared patient in an open forum setting with the patient and an audience present. In order to communicate practitioners spoke biomedical language with alternative medical practitioners relinquishing concepts specific to their disciplines. CAM and biomedical practitioners agreed on the same diagnosis communicating in biomedical terms of anatomy, physiology and pathology. In conclusion Anderson (1999) summed up that CAM in IM settings may be reduced to basic biomedical sciences when communicating on diagnosis and might “survive in integrated settings,(…), as treatment modalities only”(p 172). Lack of knowledge of scope of practise of CAM modalities and CAM language may be a barrier to integration, as it hampers biomedical practitioners from understanding CAM and limits advice for patients on CAM use and diminishes CAM paradigms to fit the biomedical paradigm.
Summary

Complementary and alternative medicine (CAM) is a collective term used in the literature denoting numerous health care systems that and are not considered a part of the general health care system, the latter term is synonymous with the biomedical system in western countries. Increasing popularity and demand for CAM and its implications within the biomedical health care has given rise not only to intellectual discourse, but also to actions to integrate CAM into the biomedical system.

The expressions ‘integrative medicine’ and ‘integrative medicine’ are used interchangeably in literature and are confusing and controversial. This literature review differentiates theses meanings of integration and distinguishes them as three distinct models of integration discussed in literature. Integrated health care pertains to integration of the existing general health care system, to rationalise health care delivery efficiently, economically and socially. Integrated medicine, it was explained, is interchangeable with integrative medicine and is used by newly emerged, dual trained, biomedical practitioners practicing a combination of CAM and biomedical health care. Both models of integration exclude CAM-only trained practitioners. The third and last model discussed integrative medicine, includes CAM practitioners integrating into the biomedical system and is essentially the only model of integration deemed sensible and of interest to CAM practitioners.

There are two ways the integrative model or integration of CAM practitioners into the biomedical is discussed in literature. One, the way CAM is currently operating within the biomedical system in an ad hoc manner. Interaction with the biomedical system is consumer driven and interactions between CAM and biomedicine are on a need-to base; for example, referral of patients between practitioners. Two, is an advanced integration, involving practitioners from both paradigms working together in an interdisciplinary team model. Research studies of this model are about shared biomedical and CAM clinics examining the working dynamic between practitioners. Findings revealed in the main a dominant leadership role by participating biomedical practitioners. In clinics operating over periods of years this dynamic was perceived as less problematic, as apparent relationships of mutual respect and trust between practitioners of both paradigms developed, when compared with pilot studies.
where biomedical practitioners did not know the scope of practise of CAM practitioners. It was prevalent that a lack of understanding of CAM created difficulties, except for one example where the participating GP was interested enough in building a relationship, which led to greater understanding and trust and better health care outcomes of treatments and reduction of health costs. It was found that openness of biomedical practitioners and understanding of CAM scope of practise led to a more equal working relationship between practitioners with resulting benefits of knowledge of both biomedical and CAM practitioners as well as better health outcomes for patients. Furthermore practitioners of government regulated CAM modalities or with strong professional bodies, for example chiropractors and naturopaths, were more likely to have equal relationships with biomedical practitioners of the interdisciplinary team than modalities with less education like massage therapists.

The Barriers to integration of CAM were listed as attitudes of biomedical practitioners, lack of openness to and knowledge of CAM scope of practise, lack of evidence based research of the efficacy and safety of CAM to suit biomedical standards and expectations. The use of different terminology and concepts of various CAM modalities, for example acupuncture, was said to be a barrier to integration. Contrary findings to most other studies were made by the Australian and Canadian study by Grace and Higgs (2010) and Gaboury et al. (2009), respectively, where biomedical practitioners’ attitudes were said to be no hindrance and good communication between practitioners appeared to overcome language barriers. Knowledge and trust appeared to overcome the lack of research evidence of efficacy and experiential evidence was considered sufficient.

The majority of research on CAM integration into the biomedical system is from a biomedical perspective. Insight into CAM perception of a language barrier and CAM attitudes towards biomedicine is rare and requires further research. This research is a first time investigation into the practices and attitudes of osteopaths in relations to the general health care system. Finding out about how osteopaths perceive integration in light of their own experience with biomedical practitioners and at the interface of biomedical system, is the subject of this inquiry.
Chapter Three - Methodology and Method

Introduction

This chapter describes the methodology and method that was used in this study. The rationale to use interpretive description and two different focus groups for data collection is discussed. Furthermore, an explanation is given of how ethical issues were dealt with. Lastly the measures taken to give the study credibility and trustworthiness or rigor, through audit trail and verification are explained.

Methodology and Method

Study design

A qualitative research method, with an interpretive descriptive approach was used to obtain rich data for analyses in this exploratory investigation. This method uses techniques to identify themes that emerge from collected data (Thorne, 2008). Interpretive description originates from nursing health science and is form of qualitative research to allow the researcher not merely to describe but also to explore, interpret and explain the deeper meaning of what is said and experienced. Interpretive description therefore suits this preliminary investigation into the phenomena of practices and attitudes of osteopaths, to explore if there is a future for further integration into the biomedical health care system (Thorne, Reamer-Kirkham & O’Flynn-Magee, 2004). “Interpretive description acknowledges the constructed and contextual nature of human experience that at the same time allows for shared realities” (Thorne et al., 2004, p. 5). General accepted truisms underpin interpretive description and form its epistemology and philosophy. These truisms, according to Thorne et al. (2004, p. 5), are that “… reality is complex, contextual, constructed and ultimately subjective.” Although
interpretive description is mainly used to explain health/illness care related phenomena, it is also suitable for this study because practising as an osteopath in the general health care system is a complex, shared reality and can be said to be a contextual and constructed individual experience.

Two separate focus groups were used for data collection in this research. Focus groups are a qualitative method used to explore topics where little or no knowledge exists (Redmond & Curtis, 2009). Focus group interviews permit participants to question, agree or disagree with each other’s views. Exposure to other opinions in this setting may provoke thoughts and stimulate discussion that would not occur in separate interviews (Redmond & Curtis, 2009). Focus groups are appropriate because they allow and stimulate discussion on the topic of how osteopaths work in and relate to the biomedical system and provoke participants’ thoughts and opinions on further integration.

Other reasons to use focus groups include when the researcher wishes to observe the group dynamic between focus group participants (Manuel & Kendall-Taylor, 2009; Redmond & Curtis, 2009). However, focus on the group in order to examine individual behaviours, use of language or group dynamics, was not the main purpose of this investigation.

**Sample**

Purposive sampling was used to recruit six participants. This type of sampling is a “nonprobability sampling method in which the researcher selects study participants on the basis of personal judgement about which ones will be most representative or productive” (Polit, Beck & Hungler, 2001, p. 468). Two groups with different characteristics were chosen. One, deemed the ‘academic group’, was composed of Unitec lecturers and tutors, who were also practising clinically at the time of the focus group sessions; and the other called ‘clinical only group’ from the pool of osteopathic practitioners currently registered and practising but not holding an academic role. The reason for choosing the diverse groups was to explore possible differences of views and ideas between the two groups and to see if being immersed in the academic aspect of osteopathy would add a different dimension to the attitude and practice of osteopathy in the general health care system.
Eight lecturers and tutors from the osteopathic faculty at Unitec were approached by e-mail and only three were able to attend, making up group one or the ‘academic group’. An attempt to recruit a ‘clinician only’ focus group from a weekend workshop failed due to lack of volunteers. Ultimately the second or ‘clinician only’ focus group also consisted of three participants and was recruited by personally approaching experienced osteopaths in a shared practice. Although the recommended number of participants per focus group is 6-14, other studies with three participants per group have been conducted (Leung & Savithiri, 2009; Manuel & Kendall-Taylor, 2009; Redmond & Curtis, 2009). After accepting the invitation to partake, all six participants individually received pre-reading material of the MACCAH report 2004, chapter five, participant information forms (Appendix A) and consent forms (Appendix B).

**Inclusion criteria**

Inclusion criteria were based on all participants being registered with the OCNZ, the professional body of osteopaths in New Zealand, had clinical practice experience of at least two or more years in New Zealand, and were able to contribute to the question of practice and attitude in relation to the general health care system in New Zealand. Inclusion criteria for the ‘academic’ group were being employed as a lecturer or tutor on a permanent or casual base, including clinical tutors at Unitec New Zealand, the only tertiary institute in New Zealand teaching osteopathy.

**Exclusion criteria**

Participants with fewer than two years clinical practice experience in New Zealand.

**Data collection**

The first focus group session was held at a convenient location for the ‘academic’ participants at Unitec’s Mount Albert campus in the late afternoon. The second group session was conducted at midday, at the clinic practice of the ‘clinician only’ participants. All participants had the opportunity to revisit copies of the pre-reading material (MACCAH, 2004), participant information forms (Appendix A) and consent forms (Appendix B). Participants were asked to
read and sign the consent forms after being advised of their rights of withdrawal and confidentiality agreement. Recording of both sessions started after a test run of the equipment.

The session was opened with a brief summary of the pre-reading; four out of six participants had read the pre-reading. Further, it was explained that brainstorming and free discussion, not consensus was the purpose of the focus group session (Kitzinger, 1995). A question guide (Appendix C) of six open-ended questions (Redmond & Curtis, 2009) based on the pre-reading material, Chapter five of the MACCAH’s (2004) advice to the Ministry of Health, was used to start the focus group discussion and whenever the dialogue became repetitive or came to an end. The pre-reading was given to enable an informed discussion by the participants; the aim of the question guide was to promote discussion that is deep and rich rather than vague and general. However, the researcher was aware of the importance not to restrict the discussion to the question guide, to avoid loss of valuable issues generated by the focus group discourse (Redmond & Curtis, 2009).

In focus group one a participant volunteered to start the discussion, while in focus group two the first question was addressed to the furthest person from the facilitator (Kitzinger, 1995). In both groups the flow of discussion was free, with participants at times building on what was said before or questioning each other’s statements (Redmond & Curtis, 2009). One group was prompted with all six questions from the question guide, while participants from the other group drove the discussion with little need for guidance.

**Data analysis**

To identify how osteopaths practice in relation to the general health care system and how their attitudes could affect greater integration. An exploratory technique with an interpretive description approach was used as described by Thorne (2008). This technique requires immersion into the data to identify patterns and themes.

Immersion into the data started during data collection and continued with numerous times of repeated listening to the recordings and reading the transcribed discussion. Field notes were taken after the focus group sessions and further notes were made during the transcribing of the
data. These methods helped to group and code ideas or statements, based on their similar meanings, and categorize them into themes and subthemes.

Firstly, the transcribing of the first focus group recordings was attempted by an outsider. However, after months of unsuccessful efforts, due to the poor audibility of the tapes, the researcher took over the transcribing of both recorded sessions. Secondly, the 51 pages, or 21,168 word count, of the combined transcripts were read and re-read to find and colour code, what appeared to be the most significant ‘key statements’ representative of participants experiences, practices, attitudes and opinions in relation to the general health care system. Thirdly, the ‘key ideas or statements’ were grouped, using a ‘cut and paste’ method and were indexed. For example, F1P1p1 stands for a statement made by, focus group 1, Participant 1, on page 1 of the focus group one transcript. Fourthly, the same was repeated with the data obtained from focus group two and “key statements” were grouped according to their similarity with statements from group one. ‘Key ideas or statements’ unique to each group were kept separate for inter- focus group comparisons. Fifthly, the ‘grouped statements’ from both transcripts, were reread and checked for repetition. Sixth, ‘core statements’ were sought from the ‘grouped statements’. During this process eight themes and additional 21 subthemes emerged and the decision that saturation of the topic was reached was made when all relevant concepts had been captured into themes. Seventhly, the emergent themes were discussed with the supervisors and it was decided to do a further sorting of the eight themes and 21 subthemes, using the open pile method, from which the final three themes and nine subthemes and one overarching theme crystallised.

**Ethical considerations**

An ethics proposal was submitted to the Unitec Research Ethics Committee and approval was obtained. Ethical considerations for this study pertain to anonymity and confidentiality, storage and destruction on study materials, withdrawal from the study, and minimization of harm, cultural and social sensitivity.
Anonymity and confidentiality

Due to the nature of focus group research and the obvious sharing of information with other participants, there are different processes to ensure confidentiality. The need for confidentiality was raised in the consent form (see Appendix C) and was a condition of participation. At the beginning of the focus group discussion the need for confidentiality was reinforced by asking participants to keep what was discussed within the focus group.

Participants’ names and information that may identify them are kept confidential. The only persons who will know what the participants have said will be the participants in the focus group, the researcher, principal supervisor of the research project, the person who attempted to transcribe the recordings of focus group one and took notes during the focus group one session. A confidentiality agreement was signed by the transcriber /note taker (see Appendix D). Ultimately the transcription of both sessions was done by the researcher, which as outlined above helped any further risks of loss of confidentiality. Names, practices and geographical locations, which may have identified participants in the transcripts or other text, were changed to numbers or replaced with XXX, to further maintain confidentiality.

Storage and destruction on study materials

All information is stored securely on a password protected computer, hard copies and consent forms are in a locked cabinet at the researcher’s home. After the completion of the research, the data is stored for five years at the researcher’s home in a locked cupboard and then destroyed, in accordance with Unitec New Zealand’s requirements. Printed copies of the transcripts will have been destroyed. The audio computer files and electronic transcripts will also be kept for five years, as per Unitec New Zealand regulations for research projects. After this period of time the computer stored material will be deleted and hard copies destroyed.

Withdrawal from study

After accepting the invitation to partake in the focus groups, participants were sent a ‘participant information form’ (Appendix A), which also advised them of their rights to withdrawal from the study any time up until two weeks after receiving the transcripts. Their
right to withdraw was again reiterated at the beginning of the focus group sessions. No participants from either focus group withdraw.

Due to the nature of the research topic, sensitive information may have been revealed during the focus groups. For this reason the participant received a copy of the transcript from their focus group, to allow them the opportunity to edit or withdraw any or all of their statements from the transcript. Only one of the six participants made changes to type and grammatical errors.

**Minimization of harm**

There is no potential for physical harm. However, there is potential for emotional stress due to the nature of the topic. Minimization of any harm was through guidance and reinforcing that the participants reveal only what they were comfortable with, and the opportunity to peruse a copy of the transcript from the focus group/interviews they attended, as well as to make amendments should they desire.

**Cultural and social sensitivity**

This study has no ethnic cultural focus. However, the information collected did involve views, attitudes and beliefs. This is potentially sensitive information. Participants were given an information sheet and an invitation to participate in the study which describes the study, the purpose of the study, and the future uses of their contributions, thus participants made an informed decision when volunteering for the research (see Appendix A). Furthermore, participants had the opportunity to withdraw up to two weeks after receiving the transcript.

**The question of rigor and credibility**

In qualitative research evaluating the quality of a study is of importance to achieve credibility, trustworthiness or rigor. These two qualitative research concepts, according to Bashir, Afzal and Azeem (2008), replace validity and reliability used in quantitative studies. In this study a clear audit trail and verification are used to ensure rigor.
Cutcliff and McKenna (2003) argue that the use of audit trail as rigor is a weak method because of the nature of qualitative research. Qualitative research is inherently subjective and auditors of data may not necessarily come to the same conclusions as they may lack the depth of background understanding the researcher has. They particularly refer to experienced researchers who are able to grasp themes quickly as they arise from the moment data is collected and where much of the processing takes place in the researcher’s intellectual realm rather than through a step by step process. However, most qualitative research use audit trail as a rigor (Thorne, Kirkham & MacDonald-Emes, 1997) and due to this researcher being a novice, the elements that make up an audit trail are identified to allow the reader to make their own audit judgments in this study. Verification is used as an additional method for credibility and to minimize the risk of bias of the researchers own preconceptions (Grace & Higgs, 2010) through checking and rechecking the original transcripts and by self reflection differentiating between the researchers own opinion and that of the participants, therefore questioning: ‘what is theirs and what is mine.’

Morse, Barrett, Mayan, Olson and Spiers (2002, p. 17) state that “verification is the process of checking, confirming, making sure and being certain”. Constant verification during data collection, processing and analysis took place by grouping similar statements and ideas, which had the same contextual meanings and thus formulated the emerging themes. A vigorous process of checking, sorting and rechecking ensured statements were used within their true and intended context and lead to the quality of the final research products.

Bashir et. al., (2008, p. 40) maintain that “in qualitative research, validity has to do with description and explanation, and whether or not the given explanation fits a given description”. Further rigor was give to this study by quoting participant’s literal statements in the presentation of the findings, thus enabling the reader validate that given explanations fit the descriptions, as suggested above. Other strategies used for credibility, as listed by McMillan and Schumacher (Bashir et al., 2008), are audio recording of the data and member checking of the transcribed data by participants.
Summary

In this chapter the methodology and method used in this research were described. Details of the data collection and analysis were given, thus providing a clear audit trail. Ethical issues and the measures taken to address them were explained. A discussion on credibility and rigor concluded this chapter. In the next chapter the results and data analysis are presented.
Chapter four - Presentation of Findings

Introduction

The following chapter presents the findings from the data of the two focus groups. Six osteopaths participated in two separate focus groups. Group one comprised of three males and had a mean age of 37 years. Group two consisted of three females with a mean age of 51 years. One group is from the academic sector, with all participants being lecturers and tutors. The other group is made up of clinicians only, form a pool of currently practicing practitioners. Unintentionally one group was all male and the other all female and that may limit some conclusions that might otherwise have been able to be drawn. Two osteopaths were trained in New Zealand, two in Britain and two in Australia. The six participants had 4-22 years experience of practicing osteopathy between them, with a mean of 12 years, and 3-22 years of practise in New Zealand with a total mean of 9 years. Two participants are members of the Osteopathic Society of New Zealand (OSNZ). An overview at a glance of participants’ characteristics is shown in Table 1.

Analysis of the discussion revealed the following three themes: ‘Interactions in the biomedical system’; ‘Integrity: being true to yourself’ and ‘Integration’; there were an additional nine subthemes and one overarching theme ‘Towards integration’. This chapter describes the phenomenon of experiences and attitudes, which shape the practises and opinions of osteopaths in relation to the general health care system. From the analysis of the gathered data emerges information, which reveals if osteopaths’ practise and opinions support a future for greater integration into the general health care system.

The first theme, ‘Interactions in the biomedical system’, brings to light how osteopathy occurs in the biomedical system; in what settings osteopaths work, their relationship with
other healthcare professionals and how osteopathy is made known in the health care system. The three subthemes ‘the role of osteopaths’; ‘the relationship with other health care professional’ and ‘promoting osteopathy’ emerged from participant discussions and conveys in greater detail the experiences and interactions osteopaths have in the biomedical system.

In the second theme, ‘Integrity: being true to yourself’, participants reveal that existing within a different medical paradigm to their own put them in conflict with their own beliefs and that of the hegemonic medical system. In the three subthemes: ‘Defining osteopathy’, ‘Fitting into the biomedical system’ and ‘Securing a place in the biomedical system’ the difficulties osteopaths experience are illustrated. Participants convey how they are trying to differentiate themselves from other physical therapies, how they confront problems when endeavouring to fit in and how they identify areas of importance when attempting to prove their worth.

In the third and last theme ‘Integration’ participants explore the prospect of integrating into the biomedical system. Under the subheadings: ‘Opinions on models of integration’, ‘Expanding the role of osteopathy‘ and ‘Concluding thoughts’, osteopaths express their opinions on what integration is not, and what may be acceptable models of integration for osteopaths. It includes further exploration of how osteopaths could further contribute to the general health care system, within and beyond their current scope of practice and lastly participants give some finishing thoughts on the topic.

The overarching theme –‘Towards integration’ is the drawing together of the first three themes with emerging requirements and conditions that would make integration a favourable proposition.

**Presentation of themes and subthemes**

*Interactions in the biomedical system*

As outlined in the literature review, interaction with health care practitioners is an integral part of integration (Dunt et al. 2006, Southern et al. 2002) and refers to the interface where
osteopathic practice encounters other health care professionals. This ad hoc model of integration according to literature already exists in the current biomedical system with practitioners in both CAM and biomedical fields referring to each other. (MACCAH, 2004) In this study participants conveyed how osteopathy is placed in the biomedical system and what osteopaths perceived to be their role, as well as how they liaise and work with other health professionals from both the biomedical and CAM fields. Some interactions with the biomedical practitioners relate to the limitations of osteopaths’ own scope of practise, are usually one way and are mostly perceived as disrespectful by the osteopaths. In contrast interactions with other CAM practitioners are two way and appreciated as respectful and collegial. Participants discussed the low profile osteopaths have in the health care system and promotional activities.

The role of osteopaths

One osteopath claimed that osteopaths are trained to be primary health practitioners, which includes providing first line treatment at times and triaging meaning referrals to GP and hospitals at times (F1P3p10&11). Another osteopath claimed to be practicing as a specialist, addressing a defined group of conditions (F1P2p10). Both agreed that patients choose if they need to seek help in the biomedical sector, which largely negates the role of ‘gate keeper’ usually carried out by GPs. All participants agreed osteopathy’s main responsibility lies in the muscular skeletal field, and had a role to play in rehabilitation, physical exercise and some nutritional education.

As pointed out in Chapter two, patient demand for CAM treatment has brought about changes in hospital policies to accommodate patients’ requests for their CAM practitioners to treat them when in hospital. One osteopath had experience in attending to their own patients in hospital at patients’ request.

“...we often go into hospitals now if patients ask us to(...) nobody bats an eye on it, as long as the parents want you to be there and as long you don’t disrupt what’s going on”(F2P1p15).
This osteopath further claimed that parents of children with presentations ranging from post acute injuries to kidney complaints sought them for osteopathic paediatric care.

Despite some District Health Boards having made changes to hospitals policies, osteopaths related experiences that revealed that the Ministry of Health does not include osteopaths in government instigated health programmes. One osteopath was part of a group of osteopaths who attended a local meeting initiated by the New Zealand MoH:

“…they were doing that central medical thing here XXX and when we went to the meetings it was pretty clear that they were not really considering us to be integrated into that. They don’t consider us as part of their model” (F2P2p5-6).

It appears that the Australian system extends some health care responsibilities to CAM practitioners, not seen in New Zealand. One participant explained:

“…in New Zealand we can’t refer people for time off work, we need to refer to a GP. In Australia as osteopaths we have the right to give them sick notice to up to about seven days” (F2P2p2).

**Relationship with other health care professionals**

Although most osteopaths practise as sole practitioners in the primary health care sector, two of the six participants work as lone practitioners, while four share with other osteopaths. One participant, sharing a practice with eight other osteopaths, told of having monthly meetings and weekly morning case discussions, but found time constraints an issue (F2P1p4). In the past a few participants shared practices with other CAM practitioners; one osteopath had experience of working in a GP practice. It appears that osteopaths on the whole communicate with each other, share patients and information; they also refer to other CAM practitioners, it seems mostly to acupuncturists, while interactions with biomedical practitioners are rare.

All practitioners expressed the view that communication with GPs was mostly scant and that referrals were very seldom directed to a named osteopath and usually without a referral letter,
but rather patients were said to be told to ‘go see an osteopath’. GPs involved in holistic medicine seem to be more likely to refer to osteopaths. However, one participant recounted that in his experience, despite being cognisant of what osteopaths do, they still appeared to refer firstly to physiotherapists.

“...despite he knew and he knew quite well what I did, he still often would refer to the physio first and then to me, even though he knew what I did because I treated his wife quite regularly.” (F1P2p3)

It was claimed that some GPs discourage or outright tell their patients not to go to osteopaths. While other GPs, were said to refer patients only as a last resort, when physiotherapy failed to help.

“They’d[patients] been going to the physio with no effect they’ve gone back after 6 or 8 treatments and said what else and they[GPs] said: “go and see this guy”(...) So, very much a poorer prognosis by the time you see them, anyway” (F1P2p6).

“...from an osteopathic point of view, with situations like that is that with the vast majority of patients. On that time frame they got to the stage where we can no longer help them, either as much or at all, as we would have been able to 6 weeks earlier” (F1P3p7).

This practice, they maintain, is not only of no benefit to their patients, but also gives a wrong message about the effectiveness of osteopathy and its reputation, when patients fail to get well.

Nevertheless, osteopaths perceive it a necessity to have a relationship with GPs when the need for further biomedical input arises, for example referring to a specialist or types of imaging. One participant conveyed this:

“...when there is something that needs to be looked at further, than I refer to GPs. In terms of getting MRI’s or being seen by an orthopaedic
surgeon or being hospitalized, if that’s what is required. (...) So, you need to have a relationship with GPs at some sort of level, they need to respect you” (F2P2p2)

Osteopaths do not seem to believe that GPs on the whole are interested in what osteopaths do, or that they want to have a professional relationship. It was claimed that, unlike osteopaths, GPs act unprofessionally when sharing patients by not adhering to professional protocol such as writing referral letters and being respectful when sharing patients. Osteopaths want GPs to communicate about shared patients, as they do with other members of the biomedical groups, such as medical consultants.

All osteopaths reported making efforts to gain a relationship with relevant GPs, including giving talks to GP groups. Some looked for rooms in GP practices and one worked for seven years in a GP practice, even though it was at a reduced income. The latter resulted in a positive experience where practitioners, from both medical paradigms, had case conferences about patients, shared resources like computers and files, and the osteopaths gained increased knowledge about the patients’ issues and health care pathways in the biomedical system. In the main, osteopaths appeared to feel frustrated by biomedical practitioners’ lack of awareness of osteopathy and their assumptions about what osteopaths do: for example, that osteopaths treat diseases, only do manipulation and are less effective than physiotherapists.

Physiotherapists and GPs appear to be the two health professional groups generating the greatest discussion amongst all of the participants. It is interesting to note that at the same time osteopaths claim to have the least interactions with these two groups of health professionals. While referring patients to physiotherapists and Pilates-physiotherapists for rehabilitation exercises, osteopaths claim that physiotherapists do not refer to osteopaths because they do not know what osteopaths do:

“... I have sent a lot of patients to the physios(...), I have never had a referral back from them and that is in eight years of working here(...). So, people just don’t understand what we do or can’t understand that it is any different from what they do”(F2P2p6).
Physiotherapists, participants observed, have a historical connection with biomedicine (F1P1p14,F1P2p15) and a professional relationship where biomedical practitioners refer to physiotherapists:

“...physios are deemed to be the people that deal with that stuff [physical therapy].” (F2P1p15)

“That referral direction [biomedical practitioners to physiotherapist] has been so established, so that it doesn’t happen any other way, unless you know the person or have a personal relationship.” (F1P1p14)

Participants reported that they occasionally referred to or had verbal communication with sports medical practitioners, radiographers, radiologists, orthodontists, orthopaedic surgeons, paediatricians, midwives and nurses. Still, osteopaths very rarely received written reports from medical specialist or other health professionals in return. One participant shared:

“I spoke quite a lot to her physiotherapist and her private surgeon at the clinic where she got it done. Again it was a one-way conversation” (F1P3p4).

Another participant conveyed the more exceptional experience of receiving a well written report after referring a patient, and felt treated with respect:

“I would write a letter and would get a very good report and sometimes I spoke a couple of times on the phone and that was very polite and very professional” (F1P2p3)

More positive relationships were reported between osteopaths, nurses and midwives. One participant recalled a positive experience with a practise nurse where mutual benefits of patient education and networking with other GP group occurred. However, this experience took place in England and it is not known if such experiences are seen in New Zealand. Still another practitioner recalled respectful treatment by New Zealand hospital nurses when attending to patients in a hospital.
There appeared to be a natural alliance between osteopaths and other CAM practitioners in their attitude and approach to health care, in comparison to bio- and para-medical practitioners. CAM practitioners such as acupuncturists, naturopaths, massage therapists; nutritionists and psychotherapists were named in their interactions with CAM. One osteopath had also liaised with a chiropractor. All participants contributing to the discussion on CAM relationships did so in a positive frame. One participant told about working with CAM practitioners:

“I have worked in clinics that are multidisciplinary, naturopaths, acupuncturists, psychotherapists, so I refer to people like that.” (F2P2p2)

In the context of osteopaths being sent patients as a last resort, one participant thought it a good idea if holistic practitioners would be left to care for patients.

“So, it would be very nice, it would be a very good outcome if we could see those people all the way through, so that they didn’t end up at that point, but that there was cross referral to us by doctors, who realised what we are capable of doing. Instead of giving them a pill, or something, some medication, and then you could get other people on board like naturopaths or acupuncturists. So, there is multidisciplinary team that is dealing on a really holistic level, with everybody treating in agreement, where you actually can communicate with each other, but I have no idea how that would happen. It feels way too hard.” (F1P1p9)

Respect from other health care professionals is an important issue for osteopaths. Osteopaths do not feel respected by the biomedical practitioners; however, they feel respected by their patients. All six osteopaths have had experiences with biomedical practitioners which made them feel a lack of respect. For example, not receiving professional courtesy by being kept informed about referred patients was a common experience. One participant shared their experience of a GP practice not wanting an osteopathic practice in their vicinity. Another
osteopath said not enough credence was given to the profession’s ability to do their professional job. Contrary to that one participant pointed out that respect could not be forthcoming if other health professionals are not cognisant of what osteopaths do.

“You can’t give respect to something you don’t know about. They have no reason to respect us, they don’t know us, they have no idea and there is no interaction. So, why would they?” (F1P2p21)

The importance of respect, one participant offered, is a bigger factor in peoples’ lives than is recognised (F1P1p21). Several osteopaths felt that they received more respect from their patients, and some claimed patients respected them more than they respected their own GPs. One osteopath summed up the importance of respect from other health professionals and patients and what it means to him as follows:

“Respect from GP versus respect from my patients, or other health care practitioners, is important to me when, where its absence compromises my ability to treat my patients” (F1P2p21-22).

Promoting osteopathy

There is recognition by all osteopaths that osteopathy is not well known amongst health professionals. One of the participants stated “if it’s going to change that means that we as a profession have to begin to educate the rest of the health sector [about osteopathy], but again that comes back to time and energy” (F2P1p6).

Two of the osteopaths had given educational talks to groups of other health professionals such as midwives, fertility clinics and GPs. Another maintained that patients are beginning to educate doctors by requesting referrals to osteopaths instead of physiotherapists. The same osteopaths suggested exposure through well written referral letters, using biomedical language that conveys the level of education osteopaths have (F2P2p10). Still another shared having given public talks to women’s institutes, Probis clubs and bowling clubs, which resulted in patients giving feedback to their GPs about osteopaths (F1P1p8). Although some osteopaths have made efforts to give talks about osteopathy, the struggle continues with the
apparently widespread lack of knowledge by biomedical practitioners about what osteopaths do.

The following experience demonstrates the benefit of exposing osteopathy to consumers and health care professionals over time:

“I’ve noticed too over the years, because I have been in practise a long period of time, that some of the top paediatricians in Auckland are starting, instead of saying to patients, who come in with their babies who have been to them, and they have said that we’ve been here (XXX), instead of saying “ahh, that doesn’t do anything”, they are starting to say: “actually that is having an effect on children”. So, some of them, the top people are actually becoming more aware of what we do, and are prepared to acknowledge that, which is pretty good.”(F2P1p7)

Summary
In the main osteopaths work alone or in shared osteopathic practices, in the primary sector as muscular skeletal specialists. They seem to have few interactions with other health care professionals with an apparent disrespectful relationship with GPs, a greater alliance with nurses and midwives and a natural and mutually respectful association with other CAM practitioners. One exceptional experience of a shared practice with a GP and one osteopath resulted in an increase of knowledge for the osteopaths but a loss of income. One osteopath maintained that their long years of working as an osteopath have resulted in persuading biomedical consultants that osteopathy works. Generally osteopaths are not well known as a health care profession, which may be one reason for a lack of ad hoc integration.

Integrity: being true to yourself
The following statement heralds the sentiment of the dilemma felt by one osteopath about the conflicting position osteopaths hold within a biomedical paradigm.
“I think in some ways the profession is caught between wanting that acceptance of main stream medicine and how do we do that by staying true to the actual original principle? Because as soon as we glean, as soon as we kind of give to the bio-medical model it’s almost [as if] we are taking away from what osteopathy is about” (F2P3p7).

In this theme participants discuss the difficulties osteopaths encounter defining themselves as a distinct professional group and working in a different paradigm. The challenges they face as a professional group when trying to maintain their philosophical principles and the expectations held at the same time by the predominant biomedical system are presented. The three subthemes ‘Defining osteopathy’; ‘Fitting into the biomedical system’ and ‘Securing a place in the biomedical system’ explore specific areas of the theme of ‘Integrity: being true to yourself’.

**Defining osteopathy**

Participants’ answers to how osteopathy is different from physiotherapy, revealed that osteopaths themselves were challenged to articulate what osteopaths do, a known phenomenon amongst osteopaths (Grundy & Vogel, 2005).

“... palpatory skills is the defining feature [of osteopathy] that makes the difference (...) understanding quality of tissue was the big deal, and it was for that reason that we were more effective at doing various techniques and tasks” (F1P1p15-16).

Their answers for what physiotherapist do ranged from saying: some of what physiotherapists do is almost identical to what osteopaths do, only they call it something else’ (F1,P2 p 15); to there is some crossover, especially in rehabilitation( F2P2 p 17); to what osteopaths do is different from what physiotherapist do, observable by the outcomes (F2P1p15). Physiotherapists are different to osteopaths, it was claimed, in that they are not holistic or hands on:
“...the hand unit was just treating the hand and not the arm(...)in the way that I have been trained to be walking people up and down things and taking people in and out of pools that just doesn’t appeal to me as an osteopath, you see, I want to work hands on, but that’s the only separation” (F2P2p17).

Being distinguishable from other physical therapists becomes an important issue for osteopathy, when trying to establish its role and exploring new roles within the biomedical health care system. Asked how the biomedical profession could tell osteopaths apart from physiotherapists, one osteopath gave a vague answer of “...what we do is quite different so it would become quite obvious” (F2P1P15). Another participant stated: “One of the defining features of us is that we say what we don’t do, not what we do do” (F1P2p14). Yet another said this:

“When you ask what an osteopath is and the answer is: a disagreement. We still can’t agree on what we do, which is sad and until we can agree on what we do and what we can’t do, and who we can treat and how, then I don’t think we can integrate as a profession” (F1P3p24).

It was argued that if osteopaths were united they would be able to give a standard message, be consistent and have quality assurance as can be observed in large business concerns (F1P2p20).

Despite being unable to articulate what osteopathy is osteopaths seem to have a clear idea about the effectiveness of osteopathy. There is confidence held by both groups, in the quality of the training osteopaths received (F2P1p20, F2P2p10). The high level of education may separate osteopaths from less educated physical therapist like massage therapists. However, what osteopaths do and their level of education it seems, is not well known to other health care professionals or the general public. Said one osteopath:
“They don’t understand how well we are trained (...) they don’t have any concept of the fact that we do pharmacology, the fact that we do pathology, orthopaedics” (F2P2p6).

Fitting into the biomedical system

Osteopathic training enables practitioners to understand the scope of practice of biomedical practitioners, to recognise when to refer patients on to other health professionals and to write letters using biomedical language when communicating with practitioners from the biomedical fields. However, participants revealed conflicts when practising osteopathy in the biomedical health care system and fears of losing the essence of osteopathy. One area identified was the Accident Compensation Commission (ACC).

ACC is New Zealand’s accident compensation scheme since 1974, with a ‘no fault’ policy for personal injury. The scheme moved New Zealand away from a litigious system as seen in Australia and the United States of America (Accident Compensation Commission, 2010). Osteopaths are one of a number of treatment providers as specified under the Accident Compensation Act. ACC bases its rules and regulations on the biomedical health care model and is one area osteopaths in both focus groups identified as problematic on two accounts (Accident Compensation Commission, 2009). Firstly, ACC providers are required to choose corresponding item numbers for body parts treated for acute injuries. This appears to clash with osteopathic treatment principles of treating the body as a whole. One participant described a sentiment shared by all participants, this as follows:

“I think there is a big problem with the whole ACC thing here, really, because of, in the way they are expecting us to treat people and what patients expect of us. How it pans out in actual fact it is really, really hard to do osteopathy. What we would like to do is, we would like to treat the person as a whole and not in terms of applying a technique at the ankle. But in terms of how we can apply osteopathic principles to a particular patient, and not make this distinction that there is that an acute injury, but there is also that old injury, that had an effect on the
gait and the pelvis and the balance and the CT junction and all of those things. I don’t know but this may take us away from where we are actually going” (F2P3p19).

The other area of concern osteopaths pointed out is that ACC’s allocated maximum of 16 osteopathic treatments, for any given acute injury, is open for misuse by patients and practitioners. While ACC gives patients, who otherwise cannot afford to see osteopaths, accessibility to osteopathic treatment, participants claimed that patients insist on treatment even after their presenting problem is resolved. Furthermore, it seems practitioners are caught in the dilemma of treating patients holistically and what might be seen as over servicing. Participants point out, where osteopathic practitioners take advantage of the system by extending the number of treatment unnecessarily, false statistics may cloud the effectiveness of osteopathic treatment. Still, one participant maintained that osteopathic treatment is a cheaper option to other more expensive intervention, such as pharmaceuticals or surgery.

One participant expressed concerns of having to compromise if further integration happens:

“With integration, we have to be so careful if we are going to be part of a biomedical model (...), it is actually getting worse. It is so prescribed, that is if we get PHO funding for example, where it’s so prescribed what we can do, we lose who we are. But then the whole way of the health sector becomes more and more standardized, somehow as osteopaths we have to find a way to fit into that, otherwise we going to go back to the dim, dark ages where we are practicing in paddocks or something...or we are seen as people that are just totally fringe” (F2P1p19).

Another osteopath responded that they would rather ‘working in the paddocks’, or being marginalized, than lost the principles of osteopathy, as practising osteopathy without its principles would not make any sense (F2P3p19).
Throughout the discussions osteopaths from both groups expressed concerns of losing osteopathy in several different contexts. Two participants commented on GPs and physiotherapists learning manipulative techniques on short courses, maintaining that osteopathic principles and its holistic approach would be reduced to application of techniques for treatments only. Educating doctors about osteopathy it was suggested may lead to doctors “adopting what is inherently ours and a watering down of osteopathic principles” (F2P2p7). Even research into how osteopathy works was seen as a possible way of losing osteopathy “...because once it [osteopathy] has been demonstrated, it doesn’t belong to anyone anymore, it’s just physical therapy anyone can do it” (F1P2p2). Still another participant believed that wanting to be acceptable to biomedicine conflicted with maintaining osteopathic principles.

**Securing a place in the biomedical system**

All participants agreed that evidence of efficacy is required to justify a place for osteopathy in the general bio-medical health care system. Efficacy, it was agreed, needs to be shown in the form of research: “You can only show the data I guess I don’t know if there is any other way” (F1P20p16). Although participants agreed that more research was needed, there was disagreement about what type of research is appropriate or needed.

Some participants believed that quantitative research was synonymous with what the bio-medical system found acceptable and required for ‘evidence based practice’, but others thought it inappropriate for studying osteopathy.

“We need to do the research that suits osteopathy. Not the research that biomedical model and mainstream medicine supports” (F2P3p21-22).

Contrary to that view another osteopath states:

“...the profession has to start to do major research, that’s evidence based and fits the model of what the bio-medical world needs, and that’s a lot of funding and time and energy as well” (F2P1p7).
Another osteopaths saw case studies as ways of “testing osteopathic potential” expressing disappointment that the bio-medical model did not accept “individual case studies as valid research” (F1P3p16). Yet another questioned why case studies should be acceptable: “Why would we want them to accept case studies, because it is hard to do other forms of research?” (F1P2p16). Talking about technique studies one osteopath found:

“...the problem is, we break it down to manipulation or to a muscle energy technique or we put them into smaller microscopic intervention that isn’t osteopathy, it’s an aspect of osteopathy” (F1P1p17).

In response one osteopath pointed out that technique studies had their place as:

“...they tell us about mechanisms and they tell us about whether they support those core ideas or principals we have, (...) but I don’t give a stuff how it works. All I want to know is that it works and that it is safe” (F1P2p17).

Proper description of outcome measures was suggested should be part of osteopathic training, so improvements could be clearly noted “I know it’s improved so why don’t I say: ‘it’s 30 degrees, it’s now 90 degrees’. They could do this, they can’t do that?” (F2P2p17). Another commented “we need to keep the records to show the effect we are having and we don’t, we are too busy” (F2P1p20). One participant from the academic group believed that outcome studies are what ultimately counts as significant:

“it’s measured in long outcomes, the measure is not immediate. And you return to work and if you weren’t working before, you know it’s like: ‘did you put a tax return in last year? No, because I wasn’t working. Did you put one in this year? Yes.’ Now that counts as an outcome. But one point better on a 10 point scale after an hour treatment, no, nobody cares about that. The ministry cares about the big chunky stuff” (F1P2p18).

All participants agree that funding was a major barrier to be able to conduct research:
“You can get other people interested; you just need to get the money. So, where does the money come from? You have to compete for it.” (F1p2p17)

It was suggested that skills for writing applications needed to be developed and that writing case studies could be a way of starting to learn such skills.

One osteopath expressed an opinion that osteopathic students were conducting research only because of course requirements and was something ‘to get over with’. Furthermore support needs to be given by the educational institution to students and post graduate practitioners “and if we could come to an understanding to what would be more supportive, then maybe more osteopaths would afterwards be more inclined to follow up on research” the participant concluded (F2P3p23).

Two clinicians related that major osteopathic research was done since the 1950’s, but it was claimed they were published in unknown osteopathic journals and needed to be published in journals like the Lancet. A current research done by Jane Carreiro, on osteopathic treatment of otitis media, was perceived as ‘trail blazing’, but had not met “the right criteria, they didn’t have the right protocols in place” (F2P1p21-22).

To be acceptable to practise in the biomedical system CAM practitioners also need to practise safely. The safety of osteopathic treatments, one participant claimed, was assured by two government agencies. One, the Health and Disability Commissioners Act, it was believed, reveals osteopathic treatment to be safe through the lack of reported complaints.

“I mean there are guidelines where they can tell how safe we are as practitioners. It is in my understanding so far, we are one of the safest professions around, in terms of people physically treating people.” (F2P1p20)

Another way of protecting the public and assuring safety, this practitioner maintained, is the second government regulation and agent, the Health Practitioners Competency Assurance (HPCA) Act, with the Osteopathic Council of New Zealand (OCNZ) as its regulating body,
which all practising osteopaths are required to register with. OCNZ sets standards on level of training, scope of practice and stipulates ongoing professional development, to assure competency and safe practise of osteopaths (OCNZ, n.d.)(F2p1p20).

Two practitioners believed that safe practices were the criteria for passing the final clinical competency (FCC) exams and overseas osteopaths to be accepted into OCNZ exams. The current high standard of education is required to enable much needed research and skilful practice. However, despite osteopaths’ faith in their high level of education, concerns of keeping the present benchmark were expressed by the ‘clinician only’ group. They feared that curriculum changes and cuts to the length of the course from the existing five to four years may be imminent and may be disadvantageous to osteopathy as a profession (F2P1p20, P2p10).

While educational standards, proof of efficacy and safety may fulfil biomedical requirements for acceptance, representation of osteopathy at a government level was raised by one osteopath. The same participant strongly advocated that without recognition of the importance of a professional society, which lobbies for osteopathic interests, osteopaths will miss out on funding from agencies such as ACC and will end up not having a voice. It was claimed that there was not enough support for the Osteopathic Society of New Zealand (OSNZ).

“Actually it[OSNZ] is in crisis at the moment and unless more people join or we get more money from somewhere, it’s going to stop and osteopathy is going to disappear down the drain, because unless we have a strong lobby group nothing is going to happen. And people sit on the fence are saying “It’s not going to affect me” [...]It is going to affect them. It’s going to affect any benefit that we get, any funding that we get, we could lose it. ACC, if we don’t lobby hard and make them realize what we do” (F2P1p6).
Summary

Osteopaths disagree on what osteopathy is or what osteopaths do, thus find it difficult to articulate or define osteopathy to differentiate themselves from other physical therapies in the biomedical system. Government agencies such as ACC appear to threaten the integrity of the holistic approach of osteopathy by expecting rules, based on the biomedical paradigm, to be observed by CAM ACC providers such as osteopaths. Participants disclosed that patients, from lower socioeconomic groups, and their practitioners find themselves in the potential situation of misusing ACC service, as this may be the only way for them to access osteopathic treatment. Furthermore, it was pointed out that unjustifiable overuse of ACC may result in incorrect statistics about the efficacy of osteopathic treatment. Osteopaths fear the undermining of osteopathic principles in a number of ways. For example, if they have to adhere to rules of the biomedical system that diminishes what osteopathy is. The biomedical system requires its values of ‘evidence based practice’ to be observed by health care professionals who want to be acceptable to the biomedical system. Osteopaths recognise the need to increase research into efficacy and safety of osteopathic treatment to prove their credibility as health care professionals and to fulfil these criteria for acceptance. Participants believe in the high standard of osteopathic education and in their ability to communicate with biomedical practitioners using appropriate medical language, thus fitting into the biomedical system. One osteopath advocated the support of the OSNZ, for representation of osteopath at a government level. It is of great important to osteopaths to maintain their integrity as a health profession, as without it osteopathy cannot exist. If integrating means losing osteopathic principles, integration does not make sense. However, because osteopathy’s survival depends on someone or something else’s acceptance of osteopathy, to remain within the system certain undertakings such as research, education and adaptation of osteopathic practise, to fulfil the standards of the biomedical system have to happen.

Integration

The definition of integration is controversial and has been the subject of many other studies covered in the literature review, chapter two. It is not the purpose of the focus groups to define integration further, instead osteopaths have been asked to make a case for or against
integration of osteopaths into the biomedical system from which the following subthemes emerged: ‘Opinions on models of integration’; ‘Expanding the role of osteopathy’ and ‘Concluding thoughts’.

Opinions on models of integration

As mentioned above, in the literature an ad hoc integration has been described, including patients choice of practitioners and referral of patients between biomedical and CAM practitioners and so on (MCCAH, 2004). Still, half of the participants dismissed this model of integration. One participant believed that ‘building a greater relationship with other health care practitioners is different from integration (F1P3p20). While yet another osteopath felt that communicating with GP by letter was not enough to be considered as integration (F2P3p3). Similarly another stated:

“... when I write to a doctor, and ask for a review of a patient, and he writes back saying: ‘good job done carry on’ and he sends two more patients, because I sent that one to him, that is just part of the referral network” (F1P2p8).

Acceptable models of integration emerged from participants’ past experiences and discussions and included: working in shared practises with GPs sharing resources, patients and case conferencing with the GP (F1P1 p 20). One participant offered an idea of how an interdisciplinary, patient-centred model could work as follows:

“Practitioners of all kind would be working together for the greater good for the patient and whatever that patient needs, is what that patient gets. And it might not involve the osteopath or the acupuncturist; it might involve a whole other therapist and an exercises program, or whatever, (...), it would be a group decision. All practitioners involved in that patient’s care would make a decision for the betterment of the patient. It would have to be set up where there is a case review day. Every week you would sit down with the patients’ files and you would have a group discussion what happened
for that patient. And that patient may come to the acupuncturist first, or the osteopath first or the doctor first. And if it’s indicated that they need something else, it’s discussed and the group as a whole decides what would be best for that patient” (F2P1p25-26).

This was said to be in an ideal scenario, however, one osteopath had reservations, pointing out that the patient’s wishes did not appear to be included, which they saw as a weighty component. It was suggested that computer technology could be a means to share patient information in the future to overcome issues of time restraints (F2P1p4).

**Expanding the role of osteopathy**

Osteopaths were shown a list of the 13 health goals of the New Zealand Ministry of Health (see Appendix E) and asked to discuss what role they could see osteopaths play in attaining them. A distinct difference was observed between the two groups on this subtheme. The ‘academic group’ of osteopaths perceived their scope of practice in the main to be limited to muscular skeletal issues, with giving some advice on physical exercise, nutrition and maybe education on obesity. Expansion into other areas, apart from rehabilitation, were said to require monetary incentives and some further education, which could be acquired as part of the general osteopathic curriculum, professional development or weekend sessions.

“…my current skill in addressing these is fairly limited, although some of them wouldn’t take much to get up to some kind of practicing level (....) but practicing these things in my environment in my suburban clinic is quite another thing to practicing these in a DHB funded clinic, you need to work within these environments to be valued, you need to be useful in them, you need to be trained in them” (F1P2p13-14).

In contrast, the ‘clinician only’ group saw great potential for osteopathy to be addressing the health goals, which also lead them to theorize about practising in a lot of different areas and settings. Child health from infancy to school health were mentioned, with osteopaths playing
a role in preventing muscular skeletal developmental issues acquired from birth, from poor postural habits and sports injuries.

“I think it would be really good to have osteopaths in schools and work with the children in schools” (F2P3p14).

“I think osteopaths could do a check on kids, once a year or something so we can check that they are developing musculoskeletally properly” (F2P1p14-15).

It was claimed, osteopathy had already proven to be effective in treatments of conditions such as otitis media (F2P1p11-14). Other areas like pre-and post surgical care, visceral problems and palliative care; post radiation- and chemotherapy treatments, osteopathy was said to have application for (F2P1p12).

Due to the length of time taken over the general osteopathic consultation, practitioners believed this put them in a better position than GPs to build trusting relationships. One clinician revealed that a mother had brought her daughter, who was experiencing mental health issues, to her seemingly based on such trust. Although, this practitioner stated, this was not the scope of practice of osteopaths and thus the patient had been referred on, this demonstrates the trust patients develop in their osteopathic practitioners, and in this context, she believes, osteopaths could play a role in areas of suicide prevention (F2P2p13). Another clinician thought that the length of time spent, and the trusting relationships between practitioners and patients, had a psychological therapeutic effect, within which patients have the opportunity to talk freely. Again it was acknowledged to be a side benefit of the consultation and not the purpose of osteopathic treatment to counsel patients, and referral to appropriate sectors was undertaken if the patients required it (F2P1p13).

Osteopaths expressed their agreement that osteopathy would have great application in the hospital setting. Yet, osteopaths theorised that because of the strong hold physiotherapists have in hospitals, osteopaths would not have a chance of working in hospitals:
“Their senior practitioners ... that have all the qualifications... they are the heads of their departments and I come along and say: I can do these sorts of manual handling approaches supported by biosocial research. They say: ‘oh, that’s good, because you wouldn’t get your foot in here anyway. And by the way we do all that and I have all my in house training around that, some of these areas. So what do you bring?’ I’m not sure what I bring. The stuff that they don’t have is the stuff I haven’t got evidence for, and so they say: ‘until you have evidence for it, I don’t want to see it anyway’. ”(F1P2p15)

Concluding thoughts

All osteopaths agreed that there is no benefit for osteopaths to integrate in the biomedical system, but believe it would be beneficial for patients. One osteopath suggested that it would give osteopaths a change to prove their worth (F1P1p21). While another added “it could be for us, if it could happen in a way that supports who we are and what we do”(F2P1p24). Most osteopaths think that integration into the biomedical system is a long way off. One osteopath in the ‘academic’ group put forward that osteopathy and other physical therapies will be merged at the tertiary level, before integration can happen:

“I reckon the chiro, physio, manual therapy, osteopaths will all be shaken up into something generic, prior to the opportunity for osteopaths to get into the DHB funded model, because that will take quite a long time. (...) Because all it will take for integration is some dean, in some faculty some boss of some university to go: you know what this PT Dip course and this manual manipulative therapy and this one over in some uni, some tech funder, some government funder is going to go, ‘you know what: this is mad, let’s put them all together, figure it out, that’s the way we are going to fund you now’. It could happen as easily as that. It’s more likely than the other. It will
happen before the other, before they are integrated separately” (F1P2p2).

Summary

Osteopaths think that other than for patients, integration is not beneficial, unless the integrity of osteopathy is respected; they believe integration is a long way off. Participants rejected the ad hoc model as integration; all but one participant accepted the interdisciplinary patient–centred model as an acceptable model for integration. Half approve of sharing with a GP, as experienced by one participant, as another model of integration. The academic group was ambivalent about expanding the role of osteopaths to address the Ministry of Health’s health goals and believe more education is needed, while the ‘clinicians only’ group see great scope for osteopathy in the general health sector including child screening programs, palliative care, pre- and post- surgical treatment, visceral health and so on. All osteopaths agree hospitals to be a good setting for osteopaths to work in, but perceive the historical strong hold of physiotherapists as a barrier. One idea emerged that osteopathy would become generic with other physical therapies at a tertiary level, before integration could happen.

The overarching theme – Towards integration

The overarching theme embraces all that has been revealed through the above themes and coalesces into prerequisites for integration. Throughout the focus group sessions, osteopaths expressed thoughts on what changes would need to take place to make integration feasible. Participants indentified five main prerequisites for integration of osteopaths into the biomedical system: being recognizable and distinguishable, change of attitudes of biomedical practitioners, appropriate changes to the biomedical system to include osteopathy, funding for an interdisciplinary model and adequate remuneration for osteopaths.

The ‘academic’ group noted that osteopaths need to be more recognizable, with a very high profile and suggested two ways:
One

“The way that osteopathy will integrate itself into the current allopathic model is for large groups of osteopaths to get together in one place, to have centres of excellence of muscular skeletal health care” (F1P1P20).

Two

“I think the necessity is for osteopaths to establish their niche… the physios kind of nailed the sports market … The chiropractors have that spinal alignment thing sorted out, maybe even that wellness idea going … we have that cranial-paediatric thing perhaps working in our favour, at the moment, people talk about cranial osteopathy. Midwives refer to cranial osteopaths; I get a lot if I do cranial osteopathy so there is a niche there, potentially” (F1P1p22).

A need for change of attitudes by biomedical practitioners towards osteopaths was demonstrated by the experiences osteopaths shared. Participants claimed that GPs still think osteopaths are ‘quacks’ and one gave an example of a biomedical practitioner who had given a physiotherapist credit for work an osteopath had done:

“I had a report back from a specialist recently saying that of somebody that was seen [by] an osteopath and a physio and then saying that the physio seems to have helped. You know, and that’s quite clear to me what that’s suggesting” (F2P2p5).

Animosity from an adjacent GP’s practice; GPs asking testing questions about what osteopaths treat; reports of referral letters being binned without even being opened; and failure to keep osteopaths ‘in the loop’ about patients’ ongoing treatment after referral, are some of the experiences shared by the participants.
The desirability to include osteopaths in policy making in an integrated system appears to have emerged, as restrictive rules and regulations pertaining to the biomedical paradigm may clash with osteopathic practice and principles:

“If integration was to happen than we will have to meet certain rules and regulations, which are not how we actually practise. Osteopaths do not practise treating one little part of the body” (F2P1p8).

One osteopath added that changes by osteopaths and biomedical professionals was a prerequisite for integration, and surmised that this could result in a paradigm shift in health care with the development of a completely new medical model (F2P3p8). Another osteopath stipulated that a shift to health rather than illness had to happen and the biomedical hierarchical system would have to change too.

“…until we stop looking at disease and the formation of diseases, and start looking at wellness and maintaining wellness then I think we’re going to struggle. But, it would require the health organisation of the system, to turn on its head and for nurses to be considered more important than surgeons (...) what health care should be aiming at is the base of the pyramid” (F1P1p13)

All participants agreed funding was a big important issue to be addressed. Funding for the time needed for interdisciplinary teams to meet and case conference patients,

“…an interdisciplinary approach it would need to be funded. This group, this ideal group needs to be funded by somebody, and everybody that participates in that group and meetings would need to get paid.”(F2P3p26)
Also the amount of money osteopaths would earn in an integrated system was of concern to participants. It was said that earnings need to reflect recognition of skills and training. As one osteopath stated:

“If the DHB or PHO would consider using osteopaths within that kind of framework, one of the first questions asked by osteopaths would be: ‘How much are we going to be paid?’” (F1P3p12-13)

**Summary**

Participants identified five prerequisites for a plausible integration of osteopathy into the biomedical system. One, osteopaths are in need of lifting their profile to be identifiable or ‘have a niche’ in physical therapies. It was suggested that osteopaths should work in large centres and become known for their excellence in muscular skeletal treatments; two, change of attitudes by biomedical practitioners towards osteopaths and a need for inclusion in policies by the biomedical system; three, a paradigm shift in health care, where both biomedical practitioners and osteopaths undertake changes with a focus on prevention and change to the current biomedical hierarchical system; four, giving osteopaths recognition for their training and skills by paying osteopaths no less than they earn now; five, funding for an interdisciplinary team to work.

**Summary**

In this chapter finding from data collected from two focus group sessions has been presented. Three osteopaths in each group provided the data, one comprised of lecturers and tutors from Unitec New Zealand, the home of the only osteopathic course available in New Zealand. The second group consisted of three clinicians not involved in teaching osteopathy at the time of the interview.

From the experiences, opinions, practices and attitudes of the participants in relation to the biomedical system concepts influencing integration into the biomedical system emerged. Exploring future possibilities of integrating osteopathy into the biomedical health care system
can be divided into: Interactions in the biomedical system, to see if integration of osteopaths occurs at the present; how osteopathy exists in the biomedical system without losing its integrity; and attitudes and opinions osteopaths have about Integration.

Interactions in the biomedical system can involve the role osteopaths perceive they have in the health care system, what settings they work in, who they interact with and professional relationships they have with other health care professionals. How well known osteopaths and osteopathy is in the health care system can influence to what degree these interactions take place. Interactions thus may be a determinant of how much osteopaths are integrated into the biomedical system.

Integrity of osteopathy is important when having to work in a different ideologically based paradigm to its own. Thus it is of important for osteopaths to be clear when defining their own principles and who they are, so they are able to convey what osteopathy is to other health care professionals and consumers of health. To further integrate osteopathy has to be differentiated from other physical therapies to know how it may fit in. Fitting into the biomedical system is met with difficulties when the principles of osteopathy clash with the expectations of the biomedical system. Compromising osteopathic principles of holism, may lead to loss of integrity of osteopathy and also loss of diversity of health care. Securing a place in the biomedical system by meeting standards required by the biomedical system such as education and prove of efficacy is not enough for integration to be acceptable to osteopaths. Changes to the biomedical system to include osteopathy and preserve its integrity are also needed.

Integration to osteopaths means interdisciplinary, patient-centred health care or a setting where GPs and osteopaths share premises and resources, patients and patient information. Exploring an expanding role of osteopaths gives an indication to what other areas osteopaths potentially may contribute to in the general health care system. The concluding thoughts of osteopaths reveal that osteopaths are ambivalent about integration. They recognise benefits for their patients but see benefits for osteopaths only if certain prerequisites are met.
In this chapter it has been ascertained from the collected data what some osteopaths’ experiences are in the biomedical system, how they practice and their opinions on further integration. In the next chapter literature on CAM integration into the biomedical system are compared with the findings of the research data in this chapter.
Chapter Five-Discussion

Introduction

In this chapter the results of this research are compared and contrasted with findings in other literature and discussed in terms of what they mean, why they are the way they are and how this matters in relation to further integration into the New Zealand biomedical system.

Review of the findings

Although the findings of this research are not generalisable, this study shows that osteopaths’ experiences, practices in and opinions of the biomedical system are congruent with and reflect other research studies findings on integration of CAM into the biomedical model. The overarching theme, ‘Towards integration’, strongly indicates that integration is not a viable proposition without some changes to the status quo of osteopathy in the current biomedical system. In chapter four, three distinct areas emerged in relation to integration into the biomedical system: ‘Interactions in the biomedical system’, maintaining the ‘Integrity of osteopathy’ and opinion of osteopaths about ‘Integration into the biomedical model’. Each of these areas indicates that some changes are required for osteopathy to further integrate into the biomedical system.

Discussion

This research investigated whether there was a future for osteopathy to further integrate into the biomedical system. The findings suggest that osteopaths, although currently not well integrated, may have potential for integration in accordance with MACCAH’s recommendation 16:
“Where evidence of safety, efficacy and cost-effectiveness of a CAM is inconclusive but has potential, research should be undertaken into the contribution that the CAM may make to the New Zealand Health Strategy outcomes” (MACCAH, 2004, p53).

The following discussion aims to look at how the experiences, practices, attitudes and opinions of osteopaths in this research relate to MACCAH recommendations for CAM integration and findings of other literature and research.

**Current integration of osteopaths in the general health care system in New Zealand**

Ad hoc integration, as explained in chapter two, exists in New Zealand with practitioners from the CAM and biomedical fields referring patients to each other, as well as patients choosing CAM practitioners as part of their health care providers (MACCAH, 2004). Ad hoc integration in the context of patients choosing osteopaths clearly exists, as osteopaths work in their own clinics with their own clients, including one osteopath’s experience of several patients’ requests to see them in hospital. However, from the aspect of interactions with other health professionals it appears that osteopaths are currently not well integrated into the general or biomedical health care system in New Zealand in an ad hoc model of integration.

**What makes a practitioner integrated into the general health care system?**

As discussed in chapter two, according to Southern et al. (2002), the characteristics of an integrated GP are interacting with other health care professionals, liaising, communicating, knowing the scope of practice of other health professionals and having an understanding of available health services to refer patients to. The current study found that osteopaths rarely interact with other health care professionals and it seems there is an underdeveloped
understanding of the complexities of the health care system. For instance, participants discussed referring patients to GPs, some interaction with consultants, physiotherapists, practice nurses and midwives. This, however, leaves out a huge number of other health professionals and health services available to their patients such as district nurses, specialist nurses, occupational therapists, NASC, Plunket as well as other health services and the health programs that they provide.

**Why this matters to osteopaths**

Osteopathy claims to be holistic and holds the belief that man is not only the sum total of his parts, but of body, mind, emotion and spirit in a particular social and environmental setting (Bell et al., 2002; WHO, 2010b; Tyreman 1999). Thus, all of these factors need to be considered when treating patients. Holism explained in terms of the systems theory, life consists of systems within systems, is discussed in the osteopathic teachings (Tyreman, 1999). The human being consists of body, mind and emotion. The body consists of systems and is influenced by emotions, which are created by the mind. The mind conversely is influenced by the wider environmental systems and so on. According to Bell et al. (2002), holistic delivery of health in the system theory involves the use of all available health services necessary to provide the best outcomes for the individual patient. Therefore, for osteopaths to practice truly holistically, in accordance with their own philosophy and principles, they must have knowledge of the general health care system, liaise and communicate with other health care professionals about patients. Most importantly they need to involve these other systems, services and health professionals where indicated, as part of their patients’ treatment plans.
Reasons why there is a lack of ad hoc integration

Language and communication barriers

Opinion papers such as Caspi et al.’s (2000) or studies similar to Anderson’s (1999), claim communication to be a problem between CAM and biomedical practitioners and pose a barrier to integration. In contrast to other CAM modalities such as acupuncture, homeopathy or ayurvedic medicine, osteopathic principles are based on human sciences that are part of biomedicine. Furthermore, apart from their own osteopathic diagnostic methods, osteopaths use the differential diagnostic approach used in biomedicine. Although osteopathic treatment approach is, according to the participants of this study, different to that of physiotherapy, many of the treatment techniques appear to be in common. Therefore, communicating and liaising with biomedical practitioners should not present a problem.

Biomedical attitudes

The findings of this study appear to indicate that osteopaths make efforts to liaise with other bio- and paramedical practitioners, as named above, and want to have recognition and acceptance by the biomedical profession. However, their aspirations do not seem to be reciprocated. Experiences of osteopaths suggest that the attitude of biomedical practitioners may be one of a number of possible reasons why interactions are rare and mostly one way. According to participants the attitudes of biomedical practitioners range from discouraging patients from seeking osteopathic treatment to referring patients as a last resort. Osteopaths convey scenarios of apparent disrespectful behaviours by biomedical practitioners towards them and perceived refusal to engage in professional discourse about patients. These kinds of attitudes, by biomedical practitioners towards CAM practitioners, are also found in other literature. Attitudes range from campaigns against CAM, for example as expressed in an opinion paper by Ernst (2009) as described in chapter two, to findings in pilot studies and observational studies of shared integrated clinics, where GPs build cooperative professional and personal relationships with CAM practitioners, including osteopaths (Emanuel, 1999; Gaboury et al., 2009; Haahr & Launso, 2006; Paterson & Peacock, 1995).
Cohen et al. (2005) surveyed 1961 GPs with 636 respondents, of average age 49.3 years, with 67% from capital cities. The authors explored the attitudes of GP’s towards CAM integration into general practice in Australia. A number of 564 GPs responded to the question whether GP’s discourage patients from using CAM. Twenty one percent of GPs actively discouraged patients from using osteopathy, compared with 16% for chiropractors. In contrast 15% of GPs actively encouraged patients to seek osteopaths and 2% of GPs referred patients at least daily or weekly to osteopaths over the period of the last 12 months, compared with 3% referring to chiropractors. Unfortunately no reasons were offered for any of these responses. Although no similar study has been done in New Zealand, the survey by Cohen et al. shows that osteopaths’ experiences of GPs’ negative attitudes are not isolated incidents, but are also balanced with referrals from GPs, the latter a seemingly rare experience for participants in this study.

**Cost effectiveness of osteopathy**

Participants believe that GPs’ habit of referring patients to physiotherapists rather than osteopaths, even when they know what osteopaths do, was partially due to their historical relationship with physiotherapists. However, another reason for referral may be the cost factor to patients.

A systematic review of cost effectiveness of CAM treatments for lower back pain, in the UK by Canter, Thompson and Ernst (2005), compared five studies, involving one of chiropractic and three osteopathic manipulation treatments, and one study of acupuncture. The authors conclude that although the cost per quality adjusted life years (QALY) was favourable for three out of five studies, when compared with other NHS funded treatments; the benefit of spinal manipulation had questionable clinical significance. Conversely, Licciardone (2007) maintains that studies in the USA showed that spinal manipulation is not only more cost effective, but significantly more beneficial in pain reduction than placebo and equal to non-steroidal pharmaceuticals, but without the side effects. The author points out that spinal manipulation was not only restricted to osteopaths, but included chiropractors and physiotherapist in the quoted research. Whether cost effectiveness is in fact a reason why GPs refer patients more to physiotherapists than osteopaths in New Zealand and is a
contributing factor to lack of osteopaths’ ad hoc integration, is not the scope of this research, but is of interest to the osteopathic profession and the MoH and requires further investigation.

**Osteopathy’s profile in the general health care system**

Cohen et al. made further findings that 19% of GPs did not feel confident to discuss use of osteopathic services whereas only 5% were unfamiliar with chiropractic practice. The reason for this may be because osteopathy is less known to GPs than chiropractic. The lack of understanding of what osteopaths do, what their educational foundations are and their treatment outcomes may lead to a lack of trust and respect. As one participant said: “You can’t give respect to something you don’t know about. They have no reason to respect us, they don’t know us, they have no idea and there is no interaction. So, why would they?” (F1P2p21).

The current research revealed that osteopathy might not be a well known health care profession in the general health care system, despite some effort in promotional activities. For obvious reasons, not being known makes it impossible for biomedical practitioners to refer patients to osteopaths. Additionally lack of knowledge about CAM practitioners and their scope of practices by biomedical practitioners is a common finding of other research studies (Frenkel & Brokan, 2003; Hollenberg, 2006; Winslow & Shapiro, 2002). This deficit of knowledge by biomedical practitioners is not only limited to CAM practitioners, but as indicated in chapter two is an identified problem of GPs integrating into the general health care system (Dunt et al., 2006), which further complicates the issue of interacting with GPs for osteopaths as health care professionals in the biomedical system.

**Defining osteopathy**

Not being known may pose the greatest issue for osteopaths in ad hoc or other forms of integration. Participants agree that osteopathy is a holistic and a hands-on physical therapy with special palpatory skills, meaning being able to feel body tissue qualities, from which they draw conclusions towards a diagnosis (Liccaridone, 2007). However, osteopaths in this study appear to have great difficulties in defining and differentiating osteopathy from other physical therapies, in particular physiotherapy. According to one participant, being unable to
agree on precisely what osteopathy is and what osteopaths do, is a long standing argument among osteopaths.

A British study by Grundy and Vogel (2005) identified what they label as three models of osteopathy: the ‘Scientific osteopathy model’, the ‘Osteopathic purity model’ and ‘Osteopathic prescribing model’. Each model has its own core values. The ‘Scientific model’ is forward looking believing that osteopathy needs to grow and progress, it values scientific evidence based practice; perceives osteopathy as complementary to biomedicine and is ready to embrace what advances efficient health care delivery. The ‘osteopathic purity model’ treasures the teachings of the old osteopathic principles, believes osteopathy is a drug free and alternative to biomedical health care, therefore capable of an independent health care delivery and biomedical scientific evidence research is not suitable for the osteopathic holistic medicine approach. Lastly, the core values of the ‘osteopathic prescribing model’ are that osteopathy is defined by its epistemology, is alternative to biomedicine, some drug use is complementary to osteopathic treatments and the founder of osteopathy, A. T. Still, its founder is held in high esteem.

Grundy and Vogel (2005) comment that this level of diversity ill serves a relatively small professional group like osteopaths, when trying to survive within the biomedical mainstream. The three described models of osteopathy clearly demonstrate the diversity of opinions osteopaths have about what osteopathy is and may be the reason why osteopaths in this study were unable to articulate neither a concise definition of osteopathy nor give a rationale of how it can be differentiated from physiotherapy. Defining osteopathy it seems is closely related to the integrity of osteopathy, the ability to clearly articulate what osteopathy is therefore of great importance.

Being distinguishable from other physical therapies as a unified health profession matters in a diverse health care system, especially in the context of further integration, to be able to determine where and how osteopathy fits into the health care system. In the USA, where osteopathy is accepted as part of mainstream medicine, according to Licciardone (2007), osteopathy also needs to differentiate itself better, but from biomedicine. Furthermore, osteopathy in the USA is said to be primary care and practitioners also use osteopathic
manipulative treatment (OMT). This is distinct from osteopathy in New Zealand where osteopaths work in the primary sector using OMT, but primary care is the domain of GPs. Licciardone’s and the current study’s findings suggest that defining osteopathy is an intrinsic long standing problem independent of being integrated into the biomedical system and needs to be addressed by the osteopathic profession everywhere.

According to Hollenberg and Muzzin (2010) and Kaptchuck and Miller (2005), an ad hoc model, where health practitioners co-operate with each other is the best model for CAM modalities, because they maintain their autonomy. In the USA osteopathy has a long tradition alongside biomedicine, which gives osteopathy an advantage over other CAM modalities and physiotherapy, a phenomenon not occurring in other countries where osteopathy is practiced. In New Zealand, osteopathy may find itself in a more challenged position when competing with other CAM and physical therapists for recognition by other health care professionals and clients. The seeming lack of ad hoc integration of osteopaths in New Zealand, due to their invisibility and anonymity in the general health care system, may be more than disadvantageous for the development of the profession and, as discussed above, for osteopaths to optimally practice according to their own osteopathic principles of holism.

However, at the recent held August 12th-14th Osteopathic conference in Auckland, the OSNZ put to its members a ‘Draft Vision & Strategic Plan 2011’ for discussion and approval (Osteopathic Society of New Zealand, 2009[sic]). The Strategic Plan puts forward, amongst other, a commitment to market osteopathy to the public and relevant government agencies. It aims to unify the osteopathic profession, develop an osteopathic profile and promote the benefits of osteopathy as a health care service.

Another OSNZ activity, which was initiated in 2011, includes representation as a participating member of the Allied Health Practitioners Association Forum (AHPAF) (V. Tate, personal communication, August 12, 2011). The purpose of the AHPAF is: to raise the profile of allied health professionals, develop reciprocal relationships and be a voice for AHPAF with relevant heath sectors, government and its agents; give advice to the MoH; provide a forum for discussion, share information and resources; educate, raise awareness of health issues and promote professional standards of members of allied health (Allied Health
Professionals Associations’ Aotearoa New Zealand, 2011). These undertakings may herald promising changes for osteopathy, of making it more visible and recognizable in its future relationship with the general health care system.

**Difficulties when working in an ad hoc integrated way**

Institutions unique to New Zealand such as ACC, as this study shows, provide challenges to the integrity of osteopathy. Osteopaths are balancing the integrity of osteopathy’s holistic approach with the rules of the general health care system, which affect them particularly as ACC providers. Although there are few studies on the difficulties CAM practitioners experience as holistic practitioners in the general health care system, compromises made by CAM at the expense of the integrity of their own modalities can be observed in studies such as those of Anderson (1999) and Hollenberg and Muzzin (2010) and are discussed by Kaptchuck and Miller (2005). Thus the experience of osteopaths in this study is not unique.

As long as the New Zealand government bases its health policies exclusively on the advice and opinion of the biomedical profession, as pointed out in chapter four, osteopaths and other CAM practitioners alike may find themselves in the potential situation of misusing ACC and similar services. Osteopathy, it emerged, may be accessible to low income earners only through ACC. Misuse of ACC, one participant pointed out may lead to false statistics of the efficacy of osteopathy, which is of concern to the osteopathic profession. Greater inclusion of osteopaths and other CAM practitioners in health policy making, where they are involved as providers, could eliminate this problem. The osteopathic profession thus requires representatives, a professional society agreeable to all osteopaths, to represent osteopathic interests and views. Furthermore, some sort of government funding for osteopathic treatment would allow low income earners access to osteopathic services.

**Beyond ad hoc integration into the general health care system**

Despite ad hoc integration being accepted as a model of integration by researchers, participants of the ‘academic group’ in this study reject the notion. The findings reveal
integration into the biomedical system means interdisciplinary, patient-centred teamwork to osteopaths in this study. Nevertheless, recommendations of MACCAH for further integration clearly state the requirements of evidence of efficacy, safety and contribution to New Zealand’s health goals (MACCAH, 2004).

**Osteopaths’ contributions to New Zealand's health goals**

The MACCAH (2004) suggest that an approach to each of the 13 health goals may involve one or more of the following interventions: prevention, early intervention, treatment and relief. Contribution of CAM in palliative care was one area of the health strategy, namely ‘reducing the incidence and impact of cancer’, that was explored by the MACCAH, because:

“CAM has also been used to alleviate symptoms related to chemotherapy and radiotherapy, as well as to provide comfort from the disease itself and increase the quality of life of patients who otherwise may despair through methods that promote relaxation, reduce stress and anxiety, relieve pain and other symptoms, and improve sleep.” (2004, p. 58)

As mentioned in chapter two, the osteopath Janine Leach (2008), narrates her participation in palliative care of a patient with gastric cancer, successfully providing pain relief. However, there do not appear to be any studies on how CAM practitioners do or could participate in the health goals of the Ministry of Health.

When asked how osteopaths contribute or could contribute to the 13 MoH population health objectives (Appendix D), the ‘academic group’ agreed on being party to the following goals: some nutritional advice and encouraging physical activity, but they were ambivalent about wanting to contribute more without further minimal training and remuneration. The ‘clinician only’ group, however, believe they already offered help in nutritional improvements, obesity, increased levels of physical activities, reduce incidence of cancer by maintaining general well being and reducing the incidence of cardiovascular disease. They also think that as osteopaths they are in an advantageous position to indirectly prevent suicides because of the trusting relationships they build with their clients and see application of osteopathy in preventative child health. However, there does not appear to be any formal
proposal for participating in the health goals of the MoH by the osteopathic profession. In view of the MACCAH recommendations, but also the growing shortage of health care professionals (Smith, 2008) investigations into how osteopaths can greater partake in addressing the MoH health goals may help understand how to best employ osteopaths as health care professionals in the biomedical system.

**Safety and efficacy**

The data shows that some osteopaths believe that the safety of osteopathic treatment is assured by the HPCA act 2003 in conjunction with the OCNZ and the Health and Disability Commissioner. However, the function of these institutions is to monitor the complaints of patients and deal with the complaints of medical misadventure of osteopathic and other health provider services, they do not assure safety of osteopathic treatment (Health and Disability Commissioner, 2009; MoH, 2010). To evaluate safety and efficacy of osteopathy research is required.

**Osteopathic research**

Osteopathy’s first long term research into osteopathy in the cranial field was undertaken by Louisa Burns in the early 1900’s. The 1940’s saw other osteopathic researchers Stedman Denslow and Irvine Korr, making contributions to the understanding of the mechanisms of osteopathic manipulative treatment (OMT) that have become well-known to the osteopathic profession. OMT is the treatment of somatic dysfunction. The definition of somatic function is: ‘impaired or altered function of related components of the body frame work (somatic system); skeletal, arthrodial and myofascial structures, and related vascular, lymphatic and neural elements.’ The clinical applications for the findings of OMT mechanisms by the 1940’s researchers, although evolving, are still poorly researched (Licciardone, 2007). Licciardone points out that the relationship between somatic dysfunction and disease, if any, has also not been well researched; he stresses the need for urgent longitudinal studies into the natural history and epidemiology of somatic dysfunction.

Nevertheless, as mentioned earlier studies that have been conducted into OMT and lower back pain have shown its effectiveness in pain reduction. Liccaridone (2007) states that
research into the diagnosis of chronic diseases including diabetes and hypertension through osteopathic palpatory skills is significant and may be what differentiates osteopathy from other physical therapies. Otitis media in children and carpal tunnel syndrome are also expected to show promising results of the efficacy of osteopathy (Liccaridone, 2007). Licciardone also strongly advises concentrated research effort into the relationship between the mechanisms of OMT and its clinical application to prove efficacy and the uniqueness of OMT, which may secure a place in the biomedical system. There is some research, which clearly supports the efficacy of osteopathy and ongoing research is required. However, what is unclear is how much research is required of osteopathy to be acceptable for further integration into the biomedical system and if the areas where efficacy is proven are areas osteopathy can make a greater contribution in another than its current setting, for example hospital settings.

**Issues relating to osteopathic research**

All participants agreed that more research is necessary to assure the biomedical profession of the efficacy of osteopathy and to secure a place in the general health care system. Findings in this study identify several issues surrounding research in osteopathy. One is a lack of funding for research projects; another is suitability of research methods for osteopathy, and still others skills and interest in doing research.

**Funding of research**

Dependent on government budgets or financing from interested parties, funding seems to be a problem for research projects in general. Osteopathy is one of many contenders for research government grants and only skilfully written grant applications have a way to succeed over other applicants. Therefore it may be wise for osteopaths and their educational institutes to focus on developing these skills, as suggested by the ‘academic group’. The MACCAH (2004) suggests government funding for CAM modalities suitable for integration, significant contributions by osteopathy to the MoH health goals may add to an incentive for governments to direct more funding to osteopathy.
The literature review of this thesis reveals collaboration in some research projects between osteopaths and biomedical practitioners (Emanuel, 1999), albeit that the aim of the research was to explore integration of CAM into the biomedical model. However, collaboration in other scientific research with biomedical practitioners may be cost saving and advance research in osteopathy. Ben-Ary’s (2010) study of dual-trained physicians as mediators of CAM integration found that 42% of dual–trained biomedical practitioners were interested in research teamwork with CAM practitioners compared to 15% of non-dual trained GPs with P<0.0001. Research into New Zealand’s dual–trained biomedical practitioners and other biomedical practitioners’ attitudes, in collaborating with osteopaths in scientific research, would shed light on the feasibility of cost saving and may increase the osteopathic research base.

**Appropriate research methods for osteopathy**

The ‘clinician only’ group is divided between: doing “major research, that’s evidence based and fits the model of what the bio-medical world needs” (F2F1p7), and doing “the research that suits osteopathy. Not the research that biomedical model and mainstream medicine supports”(F2P3p21-22). The ‘academic group’ debated what the most acceptable form of research may be. One participant suggested that outcome research may be the most appropriate research method as “it’s measured in long outcomes (....) the ministry cares about the big chunky stuff” (F1P2p18).

While there is much written about lack of CAM research not fulfilling biomedical expectations and requirements for evidence based practice, little is offered to find a solution to this apparent problem. Bell et al. (2002) examine the differences between CAM and biomedicine and why biomedical research applied to CAM modalities may only give weak results for CAM efficacy. The authors maintain that CAM’s philosophically based diagnosis and treatments are inseparable. For example, one of the basic osteopathic principles taught by A. T. Still, is the belief that the body is a dynamic, functional unit, which is self regulating and self-healing (WHO, 2010b). If a patient were to present with lower back pain, an osteopath might examine the neck and reach a diagnosis of dysfunction of a joint in the neck, which when treated might resolve the presenting lower back pain. Furthermore, included in
the diagnosis are the patient’s environments that may be the causative factor for the presentation. “Research designs that ignore the diagnostic approach of a given CAM system,” according to Bell et al. (2002), “can achieve only weak tests of the intervention program’s ability to benefit the patients” (p. 135).

Outcomes research enquires about the end results of particular health care practices and interventions and includes the patient’s perception of the outcome. This research method may not only satisfy the MoH, as suggested, but also, the scientific approach to research sought by biomedicine. When thoughtfully designed, outcomes research may best suit osteopathy with its holistic approach.

**Prerequisites for further integration**

Prerequisites and barriers to integration could be seen as two sides to a coin. Some of the findings of this study suggest what osteopaths may want to change before integration is a viable proposition for them. Some of these changes are similar to the barriers to integration found in other studies, which were discussed in chapter two. A first time osteopathic perspective is conveyed in this chapter and included changes of attitudes of biomedical practitioners, research, and communication and language issues. Other needed changes osteopaths identified are: appropriate changes to the biomedical system to include osteopathy and adequate remuneration for osteopaths, which will be examined next.

**Needed changes to the biomedical system to include osteopathy**

This study made findings that primary sector reforms by the New Zealand Ministry of Health (MoH), does not include osteopaths. Gauld (2008, p 110) confirmed similar findings in his article and maintains that “while the Labour government anticipated a reduction in medical dominance of primary care delivery, doctors and their organisations continue to drive the new PHOs”. The Labour government, under the leadership of Helen Clark and the Green Party recommendations, appointed Dr David St George as a chief advisor on integrative medicine. The chief advisors role is to “provide professional leadership, direction and advice on complementary and alternative medicines (CAM), and on their integration with conventional healthcare, particularly primary care and long term conditions” (MoH, 2008, p.13). However,
little is publicly known about the advisor’s activities, which according to the ‘Briefing to the
Minister of Health’ includes exploring models of integration of CAM, and being a
spokesperson for the Ministry of Health on matters concerning this topic (MoH, 2008). It
seems that any activities of CAM integration into the general health care system in New
Zealand are very much at their early developmental stages. How any future changes may
affect osteopathy is not known. Nevertheless, the MoH’s inclusion of other forms of health
care delivery would avoid,, as one participant feared, a more standardised health care system
with less diversity; as pointed out in chapter two, a concern also shared by Kaptchuck and
Miller (2005).

Wanting greater inclusion begs the question what contributions can be expected of osteopaths
in different settings. Greater visibility in and interactions with the biomedical system may
place osteopaths in a better position to be included in the primary sector and perhaps other
sectors. This study suggests that osteopaths may be able to make greater contributions to the
general health care system. Liaising with the Ministry of Health’s chief advisor for
integrative medicine, in respect to how osteopathy can contribute to New Zealand’s Health
strategy, could be an aim of the profession for the future.

**Adequate remuneration for osteopaths**

Some osteopaths in this study believe that a decrease of their earning potential would drop to
physiotherapist levels if integration into the biomedical system became a reality. Physiotherapist annual income in 2006-2007, was estimated at about ten thousand dollars less
than with osteopaths’ average yearly income for the same period, according to ‘Jobs and
Tertiary Education Indicator Tool’, at the Department of Labour New Zealand website (n.d).
Osteopaths agree that a decrease to income would be a barrier to integration. However, with
a limited national budget the MoH must justify health cost with health outcomes. In other
words health services and health providers are expected to prove their worth. One way for
the osteopathic profession to do this is to demonstrate efficacy of osteopathy.

To justify a different pay from physiotherapists, osteopaths have to be able to differentiate
themselves from other physical therapies. Research into techniques, which differentiate
osteopathy from physiotherapy and a comparison study between physiotherapy and osteopathy, were mentioned by participants and may provide a rationale for this prerequisite.

Summary

In this chapter findings of this study were discussed, compared and contrasted with literature on the topic of integration of CAM into the biomedical system. The current poor ad hoc integration status of osteopathy, was discussed and possible reasons why were explored using the findings of this study and other literature and research. The difficulties participants of this research experience working in the biomedical systems are compared with other studies outside of New Zealand. Further integration into the biomedical system, beyond the ad hoc integration model, was debated with consideration to the MACCAH recommendation for integrating suitable CAM modalities. This included discussions on research issues surrounding osteopathy, with a brief description of the development of research in osteopathy and difficulties associated with the lack of research. The appropriateness of certain research methods was argued. Lastly, a discussion on what osteopaths perceive as a prerequisite for further integration considered the rational of the preconditions.

Although some recommendations were given in this chapter, in chapter six, implications and recommendations for the profession, limitations of the study concluding thoughts, are presented.
Chapter Six-Limitations-Recommendations-Reflection

Introduction
This chapter points out the limitations of this research and the implications the findings have for the profession. Recommendations for education, to the professional bodies and to individual osteopaths as a way forward are made to improve the status of osteopathy in the general health care system. Possibilities for research to further this topic are proposed. Lastly reflective thoughts for this dissertation complete this chapter.

Limitations of this research

Study design
This research was a qualitative exploratory study into an un-researched area. It is field based on experiences, practices, attitudes and opinions of a small sample of purposively selected osteopaths and therefore cannot be generalised across the osteopathic profession in New Zealand and elsewhere. However, the interpretive description approach to the research design was appropriate for this dissertation, because it allowed the researcher to explore, interpret and explain the deeper meaning of what was said and experienced by participants practicing in the general health care system. Furthermore, despite this limitation comparisons of the results of this study with similar existing literature showed parallels could be drawn.

Focus groups
Several possible limitations were identified with the use of focus groups. Firstly, to recruit people and to arrange a suitable time for all members of the group is difficult, especially when drawing from a relatively small pool of osteopaths such as the ‘academic’ group, who are
asked to participate in numerous other research projects. This resulted in the small numbers of three participants per group. However, as mentioned in chapter three, there are other studies which have been conducted with only three participants. In conclusion, despite the small numbers of participants constituting the two focus groups, the desired stimulated discussion within the groups did take place, which could not have been achieved with individual interviews. Secondly, the dynamic between members, especially if they know each other, may deter some participants from fully disclosing their opinions. In this study participants were encouraged to partake equally by having questions directed at them where necessary. Thirdly, taping the group discussion may present with difficulties of unclear recordings due to people speaking on top of each other or to each other at the same time. Acoustics of the room, speaking unclearly or unforeseen disturbances of outside noises may also result in poor quality recordings and loss of data when transcribing. Although some words were lost through the above encountered problems, the meanings of the content were not diminished. Fourthly, purposive selection of osteopaths from two different areas, namely from the academic sector and the clinical sector to possibly achieve opinions from different aspects of osteopathy, were limited by the fact that one group unintentionally was all females and the other all male. It is impossible to say whether the differences of opinions in some instances were because they were of different gender or the different areas, therefore limiting the conclusions than may otherwise have been possible to draw.

The researcher

Conducting focus groups was a new experience for this researcher. The inexperience of the researcher may have failed to extract a depth of answers seen with experienced researchers. However, it appears that the use of focus groups and its accompanying benefits of stimulating thoughts and discussion provided for a rich and comprehensive data collection in this study. For similar reasons, the depth of data interpretation may have suffered, but for the guidance from the supervisor whose help ensured that all areas were covered.
Implications and recommendations for the profession

As previously discussed for further ad hoc and integration into the biomedical system to occur certain changes have to happen. Hence, the findings of this study have implications for the educational institute of osteopathy, the professional bodies and individual osteopaths.

Education

Unitec New Zealand provides the educational programmes for osteopaths and is therefore able to select the right personalities for osteopathy, who truly believe and adhere to osteopathic principles, and who are able to further the scientific research needed to prove efficacy of osteopathy. Unitec is in a position to recruit highly qualified lecturers to convey the osteopathic philosophy and to employ research fellows to conduct high quality research. Unitec is the centre for osteopathic research in New Zealand and can therefore direct a concerted effort to produce the relevant research projects that the biomedical system is asking for. At the same time, the sensitive issues around choosing the best research methods to suit osteopathy can be considered.

Furthermore, the research department may be able to invite and provide academic support for osteopathic practitioners, who might be interested in conducting or publishing a research, by offering a post-graduate research module. Moreover, liaising with other educational departments or institutions of other health professions, both CAM and biomedicine, to do joint research projects, may also be more cost effective and help to further research in osteopathy. However, to support ongoing important research osteopaths may also have to consider paying a research levy as part of their registration fees.

For osteopaths to practise in accordance with their own philosophical approach of holism, they need to interact more with other health care professional and tap into the health services available to their patients. Therefore, it might be advisable for Unitec and other osteopathic educational undertakings, such as peer groups for Continuous Professional Development (CPD) organised by the OSNZ, to include a thorough introduction into health services available in the general health sector, to inform of their function and how osteopaths can make the best use of them for their patients. It is common practice for student nurses and staff
nurses of Auckland hospital to spend time with district nurses and other health services, to familiarise themselves with the community services available in the primary sector. Including a day visit to community services and inviting guest speakers from these services may also be of interest to osteopathic students. Greater interaction with these services as mentioned in chapter five, may not only enhance the holistic health approach of osteopathy and develop osteopaths as health professionals, but may also make osteopaths more known and integrated. In turn resulting superior osteopathic health services will attract the attention of consumers and other health care professionals.

**Professional bodies**

Professional bodies include the regulatory and societal organisations. These organisations are connected with osteopaths internationally and New Zealand wide. Therefore any undertakings requiring input from all osteopaths here and overseas, makes the involvement of the professional bodies pivotal. The need for having a niche and being identifiable in the biomedical system, was one of the findings of this study and needs to be the focus for osteopathy in New Zealand and worldwide. Therefore, establishing the uniqueness of osteopathy to secure an identity as a health care profession, for further integration into any of the two discussed model, is of utmost importance and requires a strategy for marketing and consideration of how osteopathy can contribute to the wider New Zealand goals.

**Strategies for marketing**

Participants suggested that large osteopathic centres of excellence may be a way forward in creating an identifiable image of osteopathy in the community and health sectors. Creating a type of osteopathic franchise or trade mark that is recognisable everywhere, could be the start of a talking point. An aggressive, coordinated and united marketing plan has to be developed to bring osteopathy out of the shadows and into the limelight of the public and other health care professionals. A think tank of motivated, innovative and creative osteopaths and appropriate other agencies, for example, advertising consultants, to formulate a short and long term advertising campaign to convey an identifiable image of osteopathy is required. Although the issue of marketing has been addressed in the recent August OSNZ conference in
Auckland (Osteopathic Society of New Zealand, 2009[sic]), with a proposed strategy plan, undertakings are still at their developing stages and involves only a small number of participating osteopaths. Financial constraints due to low membership numbers may be a stumbling block for timely changes to take place. The collective of osteopaths may need to pay a levy, possibly as part of their registration fee to finance such a venture. However, the monetary outlay for a combined advertising campaign should be financially rewarding for all osteopaths. Further developments on this topic may be the subject of a future research.

**Contribution of the 13 population health goals of New Zealand**

The findings of this research revealed that some osteopaths believe that they are already contributing to New Zealand’s health goal; others thought a small additional education would enable osteopaths to expand their skills to participate. Contributing to the 13 health goals could gain greater recognition in the general health sector and develop osteopaths as health care professionals. Both professional bodies could discuss if and what health goals osteopaths could address as part of their scope of practice and liaise with relevant organisations to find out how to support this. The professional bodies might then consider to make a formal proposal to the MoH, on how osteopaths can contribute to New Zealand health strategy.

**Individual osteopaths**

**Holistic health care beyond the consultation room**

Individual osteopaths already in practice may find it beneficial to contact community health services or their DHB, to familiarize themselves with health services accessible to their patients through direct referrals from osteopaths and learn about their patient referral procedures. Where osteopaths practise in large shared clinics arranging for a guest speaker from such services could be perhaps a part of their professional development.

**Addressing the 13 health goals**

Participating in the 13 health goals shows that osteopaths care about the health of the New Zealand population and want to take initiative as part of the wider group of health professionals. Osteopaths may find that participating in addressing the 13 health goals can be
as simple as providing pamphlets in their clinics or referring their patients on to appropriate services. The anti-smoking campaign conducted by biomedical health care professionals, for instance, involves a few routine question about the patients desire to quit smoking and followed by handing them a pamphlet with the phone number of the quit-smoking line. To find out more about the New Zealand’s health strategies a visit to MoH website or a phone call may be all the initiative that is required.

**Research**

Recruiting osteopaths for research projects from a small pool of osteopaths can be time consuming for the participant and difficult for the researcher. The demand for evidence based practice is made on the osteopathic profession to produce relevant research. Osteopaths are notoriously busy people. However, incorporating a contribution to research projects, of time or financially, by including it in their yearly business plan is of utmost importance for the development of osteopathy.

**Further research**

There are no other studies like this research that investigate the experiences, practises, attitudes and opinions of osteopaths in relation to the general health care system, to see if further integration is plausible. One study into this phenomenon is not enough to understand this complex issue, which has many related areas that can be researched. These areas include investigating what model of integration osteopaths find most suitable; comparisons of osteopaths’ relationships with other health care professionals; exploring contributions to the New Zealand health care strategies; cost effectiveness of osteopathy, comparison studies between osteopathy and physiotherapy; investigation of best research subject to prove efficacy of osteopathy; exploring most appropriate research methods for osteopathy; how best to encourage and support post-graduate research project for practicing osteopaths; opinions on working in large osteopathic clinics; opinions on shared research projects with biomedical practitioners and other health care professionals; and pilot studies of shared practice with biomedical practitioners.
The current study has revealed that osteopaths may be presently not well integrated into the general health care system, as has been described in the ad hoc model of integration discussed in chapter five. A comprehensive study into the views of osteopaths and how they work in the general health care system may be the subject of a quantitative research project to find out the existing integration status. Investigation into how well osteopaths are known in the general health care system may help confirm the findings of this small study.

Research into how Whanau ora, as mentioned in chapter one, is integrated into the biomedical system and how it interacts with biomedical professionals may reveal an integrated health care model unique to New Zealand. How osteopaths relate to other CAM practitioners like those of Whanau ora may crystallize an acceptable integration model into the biomedical system to osteopaths in New Zealand.

**Reflective thoughts**

This small study raised some questions of how well osteopathy is integrated in an ad hoc fashion into the general health care system in New Zealand. Other questions of how well osteopathy is known and identifiably within the health care system have also emerged and appear to be a major issue when interacting, liaising, communicating and referring patients between biomedical and osteopathic practitioners. Not being well integrated into the current ad hoc model of integration has different implications for the osteopathic profession then being integrated beyond ad hoc. Integration beyond an ad hoc fashion means to osteopaths in this study, to work together in an interdisciplinary model, with biomedical practitioners in different settings than the primary, or in a shared GP practices. This raise the questions if osteopaths can consider being integrated in an interdisciplinary model before being first more integrated in an ad hoc fashion? Other health professionals and the MoH may need to understand what the osteopathic role is and how this may be expanded in the health care system to enable further integration. How are osteopaths going to best lift their professions profile as a health profession, to promote osteopathy’s uniqueness and differentiation from other physical therapies? Can osteopaths truly work in a holistic way without greater
communication, interactions, knowledge and use of other health care services and programmes? These are questions the profession needs to ponder and resolve to develop further in the health care system.

Greater integration into the general health care system according to the MACCAH, as mentioned and discussed in chapter one and five, requires evidence of efficacy, safety, cost effectiveness and the ability to contribute to the New Zealand health goals. Thus to further integrate in an advanced way of integration has different implications. The question is do osteopaths aspire to integrate further? This small study seems to suggest that osteopaths do not perceive any advantage for themselves to further integrate; however, osteopaths believe that their patients may benefit from such developments. Findings of this research suggest that osteopaths believe they are more effective than physiotherapists, have a consistent record of save treatments and are a cost effective service compared with other treatment options. More research, they agreed, is needed to confirm those claims. But what type of research suits osteopathy, how much and what areas need to be covered requires further investigation?

Findings indicate that osteopaths are excluded by the MoH and the biomedical profession when implementing new health strategies. Although it appears that osteopaths may be academically and clinically competent to contribute to the New Zealand’s health goals, the questions remain if the profession as a whole wants to participate and how such a proposal could be made to the MoH of New Zealand? It appears that when considering integration of osteopaths into the existing ad hoc model or with an interdisciplinary team work model, osteopathy first and foremost needs to be distinguishable and identifiable as a unique health profession within the general health care system.

**Summary**

This chapter pointed out the limitations of this research which relate to the nature of qualitative studies and the small number of participants preventing generalisability; limitations that may occur when using focus groups and when research is conducted by an
inexperienced researcher. Implications and recommendations were discussed in regards to education, the professional bodies and individual osteopath. Furthermore, the need for further studies is explored. Reflective thoughts on this study’s findings concluded this research project.
References


Ministry of Health. (January 2010). *How do we determine if statutory regulation is the most appropriate way to regulate health professions? Discussion document*: The Ministry of Health PO Box 5013, Wellington, New Zealand.


Winslow, L. C., & Shapiro, H. (2002). Physicians want education about complementary and alternative medicine to enhance communication with their patients. *Archives of Internal Medicine, 162*(May 27).


Appendix A

Participant Information Form

<table>
<thead>
<tr>
<th>Preliminary investigation of attitudes and practices of New Zealand osteopaths in relation to the health care system: does the future hold a greater degree of integration with the bio-medical health system?</th>
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</table>

I am a student of the Masters Degree of Osteopathy at Unitec New Zealand and I am inviting you to participate in a study concerning the osteopath in the primary health care setting. The aim of this research is to explore the practices and attitudes of osteopaths in regards to the general health care system and to see how this may relate to a greater integration with the bio-medical system. I hope to achieve this by:

- Identifying the factors that influence the opinions, attitudes and practices of osteopaths in regards to the general health care system.
- Explore how osteopaths liaise with other health practitioners in the primary and other health care sectors.
- Investigate what osteopaths think of integration with the bio-medical system.

**What is requested of you?**

To participate in a focus group discussion with 3-4 other participants. The session lasts approximately 60 minutes, but please allow for 90 minutes. You are invited to share your opinion and experiences on the above named topic. Refreshments will be provided during the discussion.

**What is a focus group?**

A focus group is a group discussion coordinated by an interviewer, which is designed to obtain perceptions on a topic. In this research the groups will be comprised of 4 to 5 osteopaths in clinical practice and/or working in education in the field of osteopathy. The focus groups will be recorded and the conversation will be transcribed. A copy of the transcript from the focus group you participated in will be sent to you on request. You will
have the opportunity to review, edit or withdraw any of your statements from the transcript for up to two weeks following receiving it.

**What happens to the statements?**

The transcripts will be analysed to illustrate the current views of educational and practising osteopaths towards relationships with the general health care system. The resulting dissertation may also be used for future purposes as part of a journal article and presentations at a conference or an osteopathic educational institute. However, your identity will be kept confidential in any outputs from the study.

**Who will know what you said?**

Only the other participants, the researcher, one assistant, the transcriber and the supervisors will be familiar with the full transcript, though short excerpts and quotes, using your pseudonym, will be used to illustrate themes in the thesis. Your name and information that may identify you will be kept confidential. All information will be stored securely on a computer and in securely held hard copy for 5 years.

**What do you have to do to participate?**

If you are able to attend the agreed place, date and time you will be invited to participate in the focus group. Agreement of participation includes agreeing to hold in confidence what is said in the focus group session. You will sign a consent form. The consent form and 12 pages (chapter 5) of pre-reading, from a longer government document, on the topic of ‘integration of complementary and alternative integration with the bio-medical system’ research will be sent to you. You may access the full document at [http://www.newhealth.govt.nz/maccah/MACCAHAdvice.pdf](http://www.newhealth.govt.nz/maccah/MACCAHAdvice.pdf)

**What are your rights?**

Signing the consent form does not stop you from changing your mind if you wish to withdraw from the project, however, due to the research schedule any withdrawal of data must be done within 2 weeks of receiving the transcript.

If you need more information or you have any concerns about this research project you can contact the principal researcher Lily Rose or email lilyr@slingshot.co.nz or alternatively you may contact the research supervisor Dr Elizabeth Niven phone 815 4321 ext. 8320 or email eniven@unitec.ac.nz.

**UREC REGISTRATION NUMBER: (2009-1025)**

This study has been approved by the UNITEC Research Ethics Committee from 5.12.2009 to 5.12.2010. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 6162). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix B

Thank you for agreeing to participate in this research project being undertaken for the Master of Osteopathy programme at Unitec New Zealand.

Consent Form

Preliminary investigation of attitudes and practices of New Zealand osteopaths in relation to the health care system: does the future hold a greater degree of integration with the biomedical health system?

Name of Participant: ___________________________________________

I have had the research project explained to me and I have read and understand the information sheet given to me.

I understand that I don't have to be part of this if I don't want to and I may withdraw from the focus group at any time during the group process. I will have the opportunity to edit or withdraw any or all of my statements from the transcript. I will be able to withdraw from the study at any time up until two weeks after I have received the transcript.
I understand that everything I say is confidential within the groups and none of the information I give will identify me. I understand that the only persons who will know what I have said will be the participants in the focus groups, the researcher, transcriber and the researcher’s supervisors. I also understand that all the information that I give will be stored securely on a computer, in hard copy for a period of 5 years and then destroyed.

I understand that my discussion within the focus group will be taped and transcribed.

I understand that I will receive a copy of the transcripts and I can see the finished research document.

I have had time to consider everything and I give my consent to be a part of this project.

Participant Signature: ………………………….. Date: ……………………………

Project Researcher: ………………………….. Date: ……………………………

UREC REGISTRATION NUMBER: 2009-1025

This study has been approved by the UNITEC Research Ethics Committee from 5.12.2009 to 5.12.2010. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 6162). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix C

Question guide

It has been suggested that there is an ad hoc basis of integration of CAM mainly in the primary sector, e.g. GP and CAM practitioners referring patients, some work cooperatively together, patients choose CAM as health practitioners, G practicing CAM.

1. I am interested to know to what extend ad hoc integration applies to osteopaths. Could you please discuss how this may apply to osteopaths practicing in the primary setting and how they relate to the general health care system?

One of the reasons to explore integration is the desire to provide a multi-faceted approach to meet New Zealand’s health strategy goals (refer to 13 health goals)

2. Could you talk about how the way osteopaths practice at the moment may contribute to fulfill these goals, and what would make it easier for osteopaths to contribute more to these of other health goals?

The demand for CAM is on the increase. There is also an increase aging population with ensuing chronic conditions. Some DHB are formulation to allow CAM use.

3. I am interested to know what other settings, than the primary sector, in the general health care system osteopaths in your opinion could work in and what areas of health they might be most effective in treating. Could you please discuss your opinions on this?

The MACCAH proposes that only specific CAM modalities are suitable for integration into the general health care system. They base this on CAM efficacy and safety.

4. Can you tell me how the MoH and other interested parties would know if osteopathy is a safe and effective treatment approach and how this may distinguish osteopaths from other CAM modalities?
Concerns about key differences between CAM and biomedicine, meaning their differences about understanding of health, illness and purpose of treatment, in regards to integration

5. Could you please discuss how differences between biomedicine and osteopathy is or may be an issue for osteopaths practicing in the general health care system?

6. Can you make a case for or against osteopaths building a greater relationship with the general health care system?

(Questions based on MACCAH, 2004, chapter 5)
Preliminary investigation of attitudes and practices of New Zealand osteopaths in relation to the health care system: does the future hold a greater degree of integration with the bio-medical health system?

NON-DISCLOSURE OF INFORMATION

Transcribing Typist/Assistant

I_________________________________________ agree not to disclose the name of, or any information that would lead to the identification of the participants in the research study being undertaken by Lily Rose and supervised by Dr Elizabeth Niven and Associate Professor Clive Standen.

The audiotapes, transcription hard copies, and computer files will not be made available to anyone other than the researchers and will be kept securely while in my possession.

I will not retain any copies of the audiotapes, computer files, or transcriptions.

Signed: ________________________________

Name: ________________________________

Date: ________________________________

UREC REGISTRATION NUMBER: (2009-1025)

This study has been approved by the UNITEC Research Ethics Committee from 5.12.2009 to 5.12.2010. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 6162). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix E

The New Zealand Health Strategy also highlights 13 population health objectives which were chosen, among other things, for the contribution they can make to improve the health status of the population, and their potential for reducing health inequalities.

The 13 population health objectives are to:

1. reduce smoking
2. improve nutrition
3. reduce obesity
4. increase the level of physical activity
5. reduce the rate of suicides and suicide attempts
6. minimise harm caused by alcohol and illicit and other drug use to both individuals and the community
7. reduce the incidence and impact of cancer
8. reduce the incidence and impact of cardiovascular disease
9. reduce the incidence and impact of diabetes
10. improve oral health
11. reduce violence in interpersonal relationships, families, schools and communities
12. improve the health status of people with severe mental illness
13. ensure access to appropriate child health care services including well child and family health care and immunisation.

(MACCAH, 2004, p.54),