

Research and Theory

Types of treatment collaboration between conventional and alternative practitioners—results from a research project at a Danish MS hospital

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Abstract

Introduction: More than 50% of People with Multiple Sclerosis (PwMS) in Denmark use alternative treatment. Most of them combine alternative and conventional treatment, but PwMS often find that they engage in parallel courses of treatment between which there is no dialogue, coordination or synergy. For this reason the Danish Multiple Sclerosis Society conducted a research project to develop and examine different models for collaboration between conventional and alternative treatment providers.

Methods: The empirical material consisted of 10 individual interviews with practitioners, a group interview with practitioners, a group interview with professional staff at the Danish Multiple Sclerosis hospital that provided the organisational framework for the project, interviews with 59 patients and written responses from participating treatment providers in connection with 29 practitioner-researcher seminars held during the period 2004–2010.

Results: Collaboration between researchers and the treatment team resulted in the development and examination of several models which describe the strengths and weaknesses of various types of collaboration. The models show that the various types of collaboration place different requirements on the degree of 1) mutual acknowledgement and understanding among practitioners and 2) flexibility and resources in the organizational framework. The analyses also point to the fact that the degree of patient activity must be considered in relation to a given type of collaboration.

Discussion: The relationship between integration and pluralism can contribute to a fruitful discussion in regards to the value of treatment collaboration. In addition to the many positive perspectives that characterise integration of different treatment modalities the project points to the importance of not overlooking the opportunities, values and potential inherent in a pluralistic ideal in the form of patients' own active efforts and the dynamism that can arise when the patient becomes a co-informant, co-coordinator and/or co-integrator.

Keywords

health policy, health planning, patient care management, primary health care, patient centred care, individual care plan, CAM, integrative medicine

Introduction

Background

Although Multiple Sclerosis (MS) is an incurable chronic disease, medical treatment can halt the progress of the disease in some cases, and a number of complications can be treated medically. In general however, treating symptoms is only partially effective and cause a number of side effects [1]. Today many People with MS (PwMS) as well as those with other chronic diseases combine conventional and alternative treatments in the management of their disease [2–4]. Many of the people in Denmark who live with an MS diagnosis have expressed the desire for an investigation to explore which treatment results can be achieved by using both conventional and alternative treatments.

MS symptoms are treated by numerous different health-care professionals with different treatment modalities. A frequent problem for people with MS is that from the patients' point of view, these treatment modalities are not generally coordinated in an integrated plan for treatment and rehabilitation. Internationally, we see more and more initiatives involving collaboration between conventional and alternative practitioners at hospitals and private centres for integrated treatment, just as alternative treatment methods are included in doctors' practices in various ways [5–20].

These initiatives inspired the Danish Multiple Sclerosis Society to initiate 'The MS Treatment Team Project' in 2004. The main purpose of the project was to investigate whether it is possible to improve treatment results for PwMS by developing an integrated treatment approach that bridges established and alternative practitioners.

The project was conducted at the Danish MS hospital; a hospital specialized in the treatment and rehabilitation of PwMS and was part of a larger research project investigating treatment results of combined treatments from different methodological angles [21, 22]. The first step of the research project included establishing and developing the treatment team of 10 practitioners. Over the following six years models for collaboration were developed and examined.

The collaboration between conventional and alternative practitioners have shown to improve treatment outcomes regarding self-reported quality of life over a period of 18 months compared to treatment as usual [21]. Furthermore, analyses have shown that patients have experienced very different types of effects from the combined treatments and that the patients' own efforts as well as aspects of

physical and cognitive learning constitute important elements in understanding the combined courses of treatment [22].

Research questions

In this article we address three key research questions:

- Which challenges and opportunities were discovered from establishing collaboration between conventional and alternative practitioners in the treatment of PwMS?
- What types of collaboration among the practitioners were generated?
- Based on the experiences gained, how can we define a model for collaboration between conventional and alternative practitioners?

Treatment project

Ten practitioners participated in the collaboration. Five conventional practitioners were selected by the head of the Danish MS hospital, and five alternative practitioners were selected by their respective treatment organisations. The selection of these five specific alternative treatments was made primarily on the basis of an analysis of the current use of alternative and complementary treatment among PwMS [23], and the existing literature on the documented effect of alternative treatments on MS symptoms (*ibid.*). Thus the treatment team comprised: an occupational therapist, a physical therapist, an M.D. (neurologist), a psychologist, a nursing assistant, an acupuncturist, a nutritional therapist, a classical homeopath, a craniosacral therapist and a reflexologist. A substitute was selected for each practitioner to fill in during illness and holidays. Some changes were made in the team of established practitioners underway in the project due to illness and changes in employment.

The project was housed by the Danish MS hospital. The motivation for the director of the MS hospital to participate in the treatment and research project was to learn anything that might be helpful in relation to the hospital's rehabilitation initiatives for PwMS. The practitioners' motivation for joining the project was the opportunity to take part in the treatment collaboration, to focus on the opportunity to create better treatment results for PwMS and being able to contribute to increased research-based knowledge in the area of integrated care [24, 25]. There was no intention that the project should lead to any permanent involvement of alternative practitioners at the hospital.

The development and examination of the treatment collaboration involved three phases:

a. The establishment phase (August 2004–May 2005)

The treatment team was selected and made preparations to offer a course of combined treatments. Practitioners and researchers met at four all-day practitioners-researchers seminars held at the Danish MS hospital in Haslev where the project was to be conducted. The researchers interviewed all 10 practitioners prior to the seminars in order to learn about the respective treatment models, that is, the team members' understanding of disease, including MS and MS symptoms, as well as the various diagnostic systems and treatment methods (including which effect mechanisms were embedded in the treatment methods). The content, procedures and results of these seminars have been described previously [4, 26, 27].

b. The treatment phase (May 2005–December 2009)

Combined treatments were given to a total of 191 PwMS. Participants were included or excluded immediately after the initiation of their hospitalization period of 3–5 weeks, and every course of combined treatment was initiated shortly hereafter (for further description of the inclusion see [28]).

In order to refer participants to specific courses of treatment, each participant filled out a referral scheme containing questions on physical and psychological condition, motivation and treatment goals. On the basis of this scheme and a short interview with each included participant, a referral team outlined a treatment plan, which was then discussed with the participant and subsequently implemented (pending the approval of the participant). The referral team consisted of the team leader (the occupational therapist at the MS hospital), periodically assisted by the nutritional therapist and the psychologist in the team). Matching participants with specific symptoms/problems to specific treatment plans was very much a 'learning by doing' process for the referral team. This process was further influenced by the mutual learning which took place among the team members in the establishment phase of the project. The referral procedure was subject to on-going discussion and evaluation among the practitioners.

After discharge from the hospital, patients were given alternative treatments in varying frequency as a supplement to conventional treatments offered under the healthcare scheme of patients' local council. All participants were given 15 alternative treatment consultations in various combinations (for a detailed description of inclusion criteria, intervention, etc., see [28]). The average length of the course of treatments was 9.5 months.

After each individual treatment session the practitioners added information to a shared medical record.

The participant was handed a copy of all medical records, for his/her own information, and to bring to the next treatment session. Another copy of the medical records was filed at the MS hospital (required by law).

Four all-day practitioner-researcher seminars were held annually throughout the treatment phase of the project. At these seminars researchers and practitioners discussed specific patient cases, e.g., by juxtaposing data from questionnaires and patient interviews with the practitioners' evaluation of the individual case. Over time these discussions added to the shared knowledge base in the team, regarding which therapies seemed to be effective in addressing which problems. In addition to knowledge sharing on clinical matters, the seminars were used to involve practitioners in the research process on integrated care, e.g., by discussing types of treatment collaboration as described in the present article.

In addition to the practitioner-researcher seminars, practitioners held regular conference meetings to discuss individual treatment plans and evaluate participants' progress. A conference meeting among the practitioners treating the individual patient was held at the beginning and in most cases also at the end of each hospitalization period. These meetings were arranged by the practitioners at the MS hospital and the alternative practitioners participated by physical or telephonic attendance. The participants did not take part in these conference meetings. Due to lack of resources it was not possible to secure the attendance of all practitioners at all meetings. The planning and execution of the conference meetings tended to become increasingly difficult towards the end of the treatment phase.

c. The evaluation and reflection phase (December 2009–June 2010)

Experience from the first two phases was discussed by the team and analysed by the researchers.

Material and methods

Research design and material

The research project was designed as a process evaluation. The part of the study reported in this article was aimed at investigating the collaborative process, and in this context was conducted as a process evaluation limited to a case study design [29, 30]. The 10 practitioners on the treatment team were interviewed individually via qualitative interviews prior to the start of the project, and re-interviewed at the conclusion of phase 1. At the conclusion of the entire project period, group interviews were conducted with practitioners as well as

with selected members of staff and management at the MS hospital that housed the project. Also used were participant observations and written reports from the four annual practitioner-researcher seminars held from 2004 up to and including 2009. All practitioners, two researchers and sometimes the head of the MS hospital participated in these seminars. Finally, the individual interviews and group interviews conducted with 59 PwMS who were part of the project were included in this investigation of the collaborative process. The main results of these user interviews will be published separately [22]; the focus of this article is limited to elements concerning the collaborative process.

Methods of analysis

In order to secure coherence in the data material, a number of selected interview themes have been addressed in the process of the data collection. Thus, the following issues have constituted the basis of the data collection in regards to the different groups of respondents.

The practitioners:

- What are the most important things you have experienced and learned from participating in the treatment team?
- Have you obtained new knowledge by cooperating in the team?—and what kind?
- Which strengths and weaknesses do you see in your own treatments and in those of the other practitioners in the team?
- How can treatment results for PwMS be optimized?
- Which types of treatment results can you contribute to with your line of treatment?

The professional staff at the MS hospital:

- Which advantages and disadvantages have you experienced in connection to having housed the treatment project?
- Has the project provided new understandings in the area MS-rehabilitation?
- Have you—on the basis of the treatment project—implemented new ways of working with MS-rehabilitation?
- Has the treatment project created new wishes or ideas for future work with MS-rehabilitation?
- Which stories are being told about the treatment project at the MS hospital?

The patients:

- Which strengths and which weaknesses have you experienced in connection to being treated by a team of practitioners?

- How have you perceived your own role when receiving treatment by a team of practitioners?
- Has the course of treatment been different than other courses of treatment you have received earlier? If yes, in which ways?

All interviews with practitioners and professional staff at the MS hospital were tape recorded and transcribed verbatim. All transcripts were subsequently approved by the people interviewed. Interviews with patients were either transcribed verbatim or written up as in-depth summaries. One researcher condensed the data, which was then checked by the second researcher connected to the project in order to ensure internal validity.

In the design of this project we emphasized the importance of maintaining an on-going dialogue between researchers and practitioners through the analytic process. This was done in connection to the four annual one-day practitioner-researcher seminars held throughout the project. After each seminar, the researchers wrote detailed minutes which were then reviewed and commented by the practitioners.

Data were analysed by carefully reading interview transcripts or summaries and minutes from the practitioner-researcher seminars, with the aim of identifying important themes.

Theoretical framework

In our investigation of the collaborative process between practitioners, we primarily used the theories of epistemic cultures [31] and learning theories [32–38]. One of the challenges of developing treatment collaboration is that there are various understandings of treatment models or epistemic cultures. Our assumption here is that transcending/expansive learning in some form, such as double-loop learning [35, 36], is necessary in order for regular team-based treatment collaboration to be established. One tenet of double-loop learning is that learning primarily takes place across individual boundaries when the individuals process the conflicting viewpoints presented to them [35, 36]. In double-loop learning, the individual is challenged by radically different understandings of, for example, disease and treatment, which can move beyond the individual's framework of understanding through self-reflection of his or her own understandings, norms, conventions and prejudices. However, double-loop learning processes are often difficult because they challenge the identity of the individual as well as his or her profession and organization.

Our choice of theory reflects our desire to gain an understanding of the crucial conditions for developing

collaboration between practitioners who represent very different professional backgrounds and widely divergent treatment models (including underlying treatment philosophy, perception of effect mechanisms, etc.). At the same time we assume that these very differences provide the opportunity for learning, reflection and development with regard to treatment as well as to the professional culture within a given treatment collaboration (see also [26]).

Results

Four types of collaboration

Based on the various types of treatment collaboration as described by Lauvås and Lauvås [39–41] the researchers outlined a continuum illustrating degrees of integration in collaboration, ranging from practitioners working in parallel with no contact at all, to practitioners working together so closely that they almost ‘become one’. The practitioners in our team had different levels of competence and experience in regard to discussing team collaboration processes. For this reason the researchers found it instrumental to present this rather crude outline to the practitioners to provide a common frame of reference, and as a foundation for discussion and further elaboration. During all three phases of the project this was regularly discussed at the seminars, each time building on the practitioners’ growing experience with collaborating in the project. Over time the practitioners and researchers thus jointly formulated four possible types of collaboration between conventional and alternative practitioners. The four types are described in Table 1. The objective was to investigate which type and to what degree collaboration could be achieved during the project. Knowledge was gathered about the advantages, disadvantages and prerequisites attached to the four types of collaboration, respectively.

In order to condense the knowledge about the advantages, disadvantages and prerequisites regarding the four types of collaboration, in our analysis of the data we have chosen to focus on two themes that practitioners and hospital staff in the project considered important for developing treatment collaboration: 1) A collaboration perspective dealing with relations and learning within the team, 2) An organizational perspective dealing with the organizational framework for the project.

Mutual acknowledgement and understanding within the team

As described above, the project was based on the assumption that expansive learning would have to take

place if actual team-based treatment collaboration were to be developed. At the conclusion of the project, practitioners emphasized that gaining insight into a spectrum of types of treatment and traditions very different from their own developed them professionally in various ways.

“I gained insight into the ability and knowledge of other professional groups about treating people with MS (...) I acquired new knowledge that I can use not only for this project but otherwise. (...) Our individual backgrounds and approach to treating sclerosis and treatment generally mean that we emphasize different things.”

(Physical therapist)

“What I can’t say I have learned but need to learn is to relate to new research and concepts (...) I need to focus on the needs and requirements of patients and on diversity.”

(Neurologist)

“I learned, or so I tell myself, something about treatment collaboration. (...) What it means to be part of treatment collaboration to a far greater extent than I am used to in daily practice. And I have certainly learned more about MS, about its complexity (...) and thus I also feel that I have learned something about when it is realistic to expect results and when it is less realistic.”

(Homeopath)

The process of mutual learning showed to be extensive, though. As described above, an establishment phase (phase 1) was planned and implemented even before the treatment project got underway, in order to give the team the opportunity to gain insight into each other’s treatments, treatment philosophies and effect mechanisms. All the same, according to the practitioners, it took several years of actual collaboration in the project before they felt that they could ‘seriously’ collaborate with a certain degree of insight into each other’s strengths and weaknesses as practitioners regarding a complex chronic disease like MS.

“And we still have a long way to go! I mean it (...) It has been very educational to have had the opportunity to be part of a project like this and actually see the complexity. I have to admit that I would never have imagined the degree of complexity, not in my wildest dreams.”

(Acupuncturist)

“Only now are we at the point of understanding each other’s treatments [at the conclusion of the project].”

(Nutritional therapist)

According to Argyris the prerequisite for expansive learning are openness and desire to enter into mutual learning processes [36]. The practitioners became aware of this early on in the process and stressed the

Table 1. Various types of treatment collaboration between conventional and alternative practitioners in treating PWMS

Type of collaboration	A) Separate parallel treatment	B) Informed parallel treatment	C) Team-based treatment	D) Interdisciplinary treatment team
Features	Patient treatment is provided by practitioners who do not communicate with other practitioners about the course of treatment and do not have any knowledge of each other's treatment models.	Patient treatment is provided by practitioners who have acquired knowledge about each other's treatment models. This knowledge is either acquired before the alternative practitioners begin their treatments or once treatments have started. Treatments are thus informed by each other to some degree, but there is no combined treatment plan, as treatments are provided in parallel by 'isolated' practitioners.	Based on knowledge of each other's treatment models and acquired knowledge about which treatments can promote or impede others, a treatment plan is drawn up in cooperation with the patient focusing on the patient's needs and goals. The combined treatment plan (which treatments, how many, how often and in what order) is evaluated and adjusted underway.	Based on in-depth knowledge of each other's treatment models and acquired knowledge on which elements from different treatments can promote or impede others, a synthesis of treatments is generated with regard to the needs and goals of the individual patient. In other words, a new treatment is developed, one that contains elements from the treatment models of the participating practitioners. A combined treatment plan is drawn up indicating how treatment will be carried out, and the plan is evaluated and adjusted underway.
Illustrative examples in which a patient P receives treatment from four practitioners (conventional and alternative)	P contacts and consults each of the four practitioners. P is the sole 'designer' of his/her treatment plan, deciding when to consult which practitioner, and whether to consult them in parallel or consecutively. The practitioners have no knowledge about the other treatments that P receives, unless P chooses to inform them. Often P will experience that the practitioners are not interested in this information, partly because they may not believe the other treatments to be effective, partly because they do not have the knowledge necessary on how the other treatments may affect their own treatment.	P contacts and consults each of the four practitioners. Each practitioner has fundamental knowledge about the other treatments. P is still the sole 'designer' of his/her treatment plan, but each practitioner will be able to guide the treatment decisions based on this knowledge of the other treatments. Practitioners may contact each other sporadically concerning P's treatment, but oftentimes there will be no direct contact concerning an individual patient, since each practitioner is only responsible for his or her own treatment and treatment goals.	P contacts a team consisting of the four practitioners. Based on the problems and symptomology presented by P, the team draws up a treatment plan. Some or all of the four practitioners may be involved in any given treatment plan, depending on the individual case. The treatment plan consists of a number of specific treatments given by the practitioners at specific times in a certain order. Also the plan specifies when it is to be evaluated and perhaps adjusted. This is done in cooperation with P. The practitioners will confer with each other continuously regarding the progress of P.	P contacts a team consisting of the four practitioners. The practitioners have different professional backgrounds, but in the team they transcend mono-professionalism by tailoring a new individualized treatment for P (a synthesized treatment, that may include mono-professional elements, but also new and hetero-professional elements). The treatment is based on the problems and symptomology presented by P. This is the case for each new patient being treated by the team. P will meet regularly with members of the interdisciplinary team in order to evaluate progress and perhaps adjust the treatment.

need to cultivate an atmosphere that facilitate open-minded discussion, disagreement and learning from each other.

"If you really want to you can find critical assessments of all the professional skills involved in the Treatment Team Project. So there can be a lot of prejudices that are not talked about. There can be a lot of useful knowledge hidden in these prejudices if they are

put on the table and discussed. However, this means that people cannot be overly polite and superficial, but rather willing to make an honest investigation of their mutual reservations."

(Psychologist)

Much effort went into trying to establish such an open-minded atmosphere as part of the collaborative process.

Despite this focus and knowing that bridge-building would be necessary, developing mutual acknowledgment and understanding within the team was a very time-consuming job. In this connection some of the practitioners have pointed out that sufficient learning is not only a question of time, but also a question of willingness to change fixed convictions.

Obviously, 'integrating' a group of alternative practitioners to be part of a team on an equal footing with conventional healthcare providers, is a challenge to existing structures and procedures in the conventional system. A recurring theme in discussions and the practice of the team was the fact that the doctor is on the top rung of the professional hierarchy in the conventional system, and has top-level responsibility for treatment. Thus in many cases the doctor has what one could call 'power by definition' in the professional culture, and alternative practitioners have found this to be the primary barrier to establishing team spirit on the theoretical level.

In the experience of alternative practitioners, the doctor maintains a mono-professional approach that makes it difficult to establish a common professional culture. The doctor's treatment model, founded in a clinical medical culture, is the basis of treatment in the conventional system and for its various professional groups [42]. At the same time, the alternative practitioners are also used to work within a mono-professional approach:

"Underway we were not very good at letting go of our own treatment forms and reaching out to others. We did improve in the course of the project."

(Reflexologist)

However, because in the final analysis the alternative practitioners lacked power by definition, and because it is basically the doctor who has the top-level treatment responsibility for the patients being treated at the MS hospital, in many situations it is the doctor's openness as well as the opportunity for and willingness to cooperate that makes all the difference. The problem of mono-professionalism came to the fore in particular in connection with defining and discussing several basic healthcare concepts such as 'outcome', 'documentation', 'improvement', 'ill', 'healthy', and 'diagnosis', which led to a clash of various perceptions and understandings among practitioners [4, 26, 27, 42–46]. At the same time, the alternative practitioners pointed out that during the project, doctors were more open than expected, which made a positive contribution to collaboration.

As described above, practitioners were highly motivated to participate in the project, and thus willing to enter into the necessary dialogues, and basically willing to make room for each other's treatment models, philosophies, methods and so on. One recurring discussion in the collaboration process was the extent to

which it is realistic to imagine that they could understand each other's types of treatment without having had a complete education within that particular field. The psychologist on the team remarked:

"If I were to work together with a dietician, for example, (...) I would feel that I wanted to really become knowledgeable about that field too, that is, so that we had a common language, but also to understand what it is that Q10 instigates on the cellular level. Perhaps it is true that things can work in parallel. And if you are then working together with three different directions in addition to your own, you certainly have your work cut out for you! (...) And you have to get a handle on each other's fields and read more about them."

(Psychologist)

The neurologist continues along the same lines:

"If one collaborates, including within the conventional system, but particularly together with the alternative system, it is imperative that you are the very best in your own field when communicating within a team. And I cannot really acquaint myself with how craniosacral therapy, reflexology, and nutritional therapy work, because it is the others who should be telling me. I would really have my work cut out if I had to go into the effects and side effects of alternative systems. And that is where you have to put your faith in mono-professionalism, if I may put it that way."

(Neurologist)

Knowledge of each other's skills as therapists is also coupled to knowledge about the individual practitioner as a person. Knowing this, the practitioners state that collaboration was vulnerable in those cases when team practitioners were replaced.

Despite general widespread willingness to put themselves into someone else's 'shoes' with regard to treatment philosophy, there was a basic tendency to maintain two 'camps', as two professional cultures: conventional and alternative. The practitioners describe this maintenance of the two camps as inexpedient with regard to establishing close treatment collaboration, but at the same time, the team accepted that in certain cases there were vast differences in treatment theories and views of people held by the various members of the team. Although these differences were recognized from the beginning, the process of collaboration did not bring about the expansive learning within the team that had been hoped for, and which had been assumed to be one of the prerequisites for achieving regular team-based treatment collaboration [35, 36, 38].

The organizational framework

As mentioned earlier, a key research question in the overall research project has been investigating the

extent to which treatment collaboration can optimize treatment results for people with MS. Therefore, the basic premise of the project was that the treatment team should operate as an integral part of the conventional hospital system where people with MS are treated and rehabilitated. We did not want to create a 'laboratory' with conventional and alternative practitioners who then treated PwMS, but who had no direct contact with the real societal structures of health-care and rehabilitation in Denmark. Therefore it was clear from the start of the project that although the organizational framework for the project presented a considerable challenge, it was also a prerequisite for successful collaboration. As mentioned earlier, the MS hospital's management was motivated and took an active part in establishing the team. The director of the MS hospital stressed the necessity in a project, such as this to *"have a supportive organisation, and to have employees understand that we bent the rules on working hours in order to organize the project; that is, to be a 'friendly environment' that does everything possible to lay out the tracks on which the project can run"*.

Despite the large store of willingness, the project also generated some frustration among staff. In the beginning the project was buoyed by the enthusiasm of hosting an innovative research project in which both conventional and alternative practitioners showed great flexibility and commitment, for example, with respect to holding joint team meetings. However, The co-ordinating practitioners (in physical therapy and nursing care) recall that commitment waned considerably on that point later in the project. According to the hospital's coordinating physical therapist:

"At the end it was really hard to get people together [practitioners at team meetings]. So it took some doing to get things to work. It was a struggle. It was exciting but a real challenge."

(Coordinating physical therapist)

The practitioners in the quotes below bring up the theme of resources with regard to commitment. This is a theme that the practitioners generally stress highly for getting the teamwork to function optimally. In general, the practitioners did not think that team meetings were held on a satisfactory level. For one, not enough resources were devoted to dedicated conference time regarding individual patients, and in addition, planning/coordinating team meetings was difficult in a working world in which practitioners had many obligations other than the present project.

"One of the things I have also thought about is how important it is to have the time and money for a project like this. Also in terms of our team meetings: If we could have worked out much better team meetings, if there

had been both time and money for that, we might have been able to do things better."

(Nursing assistant)

"There was no lack of willingness. The problem was resources. There haven't been any genuine team meetings, because we never got all the practitioners together at the same meeting."

(Homeopath)

As described earlier, a course of rehabilitation at an MS hospital in Denmark typically lasts from 3–5 weeks, during which the patient is hospitalized at the hospital. The project was obliged to fit into this framework. This meant that the conventional practitioners who have a permanent connection with the hospital did not usually have contact with users once they were discharged. The alternative practitioners were thus more or less alone during the subsequent long treatment period in which several alternative treatments were given, either at the clinics of the various alternative practitioners or as ambulatory treatment at the MS hospital. Since the project primarily focused on the users' and practitioners' experience with the course of treatments, the alternative practitioners had greater insight into the course of treatment for the individual users over time, and thus their experiences were given more room and speaking time at the researcher-practitioner seminars and in the research project as a whole. This led to frustration in some cases. The team leader states (occupational therapist):

"We have felt, and I have heard this from my colleagues here, that we have not been very visible; we have been the small part while the alternative practitioners have been the really big part, and given more prominence than we have. We know we've done good work, no doubt about that, but it has simply not been talked about as much. But every time an alternative practitioner has said something or other, there has been more focus on it. So (...) things haven't really been equal. But I think things could have been equal if it had been discussed. Perhaps more things should have been said in the beginning."

(Head occupational therapist)

This quote shows that in case of a mediator assisting the collaboration process it is important to acknowledge all members of the collaboration equally, in order to establish the necessary mutual recognition within the team. The organisational framework has also showed to play an important role in this connection as both the conventional and the alternative practitioners have felt that they had to set aside their 'normal' work in order to participate in the collaboration. The conventional practitioners working at the hospital experienced that the project and the alternative practitioners

had first priority, and the alternative practitioners who had to close their practice in order to go to the hospital whenever they were to treat PwMS, participate in meetings or seminars, experienced that the conventional practitioners and their work were given top priority. In this context, collaboration taking place on mutual ground as in an integrated medical centre would be preferable. However, this is far from the reality that practitioners and PwMS meet today and would thus be counterproductive to our aim of carrying out the project in a realistic non-laboratory setting. Further, it would require new establishments and a substantial amount of additional resources.

Regarding the experiences among the (rest of the) staff at the MS hospital these are mixed. Sometimes the project took up too much space in the daily routine, but it is also described as having been exciting, with the point made that it has been a privilege to take part, and educational both professionally and personally. In general, the staff have been happy to 'house' the alternative practitioners, and have received a lot of inspiration and knowledge that they describe as useful in their own work with treating and rehabilitation. One ward nurse describes:

"We used to offer everyone the same thing, but we've already changed that, so when I think back on it, I think: 'Wow that was a long time ago', because so much has happened since. And I think we have taken some of that learning to heart (...) the part about offering different treatments to different people."

(Ward nurse at the MS hospital)

The team's physical therapist says:

"...among physical therapists at the hospital we have talked about the significance of diet, and that has led to introducing some new measures here (...) I think it has been a big eye opener."

(Physical therapist)

Embedding collaboration into an established organizational framework has caused not only team members but also the rest of the staff to feel that they have been part of a developing process. Thus like rings in water, collaboration had an effect that went beyond the team itself.

One of the organizational challenges in the project was in the interface between various traditions and habits regarding the way to formulate goals, to evaluate and to record information in patient files. Whereas staff at the MS hospital had developed a certain tradition in these areas over time, the alternative practitioners use various concepts. Although the collaboration process focused on developing common guidelines in these areas, and with some success, the tradition at the MS hospital, which served as the organizational

framework for the project, was in many cases decisive in the end.

Collaboration models

What type of collaboration was achieved during the project?

As described previously, researchers and practitioners evaluated treatment collaboration continuously in the project. Referring to [Table 1](#), it can be summarized that treatment collaboration in this team project involved aspects from 'Informed parallel collaboration' and 'Team-based treatment' equally. Practitioners have acquired knowledge about each other's treatment models, and a certain degree of common knowledge arose regarding which treatments can promote or impede each other in the treatment of MS related symptoms. However, genuine team-based treatment was not achieved. Constraints relating to organizational matters as well as time and resources limited the opportunities for joint evaluation and adjustment of treatment plans underway in the course of treatments. Similarly, several factors such as the existing hospital hierarchy, and team member replacements, limited the opportunity for further development of collaboration.

"It was more parallel treatments than actual interdisciplinary work. It is not as though we sit in a group and stay within that group and together we follow this user over time, so that with each new intervention we are always ready to evaluate whether we should do something else, and so on. We are not sitting together and making that evaluation. That happens in each one of our clinics. That is just the way it is. We haven't made it there yet."

(Homeopath)

The team's craniosacral therapist found actual team-based treatment to be the underlying objective of collaboration in the team, 'but', he continues, "we found ourselves in informed parallel treatment instead (...) an interdisciplinary treatment team has proved unrealistic—it required too many resources."

Prerequisites for various types of collaboration

The fact that treatment collaboration resulted in a somewhat equal mix of 'Informed parallel treatment' and 'team-based treatment' is understood as a result of the given prerequisites in this explorative project. On-going efforts were made during the research process to investigate which requirements needed to be met in order to achieve a given degree and type of treatment collaboration. Encouraged by the

researchers, the team continued to discuss this, in the light of how treatment collaboration had taken place in connection with the participating PwMS. The prerequisites for each type of collaboration are summarized in [Table 2](#).

As indicated in [Table 2](#), the prerequisites for carrying out the four types of treatment collaboration basically increase in terms of requirements for mutual acknowledgement and understanding between practitioners, and in terms of requirements for flexibility and resources in the organizational framework. In this connection the increasing demand for readiness to engage in learning processes and willingness to abandon mono-disciplinary thinking among the practitioners, can be seen as fundamental challenges in obtaining collaboration that exceed parallel treatment.

Advantages and disadvantages

These prerequisites form the basis of a number of advantages and disadvantages that can be generally ascribed to the four types of collaboration. As shown in [Table 3](#), all four types of treatment collaboration have opportunities and limitations: at one end of the scale ‘Separate parallel treatment’ can be characterised as a type of collaboration that requires no resources of coordination, and offers a high degree of patient autonomy. However, this also means that practitioners do

not have the opportunity to factor in other treatments, which can lead to counterproductive treatment. At the other end of the scale it can be stated that although an ‘Interdisciplinary treatment team’ offers many interesting and positive perspectives, it is also a model that requires an extensive amount of resources as well as an extensive amount of collaborative willingness among the practitioners.

What is the role of the MS patient in integrated care?

When discussing advantages and disadvantages related to different types of treatment collaboration, the role of the patient has turned out to represent an important aspect in the MS Treatment Team Project. It is important to emphasize that the patients in the MS Treatment Team Project were not allotted any formalized role in relation to the actual team cooperation. At any one point in time the patient would typically only be in direct contact with the practitioner treating him or her at that moment, thus patients were at all times an arm’s length away from the joint team of practitioners. The patients of course regularly offered their feedback to the respective practitioners, regarding the effects of treatments. This was very much encouraged and recorded in the shared medical records, and to a certain extent the practitioners also passed on this feedback to the joint team of practitioners for discussion.

Table 2. Prerequisites for various types of treatment collaboration between conventional and alternative practitioners in treating PwMS

Type of collaboration	A) Separate parallel treatment	B) Informed parallel treatment	C) Team-based treatment	D) Interdisciplinary treatment team
Requirement for mutual acknowledgement and understanding between practitioners	None	Requires practitioners to be motivated and open to acquiring knowledge about each other’s treatment models, but does not require actual understanding.	Requires that practitioners acknowledge each other and show understanding. They must have a desire to learn and be open to discussing and recognizing the strengths and weaknesses in their own treatments and those of others. Requires a certain amount of learning across professional disciplines and mono-disciplinary cultures.	Requires in-depth understanding and knowledge about each other’s treatment models, and willingness to abandon mono-disciplinary thinking in favour of thinking in treatment syntheses. Requires extensive learning across professional disciplines and mono-disciplinary cultures.
Requirement for flexibility and resources in the organizational framework	None	Practitioners need time allocated daily for knowledge sharing in the form of actual meetings as well as reading and discussing written materials.	Practitioners need time and a physical framework for conducting regular meetings with each other. This requires a great amount of flexibility on the part of everyone involved, if activities in the team are to be combined with other work obligations.	The organizational framework is crucial. Collaboration must have the highest work priority for everyone involved, and the economic and physical framework must be organized to accommodate activities in the interdisciplinary treatment team.

Table 3. Advantages and disadvantages of different types of treatment collaboration between conventional and alternative practitioners in treating PwMS

Type of collaboration	A) Separate parallel treatment	B) Informed parallel treatment	C) Team-based treatment	D) Interdisciplinary treatment team
Advantages	No resources expended on coordination. Patients are completely autonomous with regard to individual practitioners and free to choose or reject treatments without these choices having any notable influence on treatment collaboration.	Limited use of resources. Patients find practitioners knowledgeable about other treatments received. This in turn produces a more qualified dialogue between each practitioner and the patient about the treatments.	Patients meet a team of practitioners who work together with each other and the patient to plan the course of treatment. The patient receives a treatment combination that is evaluated as optimal for the individual. Patients are better safeguarded against over-treatment because efforts are coordinated and followed up underway.	Patients receive a combined treatment that is specially developed to match their individual needs and goals. Ideally patients face the lowest possible risk for overtreatment.
Disadvantages	Practitioners do not have the knowledge to consider the strengths and weakness of the other treatments the patient is receiving. Therefore there are no considerations about the extent to which treatments promote or inhibit (or even directly counteract) each other. Risk of over-treatment.	Practitioners can relate to only a limited extent to the strengths and weakness of the other treatments the patient is receiving. Treatments are given in parallel so there is limited coordination, as well as the risk of over-treatment (although a smaller risk than for A).	Considerable resources needed for on-going conference participation/ team meetings: In the beginning in order to refer the patient to the right combination of treatments, and subsequently to evaluate the course of treatments and possibly change referrals.	Very high resource consumption in order for the practitioners to be in good rapport, to meet sufficiently often to 'design' individualized treatments and to evaluate the course of treatments for the individual.

The patients in the project have therefore to a very large extent been free to choose which role they wished to assume in the courses of collaboration treatment. When asked about this role in interviews, many patients emphasized the importance of being an active patient who takes co-responsibility for his or her own treatment as well as participating in the coordination of the combined interventions. One patient argues in an interview:

“When you can feel that there are changes, you become interested and listen. It has to be something you can follow upon yourself. I don't believe in anything where you just sit there passively.”

(Man, age 27)

In the project our aim was to enable the participants to assume an active and participating patient role if they so wished, by giving each participant a copy of all entries to the shared medical record (described previously). In relation to that, another patient states:

“Knowing the options (of different treatments) is part of a kind of patient education. The combination of alternative and conventional practitioners has sharpened my feeling for treatment (...) but you have to know when to take a break.”

(Woman, age 57)

Some participants, however, have not felt the need or desire to assume an active patient role. Rather they have preferred the role of passive recipient with regard to the course of combined treatments. Some have also felt confused about receiving various treatments in combination. A female participant recalls:

“I found it complicated to have two different practitioners. You don't know what is what. I needed to separate the two practitioners. First I got three acupuncture treatments and then five craniosacral treatments.”

(Woman, age 64)

This difference in patient role has constituted a challenge in the treatment collaboration. Some PwMS do not have the knowledge needed to optimally integrate conventional and alternative treatments according to their individual needs. Further, many people suffering from MS do not possess the surplus energy it takes to be actively involved, ask questions and make demands. That is one of the reasons, in the design of this project, we wanted to give the participants the freedom to choose which role they wanted and were able to assume.

At the outset of the project, as described in this article, no specific model for—or degree of—cooperation was determined, as we wanted to explore the character-

istics, possibilities and limitations in different types of collaboration. In other instances, however, when the model or degree of cooperation is fixed from the outset, it can be of great relevance to closely consider which role the MS patient is expected to have; and to what extent the patient can be flexible in this role, depending on his or her desires and abilities. In connection with this it should be considered which advantages and disadvantages the MS patient might experience in relation to different degrees of cooperation.

If we look upon the different types of treatment collaboration from the perspective of the patient's role, we can state that if treatment collaboration is to take place within 'Separate parallel treatment', very high requirements for patient activity are needed, since the patient is left with the sole responsibility of coordinating the different treatments. These requirements are less high in the other types of treatment collaboration, where an increasingly greater part of the coordinating work is embedded in the collaborative efforts of practitioners. In the case of 'Informed parallel treatment', a great deal of the coordinating work is left in the hands of practitioners, while the requirement for patient involvement falls. This feature is even more pronounced for 'Team-based treatment' and 'Interdisciplinary treatment team'.

These different levels of patient involvement and activity can be seen as advantages or disadvantages, depending on the individual patient's preferences, resources and skills. As we have illustrated in this section, some patients will benefit from the opportunity to play an active part, while such a role for other patients will be seen as an unwanted burden. Overall, the results of this project point to the importance of contemplating possible patient roles in various types of treatment collaboration. Partly in relation to which patient roles any given type of collaboration model will offer and allow, and partly in relation to which patient roles the individual wishes and/or is capable of assuming.

Discussion and conclusions

Types of treatment collaboration between conventional and alternative practitioners—the main results

In this article we have presented results from one part of a MS Treatment Team Project. The aim of the overall research project was to investigate how to give PwMS the best treatment results with integrated care. In the present article we have presented issues relating to the collaboration as it played out among the practitioners in the treatment team, and we have discussed

pros and cons of various types of collaboration in integrative care.

The message is that there are different requirements for the various degrees of cooperation and treatment collaboration in two basic areas: 1) The degree of mutual acknowledgement and understanding between practitioners, and 2) The degree of flexibility in the organizational and administrative framework in which the treatment collaboration is situated. A number of prerequisites in these areas must be met in order to carry out a given type and degree of treatment collaboration, and the respective potentials as well as limitations must be weighed in each situation relative to requirements. In this connection an important aspect to be addressed has turned out to be the patient's ability and desire to assume a role as active participant in the collaborative treatment. The different types of treatment collaboration meet with different degrees of patient activity, and this aspect must also be taken into consideration when choosing which kind of treatment collaboration to pursue in a given situation or treatment project.

The practitioners emphasize the importance of mutual acknowledgement of professional skills. There is a long and pervasive tradition of mono-professionalism in both the conventional and alternative practitioner world. It has been a large step for the practitioners in the team to work towards team-based treatment, perhaps even to the extent where we could describe it as an 'interdisciplinary treatment team' in which treatments 'amalgamate' into new syntheses.

The interviews with practitioners illustrate that there is still a long way to go. They say almost with one voice that although they have come a long way and have learned a lot, it is only one step forward towards true team-based treatment. Several practitioners state that they did not get a true understanding of each other's treatments until the end of the project. Thus, the collaborative process clearly depends on existing structures on professional and organizational as well as individual levels. The individual level deals with how the individual practitioner conceptualizes disease, health and treatment, and how the practitioner relates to the treatment philosophies and knowledge of other practitioners. Despite a great store of good will and openness from the organization and practitioners, these structures are resilient and change only slowly.

The project pre-phase was scheduled prior to the inclusion of participants, so that the practitioners could learn about and from each other's treatment models without being 'disturbed' by pressure to achieve treatment results. But the study shows that even this unique approach to mutual learning early in the project was not enough. The practitioners say that they still want more knowledge and more time allocated for dialogue

and learning, which they see as a prerequisite if collaboration is to be closer than was achieved in this project.

It is also clear that the collaborative process was vulnerable to changes in the team. The learning and development process required to develop a common professional culture needs stability and continuity. Given the fact that the conventional practitioners' direct contact with the patients was limited to the 3–5 weeks hospitalization, resources for planning and holding team meetings were of great importance, and the project was unable to honour these demands completely.

What have we learned about treatment collaboration?

Close teamwork has proven to be challenging and time-consuming in this project, and in many cases professional and practical obstacles, as well as obstacles relating to resources, brought setbacks to collaboration. The experiences of the practitioners and researchers thus present relevant questions, the main one relating to learning: which issues should future similar 'bridge building' projects take into account, in the design of an integrated collaboration model? That is: how can obstacles and burdens as experienced in this project be diminished so that it does not impede collaboration? Some experiences from the MS Treatment Team Project can be mentioned that might be of value to other similar projects:

- Integration of different treatment modalities requires an extensive amount of resources. Time and flexibility to organise an appropriate amount of seminars, conference meetings etc. must be available.
- In the MS Treatment Team Project one year was initially spent as a pre-phase for the five years treatment collaboration. One could argue that even a longer period of preparation is needed, depending on the number of different treatment modalities taking part in the collaboration, if a mutual understanding within the team is to be obtained.
- The integration of 10 different treatment modalities is a very ambitious project. A smaller amount of modalities might be relevant, especially if resources are limited.
- The level of ambition in regard to the type of treatment collaboration one is aiming at may be weighed against the number of treatment modalities included.
- Collaboration between practitioners with very different treatment philosophies—i.e., in the field of integrative medicine—requires extensive willingness among the practitioners to engage in learning processes.

- In the MS Treatment Team Project we have experienced advantages as well as disadvantages in connection to the project being housed by The Danish MS Hospital where the five conventional practitioners are employed. One might consider possible advantages in having a neutral organizational frame.
- The treatment collaboration has been highly sensitive to replacements in the team. One might benefit from weighing such risks carefully from the beginning of a collaboration process and prepare strategies for transfer of knowledge in case of replacements.

The patient role in treatment collaboration—a complex matter

In the Treatment Team Project we wanted to develop the treatment collaboration towards an increasingly interdisciplinary treatment team, where a synthesis of treatments targeted at the individual patient was generated. At the same time, however, it became clear to us during the research project that there are many people with MS, who are motivated by the fact that there are various 'sectors' with various treatment models and philosophies that they can actively and selectively use and combine in their mastery of their disease. One could question whether one risks counteracting this active patient role if treatment is largely set and managed by a close-knit and coordinated treatment collaboration that presents itself to the user as 'one voice'?

As a part of their rehabilitation work, the Danish MS hospital operates with the concept of 'MS manager', where the user is seen as the co-integrator of the various treatment measures. In this context, the user is encouraged to make the effort and use the skills needed to function as his or her own 'MS manager'.

It can be argued that the treatment system should be able to deal with differences in patients in this connection, that while some can and want to manage their own course of treatment and have the ability to integrate treatments, others (such as people who are very ill or have substantial cognitive problems) cannot manage on their own and need assistance.

Could it be that the provision of close and coordinated collaborative treatment, in which the patient and his or her needs are largely in the centre and the coordination of treatments is thoroughly embedded in the treatment collaboration, poses a theoretical risk of making active patients passive? With professionalization so high and co-treatment collaboration so close as described and pursued in 'Interdisciplinary treatment team', there might be a danger of choosing *for* the patient instead of *with* the patient. Whether this is considered positive

or negative depends again, of course, to a great extent on the individual patient, but it might be a disadvantage for those patients who wish to play an active part in their course of collaboration treatment.

Opposition, integration and pluralism

In this connection, Kaptchuk and Miller [10] study three relationships between mainstream and alternative medicine: opposition, integration, and pluralism. They state that opposition to what is now called complementary and alternative medicine has recently eroded and its polar opposite, 'integrative' medicine is increasingly espoused. They raise the question of whether the move toward integrative medicine (a fusion) is the most appropriate approach.

Kaptchuk and Miller advocate the pluralistic model with the following premises in mind: 1) diverse medical systems, based on fundamentally different medical theories and methods of validating treatments, inhabit the medical landscape, 2) despite many irreconcilable epistemological and practical differences, conventional and alternative medicine share the goals of promoting health, relieving suffering and avoiding harm, and 3) both mainstream and alternative medicine should respect the autonomy of competent patients to make therapeutic choices in consultation with mainstream physicians or alternative providers [10].

Kaptchuk and Miller [10] thus point to the potential value of treatment pluralism (rather than integration) and the options for active and competent participation this gives the patient. Although the goal in the MS Treatment Team Project has been to develop a treatment collaboration as far as possible for the benefits of the patients, we find this pluralistic ideal interesting in several ways, as it questions the balance between the advantages and disadvantages of the integrative ideals: in our wish for better mutual understanding and corporation in the field of integrative medicine we might need to pay more attention to the importance of not overlooking the opportunities, values and poten-

tials inherent in the patient's own active efforts and the dynamics that can be generated when the patient becomes a co-informant, co-coordinator and/or co-integrator. At the same time, it must not be overlooked that taking on such a role can be a great challenge for some patients.

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