Journal of Complementary and Integrative Medicine

Volume 4, *Issue* 1 | 2007 | *Article* 7

Bridge Building and Integrative Treatment of People with Multiple Sclerosis. Research-based Evaluation of a Team-building Process

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Bridge Building and Integrative Treatment of People with Multiple Sclerosis. Research-based Evaluation of a Team-building Process*

Laila Launsø and Niels Haahr

Abstract

Background: The Danish Multiple Sclerosis Society has initiated a research project dealing with bridge building and integrative treatment. Little attention has been paid to research on the experience of conventional and alternative practitioners with bridge building and integrative treatment through teamwork. **Objective:** The objective of this article is to describe essential features of the preparatory phase of the research project focusing on the process of initiating and developing a team of conventional and alternative practitioners before treating people with Multiple Sclerosis at a specialized MS hospital in Denmark. The team consists of five conventional and five alternative practitioners. **Materials and Methods:** The preparatory phase took place from August 2004 to May 2005. In-depth, semi-structured interviews were conducted with the ten team practitioners. Each practitioner was interviewed before and eight months after joining the team, and after participating in four practitioner-researcher seminars. Written materials and participatory observations of practitioner-researcher seminars have been used in addition. **Results:** The team-building process involved motivation, emotions, challenges, professional and personal competences, and the development of a professional team identity. The practitioners assessed the preparatory phase based on researcher-practitioner seminars as an essential basis for moving on to provide treatments to people with MS.

KEYWORDS: chronic disease, integrative treatment, integrative medicine, integrative care, learning theories, team development, facilitators, challenges, qualitative interview, multiple sclerosis

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*Many thanks go to the team practitioners for the time they devoted to interviewing people and developing the team. Thanks also to students Tine Olavsgaard and Rebecca Preisler Ahmad who transcribed the interviews. Finally, we express our gratitude to the Aase and Ejnar Danielsen's Foundation, VIFAB (The Danish Knowledge & Research Center for Alternative Medicine) and The Danish Multiple Sclerosis Society for the economic support that made conducting the prephase possible.

1. Introduction

Multiple Sclerosis (MS) is a chronic and progressive neurological disorder that can lead to severe disability. The aetiology of the disease is unknown (Li et al. 2004, Munger et al. 2004, Riise et al. 2003, Sørensen et al. 2004). About 400,000 people have been diagnosed with MS (EMSP 2004) in Europe as a whole, 7,400 of them in Denmark. MS cannot be cured by any known conventional treatment, but the progression of the disease can be slowed down medically in some cases, and a number of secondary symptoms can be treated (Sørensen et al. 2004). However, the symptomatic treatments are generally characterized by having only partial effects on the symptoms, and by having a number of adverse effects (ibid.).

MS symptoms are approached from a range of health professionals and treatment forms. From a patient-centered perspective, these treatment approaches are generally not coordinated in an integrated plan of treatment and rehabilitation. A report from EMSP[1] (2004) underpins the importance of using interdisciplinary treatment approaches for MS. Interdisciplinary approaches are assessed as being more effective than multidisciplinary approaches (EMSP 2004).

An increasing use of alternative treatment is documented among people with MS (PwMS) (Marrie et al. 2003; The Danish Multiple Sclerosis Society 2002, Storr 2002). Using a method of trial and error, many PwMS combine conventional and alternative treatment without any counseling or advice from the health care system. PwMS have increasingly implored The Danish Multiple Sclerosis Society to initiate a research project dealing with bridge building and integrative treatment. The core question raised has been: Is it possible to improve treatment outcomes for PwMS by developing a model for bridge building between conventional and alternative practitioners, and developing an integrative treatment approach?

In this article, we define bridge building and integrative treatment as follows:

Bridge building refers to interdisciplinary cooperation at institutional level (public as well as private) between practitioners. More than just cooperation, bridge building requires the representation of different treatment models. The term treatment model refers to four components of the practitioners' medical paradigm: disease understanding, diagnostic approaches, treatment methods and expected outcomes of treatment methods used (Launsø & Rieper J 2005).

Several researchers and practitioners define **integrative treatment** as any treatment that aims to restore and prevent physical, emotional, mental, energetic,

[1] The European Multiple Sclerosis Platform (EMSP) is an association of national MS societies.

spiritual and social unbalances, based on the body's innate ability to heal (Launsø 1996; Mulkins & Verhoef 2004). This definition reflects an understanding of causality that is 'situated' in the generative capacity of body processes. Accordingly, treatment outcomes depend on an interaction between generative body processes, the social contexts in which a person is embedded, and the treatment intervention. The point is that the treatment intervention itself is not assumed to be the determining cause of treatment outcomes. Further, integrative treatment is a clinical practice that reaffirms the importance of the relationship between practitioner and patient (this definition can be found on the website of the Consortium of Academic Health Centers for Integrative Medicine 2005: www.imconsortium.org).

We believe that integrative treatment refers to the content of a patient-centered treatment approach. In practice, an integrative treatment approach may incorporate different conventional professionals as well as conventional and alternative practitioners, who must work from a patient-centered perspective, utilizing an interdisciplinary approach.

In Denmark as in other western societies, patients, patient associations and health care providers (conventional as well as alternative practitioners) are demanding new types of health care that encompass different concepts of health and disease, diagnostic systems, treatment methods and outcomes, and which integrate conventional as well as alternative practitioners (Launsø 1989, 1996; Bell et al. 2002; Scherwitz et al. 2003; Mann et al. 2004; Mulkins et al. 2003, 2005).

No blueprint exists on how to develop bridge-building processes in which cooperation is initiated between conventional and alternative practitioners within the health care system and for the purpose of developing integrative treatment approaches to PwMS. We assume that the process of building a team to develop integrative treatment approaches to PwMS is a professional prerequisite for initiating the treatment of PwMS. As very little research has focused on the development of teams consisting of conventional and alternative practitioners, and on team-practitioners' experience working with this development, we have explored the practitioners' self-experienced learning based on their participation in four practitioner-researcher seminars held over a period from August 2004 to May 2005. The lessons learned from this project might be applicable to health care providers treating other groups of patients with chronic diseases.

The research questions were:

1. What can the practitioners learn from participating in a bridge-building project and from developing an integrative treatment approach to people with MS?

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2. How do the practitioners assess practitioner-researcher seminars as a tool for developing bridge building and an integrative treatment approach to people with MS?

The theoretical frame of reference is based on learning theories.

2. Background

2.1 Evidence-based evaluations of integrative treatment and bridge building in the management of chronic disease

Searching the literature published within the last five years did not yield any publications describing a research-based evaluation of integrative treatment and bridge building relating to chronic disease, in which an interdisciplinary team of conventional and alternative practitioners offer treatments[2]. Research-based evaluations (including establishing a team of practitioners, the practitioners' treatment models, the development of integrative treatment, and an evaluation of outcomes related to the integrative treatment) have apparently not been carried out and published. In the USA and Canada, integrative treatment approaches have been assessed by patients and practitioners (Mulkins et al. 2003, 2005, Scherwitz et al. 2003). However, in the patient evaluations, the outcomes were not related to the treatment combinations used by patients. Further, these teams were characterized by a number of practitioners (conventional and alternative) operating in parallel and referring to each other, thus characterized by a multidisciplinary rather than interdisciplinary approach.

A trend moving towards integrative treatment is taking place internationally (Gamst et al 2005, Mann et al. 2004, Boon *et al.* 2004, Ruggie *et al.* 2005), including cooperation between conventional and alternative practitioners in hospital settings, and between hospitals and private sectors. A number of institutes and university-based centers for integrated medicine/care have been established in the USA in particular. However, systematic research-based evaluations of actual integrative treatment efforts using an interdisciplinary approach have yet to be carried out.

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[2] The search was carried out in the databases PubMed MEDLINE, EMBASE and The Cochrane Library, using the key words: Integrated/Integrative/Alternative/complementary/supplementary + medicine/treatment/care.

2.2 A bridge-building and integrative treatment project is initiated

Against this background, the Danish Multiple Sclerosis Society initiated a large-scale bridge-building and integrative treatment project to take place from 2004-2010 at a specialized MS hospital[3]. In this project, a team of five conventional and five alternative practitioners has been set up to work together to develop and offer individualized treatments to 400 PwMS at the MS hospital. The conventional practitioners (all staff members of the MS hospital) comprise one medical doctor (neurologist), one occupational therapist, one physical therapist, one psychologist, and one nurse. The alternative practitioners included in the team are one acupuncturist, one nutritional therapist, one classical homeopath, one cranio-sacral therapist, and one reflexologist.

Patients are included from the population of patients referred to the MS hospital. Participating PwMS are treated at the hospital during an initial hospitalization period of five weeks. Subsequent treatments take place in hospital on an outpatient basis or in the practitioners' clinics, depending on the geographic residence of participants. Patients are included on an ongoing basis from 2005 to 2010. Each patient is included for 18 months, during which he or she receives the usual conventional treatments, combined with approximately 15 alternative treatments.

The project has been approved by the responsible national ethical committee, and all participants must sign informed-consent forms prior to inclusion.

This article aims to describe the initial establishment and development of the team prior to recruiting PwMS for treatment in the project. A number of preliminary initiatives, including a public hearing, qualitative interviews and a literature review, have been described elsewhere (Haahr & Launsø 2006). The researchers intentionally decided to use a substantial period of time for the preparatory phase, before asking the team to initiate treatments. The time period for developing and setting up the team was from August 2004 to May 2005.

The core research questions of this evaluation study (described above) are related to theories of learning, taking into account the very different professional discourses the practitioners present. The purpose of the project as a whole is to develop a model for bridge building based on research-based evaluation of an integrative treatment approach to PwMS, and to explore whether treatment results

[3] The project is conducted at The MS Centre at Haslev, one of two specialized MS hospital facilities in Denmark. At the other centre, The MS Centre at Ry, a group of PwMS is defined as a comparison group. Geographically, the centres are located in the eastern and western parts of Denmark respectively.

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can be improved. The purpose of the article is to give health care providers an insight into learning experienced by practitioners who take part in setting up a team consisting of both conventional and alternative practitioners. Perhaps this insight can serve as a basis for further reflection and development of bridge building and integrative treatment.

2.3 Theoretical frame of reference and research design

To describe and understand the process of building a team of practitioners representing different treatment models, we have chosen learning theories that incorporate the following:

(1) the challenge of meeting different understandings of treatment models or different epistemic cultures (Knorr-Cetina 1999)
(2) a self-reflective scrutiny of one's professional strengths and limitations in the treatment of PwMS. Self-reflection is characterized by the therapist's capacity to know and assess the strengths and limitations of his own treatment models and practices, as well as those of other therapists
(3) the premise that confrontation and conflict are prerequisites for double-loop learning
(4) the premise that innovation and change are promoted by staging a context that legitimizes and further invites and encourages confrontation and conflict (Morsing 1995, Engeström 1996; Argyris 1991,1992; Pawlowsky 2003).

In order to develop an interdisciplinary team and an integrative treatment approach to people with MS, we suggest that double-loop learning has to take place. Double-loop learning points out that transcending learning primarily occurs through the individual's processing of opposing views and conflicts when they emerge. The theories on transcending learning provide an understanding of change and innovation as based on an inner psychological transcendence of an existing frame of understanding. Hardy et al. (1998) emphasize the importance of being aware of the conflicts that the participants experience in a process of interdisciplinary or inter-organizational cooperation in relation to identities, competences (professional and personal skills) and emotions created through the process of cooperation.

The concept of learning refers here to three integrative dimensions: a content dimension concerning knowledge and professional and personal competence; a psychodynamic dimension concerning motivations and emotions; and a social dimension concerning the professional and organizational surroundings (Illeris 1999).

3. Materials and methods

In-depth, semi-structured interviews with the practitioners were conducted by the two researchers involved in the project. Written materials and participatory observations[4] of the four practitioner-researcher seminars were used in addition. The study was carried out from August 2004 to May 2005.

The ten practitioners on the team were each interviewed before the team met at the first seminar, and re-interviewed after participation in the first four seminars. One- to two-hour semi-structured interviews were conducted using two interview guides: one for each round of interviews. Qualitative interviews were chosen because the research questions focused on the practitioners' experiences and reflections on their learning processes during team building. Further, the study was explorative and characterized by no pre-formulated hypotheses. Formative evaluation (Patton 2002) was chosen as the research design, because we (researchers and practitioners) are entering the tentative beginnings of developing new treatment approaches to PwMS. Further, we aim to develop a model of cooperation between conventional and alternative practitioners, in a context represented by a wide range of professional knowledge and different approaches to treatment.

The first round of interviews took place in August and September 2004, before the practitioners joined the team. The interviews focused on each of the practitioners:

- Background, formal training and experience with treating PwMS
- Treatment models (the practitioners' understanding of MS, diagnostic approach, methods of treatment and expected treatment results)
- Prior knowledge of the other therapies represented in the team, and expectations about the results of combining therapies in the treatment of MS
- Motivation for participating in the project, and perceived professional and personal strengths/weaknesses.

Before conducting the second interview in April and May 2005, the first interview was re-read in order to follow up on the answers and questions formulated. The researchers conducted five interviews each in each round of interviews, shifting the interviewees in the second round of interviews.

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[4] Reports were written after each seminar, which included materials from the seminars and the observations of the researchers. The reports were disseminated to the practitioners for their approval before being made accessible to people outside the team and the researchers.

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The second round of interviews focused on each of the practitioner's:

- Personal and professional challenges, strengths and weaknesses on the team
- Knowledge gained through the seminars, and knowledge still lacking for optimum team cooperation
- Assessment of the most important professional and personal skills that practitioners participating in an integrative team must possess or develop
- Assessment of possible criteria of success for the team, in terms of treatment results.
- Assessment of the practitioner-researcher seminars as a preparatory phase before initiating treatment of PwMS.
- Characterization of the present team in terms of core values, patient-orientation, treatment goals, organizational structure, ability to share knowledge, strengths and weaknesses on the team as a whole.

The results presented in this article draw mainly on the data from the second round of interviews.

3.1 Analysis

All the interviews were taped and transcribed verbatim. These transcriptions were sent out to each of the therapists for validation prior to analysis. In the interests of internal validity, the procedures for meaning condensation and thematic and person-based analysis were conducted by one of the researchers and controlled by the other. The procedure for data analysis was:

(1) To identify themes by carefully reading the interview transcripts

(2) To compare these themes with the concepts derived from learning theories (Morsing 1995, Engeström 1996; Argyris 1991,1992; Pawlowsky et al. 2003): identity at the personal and team level; professional and personal competences; motivations and emotions; the professional and organizational surroundings; the context for learning to take place; confrontations and conflicts; the importance of integration of the bodily and mental dimensions

(3) The concepts and categorization of concepts were identified and specified concurrently with the empirical analysis. Open coding and constant comparison were used, while also re-reading to take into account the individual interview as a whole (Kvale 1996; Taylor and Bogdan 1998; Strauss and Corbin 1990; Launsø and Rieper O 2005). The analysis was disseminated to the practitioners for feedback on the validity of selected quotes from the interviews. The practitioners pointed out what they

perceived as the quotes most apt for describing their assessment of the team-building process. None of the practitioners indicated disagreement about any of the quotes. The excerpts from transcripts were selected to cover the variations in meanings related to the different themes.

4. Results[5]

The connection between the concepts from learning theories and the themes derived from the analysis of the interviews generated the following themes to describe and understand the internal learning processes that took place due to the practitioners' narratives collected from the interviews:

- The practitioners' *motivations* for entering into the bridge-building project
- The *emotions* the practitioners are experiencing
- The *challenges* the practitioners are facing
- The practitioners' experiences with developing an integrative treatment approach to people with MS
- The acquired and desirable professional and personal *competences.*

Finally, the practitioners assessed the practitioner-researcher seminars that served as the main stage and context for the bridge-building process.

4.1 The practitioners' motivations for entering into the bridge-building project

The multi-disciplinary element was an attraction for practitioners when choosing to participate in the project. One aspect was the opportunity to gain access to a 'free zone' in which conventional and alternative practitioners could meet each other on an equal footing. Further, each practitioner had a strong desire to learn from the other practitioners, and to develop treatments that may lead to better treatment options for PwMS. Practitioners also had a need to gain insight into the strengths and weaknesses of the various therapies. With one exception, all practitioners were highly motivated from the start of the project to participate on

[5] It was necessary to strictly limit the number of interview quotes in the analysis section for reasons of space. We gave priority to the quotes that are most perceptive and represent the views in the majority of the interviews. We did not include quotes for some of the themes.

the team[6]. However, the one exception became highly motivated after participating in the first seminar:

> *"…I have been positively surprised and it is exciting… I find the multi-disciplinary work very exciting; … It can be very difficult for us to treat [e.g. neurogenic pain], that is not our strong point. But at the last seminar I learned that the acupuncturist has good experience treating neurogenic pain. So I thought 'yes', it would be great if we could combine two treatments that way and get further than we can by ourselves."* (Physical therapist)

4.2 The emotions the practitioners experience in the bridge-building process

Some emotions reflect how practitioners perceive the project in relation to the surrounding environment. The practitioners indicate that the project is exciting and risky at the same time, with regard to existing organizational routines and disciplinary boundaries in the conventional health care system. The following quote illustrates emotions in the context of the project as part of a larger organizational framework:

> *"Something very exciting has been set in motion. It is characterized by doing what ought not to be done, since it is too difficult, vested with problems because it is so innovative… It is marked by daring to challenge the conventional practitioners, who may not be so conventional, and alternative practitioners, who may be more alternative than they know in some areas, and more conventional than they want to admit… Our own vanity is all that stands in the way, whether we are senior physicians or professors. Organizationally, I see this as extremely exciting in terms of creating movement and making changes between people, within organizations and research methods. I think we need a lot more of that in this world we live in."* (Psychologist)

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[6] Data from the first round of interviews with the practitioners in August-September 2004

4.3 The challenges the practitioners face in the bridge-building process

All the practitioners experienced a number of challenges in the preparatory phase of the project. The eight most important challenges will be outlined in this section.

(1) Overall the practitioners found it challenging to be directly **confronted** with other professional capabilities and other ways of understanding diseases, and thus also being confronted with their own professional standards. Several practitioners felt their self-image had been 'shaken up', and described the experience as hard, frustrating at times, but also positive and rewarding.

> *"…the professional [challenges] have almost been greater than the personal, but that might be difficult to distinguish. It is always fun to meet treatment paradigms that one has not dealt with before, because they are completely different ways of conceptualizing human beings…. The challenge has also been how to avoid being too self-sufficient, something we all know… when you believe that the only way to do things is the way you do it yourself."* (Psychologist)

(2) It was a great challenge for the practitioners to **collaborate** so closely with practitioners from other disciplines. The alternative practitioners in particular are used to working very independently in their clinics. Through their participation in this project, several conventional practitioners became aware that professionals in hospital settings tend toward parallel rather than interdisciplinary work. Interdisciplinary work is challenging because it requires the practitioners to break with the habitual thinking of their own profession, and to open up toward each other.

> *"What I have worried about the most along the way is professionalism. This is a multi-disciplinary project, and interdisciplinary integration is based on professionalism. Each profession must be expressed and be heard; otherwise the integration will not be good enough. That has been my concern.*
>
> *I also feel that my area of expertise, nutrition, is characterized by a lot of dogmas. We all eat food and we all have opinions about it… One person's professionalism can never be passed on completely to another person, since it has taken years for each practitioner on the team to build this professionalism. But it is possible to pass along basic information about a profession, the bottom layer of the cake one might say - some fundamental things that must be taken into account in my opinion …."* (Nutritional therapist)

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"For me, the biggest challenge has been seeing how this could work in practice with so many people from different backgrounds; how we can find a common way forward, so to speak." (Medical doctor)

(3) It can be difficult for the practitioners to verbalize and **communicate** their practical experiences. During the practitioner-researcher seminars, it was important to create a 'safe space' necessary to allow everyone to speak freely, and to enquire into other practitioners' and researchers' statements. The teamwork in the preparatory phase has been characterized precisely by knowledge sharing. The importance of this is strengthened by the fact that it is naturally often difficult for practitioners with a high degree of practical and clinical-based knowledge to communicate this 'tacit knowledge' to other practitioners and researchers.

"It has been [a challenge] to deliver my message. To be specific about the experiences I have, and to make them work on a team basis. In other words, to implement my experiences in the practice of the team. I find that difficult." (Reflexologist)

(4) For some practitioners, preparation for the seminars, i.e. reading materials distributed by the researchers, was also a challenge.

"It has been difficult for me to familiarize myself with some of the alternative practitioners' areas of expertise – but it has also been a positive challenge and educational. It has been a challenge to think along new lines. There has been a lot of reading, but I feel that it develops my skills. I think I have become better at speaking up when I don't understand something. In the beginning I was a bit reluctant, thinking 'it is just me who doesn't understand this' and 'what am I doing here?'" (Nurse)

(5) The **medical doctor** plays a critical role on the team, since he or she can create vital opportunities by being open to initiating treatments other than medical (drug) treatments with regard to MS and MS symptoms.

"The biggest challenge we will have is how flexible the medical doctor is, and how dynamic he is willing to be in relation to the participants in the project. How much is he actually ready to experiment? Is he willing to say 'let's see if a homeopathic remedy or reflexology or some needles can make a change instead', so we can save the drugs along with their consequences in terms of adverse effects and economy. That is going to be very exciting." (Classical homeopath)

(6) The practitioners describe the scope of practice as building on a non-hierarchical structure. At the same time, however, they are aware of the **professional hierarchy** and priorities characteristic of the health care system. In this sense, the hierarchy of the health care system impacts on the team and their self-understanding, as illustrated by the following quote:

> *"Yes, this team is [democratic]; I believe that to be true. I will then add that we do see some degree of hierarchy due to the fact that - in my conceptual framework anyway - the medical doctor is placed a little bit higher than the rest of us. After all, he has the medical responsibility, so it is important he understands what is going on when we do various things. That he looks at [what we're doing] and says 'yes' or 'no', and poses the qualified questions from the point of view of the established health care system. We have to acknowledge that we are doing this on the premises of the established health care system. We have to accept that there are limits to what we are allowed (...) to do, and we need to know those limits."* (Cranio-sacral therapist)

(7) It has been a challenge on personal as well as professional levels for the practitioners to **participate actively** in the research project. They describe the process as initially characterized by feelings of frustration about new concepts and demands. They describe how meeting researchers and other practitioners led them to question their own self-sufficiency, making them reflect upon their own professional standards in new ways. In the process, the majority of these frustrations have been replaced by an interest in being part of a learning process that is clinically relevant for each practitioner.

> *"[The biggest challenge] has been the team of researchers. As practitioners we take action; it is all in the hands. As researchers, you have a very different approach ... Practitioners tend to think in very practical terms, whereas researchers tend to think in overall terms."* (Acupuncturist)

(8) The practitioners indicate concern about not having sufficient **knowledge** about the other disciplines' strengths and limitations. At the core of their concern lies the question of when one's knowledge is sufficient to allow interdisciplinary work. Building this knowledge requires calendar time and places to meet.

Differences in the challenges as described by the practitioners primarily reflect previous professional experiences in cooperating with other professional groups and being involved in research projects. The differences are not related to being conventional versus alternative practitioners.

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4.4 The practitioners' experiences with developing an integrative treatment approach to people with MS

Building a common professional identity relating to the development of an integrated treatment approach to PwMS takes time, and the preparatory team-development phase is only the first small step. After the fourth seminar at the end of the preparatory phase, several practitioners said they felt a team spirit developing. The practitioners acknowledge that they are facing a disease about which they (and the medical community as such) know very little. Despite his extensive knowledge of MS, the medical doctor indicated that in order to reach a further understanding of MS, we may need to look at areas and levels other than the biomedical level that has been dominant so far. His acknowledgement makes room for curiosity and openness towards his own as well as other practitioners' knowledge, strengths and weaknesses. One aspect of building the team identity is to gain a greater understanding of MS, and thus be able to optimize treatments as a team effort. The team has developed an explicit focus on *the person with MS*, rather than the disease MS as an isolated biochemical entity.

As a part of the production of a collective identity, the practitioners develop central concepts and common practical approaches for dealing with integrative treatment approaches to PwMS:

- Symptom images refer to symptoms embedded in different layers: functionality, physical symptoms, mental symptoms, emotional symptoms and existential problems. All layers and symptoms are carried by a person with a life story, going new places in his or her life, facing opportunities and limitations. These layers can be visualized in a three-dimensional space. It has become significant for the team to verbalize and visualize symptom images for each patient. The basic position in the team is that for PwMS, it is a highly individual matter who you are, what you need and how you can be strengthened, i.e. how the self-healing processes of the individual can be mobilized.
- Core symptoms refer to symptoms that determine other symptoms in the same or other layers. Thus it is important for the team to localize these core symptoms.

The practical attempts to develop integrative treatment approaches to people with MS uncovered the following challenging issues:

- To be able to distinguish between secondary complications derived from MS and other symptoms caused by conditions other than MS
- To delay initiation of symptom-related medication, if this is medically justified
- To develop a broader understanding of MS than the one setting the stage for medication. It is a widely held opinion within the team that a

biomedical understanding of MS cannot stand alone, and that this understanding is not a sufficient guide for treatment efforts

- To initiate curative processes. A curative process refers to initiating a remedial process, i.e. the person is free from symptoms locally and overall, and new and worse symptoms do not occur in other symptom layers. Initiating a curative process *does not* mean that the person will be cured. Both the conventional and the alternative practitioners emphasize the necessity of being very cautious when talking about curative processes
- To develop a mutually high professional level. For each practitioner, interdisciplinary teamwork means having to communicate what the practitioner sees and does. At the same time, practitioners feel that the prerequisite for this communication is being 'mature' and established in one's profession and in the execution of that profession. This means having to listen to one's professional uncertainties and to share these with the other practitioners on the team
- To define success criteria in terms of treatment outcomes in PwMS. The success criteria for the team's treatments are defined as: being able to measure a reduction in symptoms, greater freedom from symptoms, improvements in general well being, greater acceptance of life situation and diagnosis. In cases of highly advanced pathology, the team expects to see limited changes in the level of physical symptoms. Instead they will expect to see a significant decrease in symptoms on levels other than the physical. Finally, the team highlights that a learning process through teamwork is also a criterion of success
- To operate as one united team in order to be of more help to PwMS
- To learn to be aware of and communicate what will be adverse effects and what will be reactions to treatments. This is deemed very important for cooperation regarding PwMS, with the aim of avoiding improper treatment and increasing the effectiveness of each course of treatment.

The members of the team sum up their treatment rationale like this: The goal of the team is to develop therapeutic approaches characterized by the fewest possible treatments with the largest possible positive outcomes.

4.5 Acquired and desirable professional and personal competences in developing an interdisciplinary and integrative treatment approach to people with MS

Importance is attached to professional as well as personal competences among team members. It is noteworthy that the two kinds of competences very much

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overlap for all practitioners. The following competences are considered particularly important: 'Thinking as a team', openness, willingness to cooperate, not being prejudiced, being explorative and curious, not being dogmatic, being respectful towards other therapists and other professions, being confident that other practitioners are competent professionals, putting personal interests aside, being willing to develop a team-based attitude, wanting to solve tasks in common, which in many cases means that 'my treatment' may not be the one to use in a given context. Overall, being aware of one's strengths and weaknesses as a practitioner and as a private person. In the practitioners' experience, thinking as a 'team' is a decisive challenge.

> *"The ability to cooperate, being flexible, having respect for each other, being able to listen. It is about seeing it [cooperation on the team] in terms of the welfare of the users… Always being aware of what is best for the people we are dealing with… That we can back out when there are things we are not able to do… That is very important."* (Occupational therapist)

> *"Not being prejudiced. That is the most important thing in my opinion… Not to be dogmatic and to be prepared for surprises. Being ready to be more flexible… My own weakness has been my lack of experience in broad-based team cooperation. One strength is that I have treated people for many years. As a result, I have seen a lot of things through the years that have geared me for entering this project. So it goes both ways."*
>
> (Classical homeopath)

> *"I think the personal competences are important; being respectful towards the other individuals on the team, being interested in and open towards the team… And trusting that they [the alternative practitioners] are competent practitioners. That is part of it too: They have their sense of professionalism and the desire to get results with the people they are treating. For me that is fundamental; the alternative practitioners carry out treatments based on their professionalism, and they do it in a sober and competent fashion… To the extent that the group is interested in drawing on my knowledge, naturally I will be happy to share it, but I don't know if it is a prerequisite for the treatments as such."* (Medical doctor)

> *"It is very important to have the target in sight; that we are focusing on treatment combinations. That means thinking as a team and putting aside one's personal interests."* (Cranio-sacral therapist)

> *"It has to be the best education and training available within a given field. I don't think you can just pick any recently qualified person. Some experience is needed. I would say at least five years of clinical experience, as a guideline."* (Reflexologist)

4.6 Assessment of practitioner-researcher seminars – strengths and weaknesses

According to learning theories, the 'stage' at which learning processes take place is very important. All practitioners on the team agree that the preparatory phase with four practitioner-researcher seminars at the MS hospital was essential, although several practitioners think that even more time could have been allotted to this phase. The practitioners put great emphasis on creating an atmosphere of trust within the team, which then allowed them to freely express their opinions.

In Figure 1 the strengths and weaknesses of the preparatory phase, as voiced by the practitioners, are lined up.

Figure 1: Practitioners' statements concerning the strengths and weaknesses of establishing the team in the preparatory phase of the project.

STRENGTHS	**WEAKNESSES**
Establishing a 'free zone', an atmosphere of trust with open lines of communication that challenge and expose 'tacit knowledge' *"Discussions are carried out in an open and positive forum"* *"Building mutual confidence and loyalty"* *"Communication and mutual respect for each other's professionalism would not exist without the preparatory phase"* *"A 'free zone' has been established. This means moving beyond the ordinary rules"*	**Time shortage** *"Frustrating to be making good progress at a seminar when the time runs out"* Several practitioners would like to set aside a weekend to discuss issues in more detail than time allowed at the seminars. The first seminar should have

"Getting acquainted personally as well as professionally" *"The researchers initiated thought processes that had been unconscious for the practitioners"*	allowed each practitioner to present his or her treatment in more detail.
A structured and intensive preparatory phase *"It didn't take us that much time to get where the team is today"* *"The content of the seminars has been appropriate on a social as well as a professional level"* *"There was plenty of time to read the distributed material prior to each seminar"* *"This is the first time I have been part of a project that is so structured; problems are verbalized and speedy feed-back given. That has been very good"*	**More practitioner-based dissemination of knowledge** Several team members would like to have seen a more practitioner-based dissemination of knowledge throughout the seminars. This could be in the form of video recordings of treatments, or observing each practitioner's treatment of a patient.
Dissemination of new knowledge *"The practitioners now have a better understanding of each other's methods"* *"[The team] has expanded my knowledge in several areas"*	
Prerequisites for initiating the treatment phase *"The preparatory phase gives us a sound basis for moving on [providing treatments to people with MS]"*	

4.7 Answers to the core research questions

1. What can the practitioners learn from participating in a bridge-building project and from developing an integrative treatment approach to people with MS?

Conventional and alternative practitioners' learning can be characterized as a process involving:

- *Motivation.* We found that planning for the practitioners to be actively involved in establishing the interdisciplinary team was very motivating in terms of their entering the project. Further, the focus on a mutual effort to create improvement in treating PwMS was a highly motivating factor.
- *Emotions.* The practitioners expressed strong emotions about participating in what they regard as an innovative project that challenges conventional routines in the care of PwMS.
- *Challenges.* (1) When confronted with treatment models different from their own, the practitioners are simultaneously confronted with the strengths and limitations of their own professional capabilities, described as a frustrating but also nourishing and positive experience. (2) This confrontation is inevitable due to the close collaboration of practitioners from different disciplines. Alternative as well as conventional practitioners tend to work either alone in a clinic, or in parallel rather than in an interdisciplinary manner. Interdisciplinary work requires professional reflection and an open attitude towards other professions. (3) Collaboration is further complicated by the fact that it is challenging for many practitioners to communicate the 'tacit knowledge' embedded in their clinical experiences. (4) The time and effort required to prepare for the practitioner-researcher seminars was a challenge for some practitioners. (5) A key issue is the role played by the medical doctor on the team. Due to his position in the health care system, he is the 'gate-keeper' when practitioners in the project are discussing whether to initiate or discontinue medical treatments. (6) The hierarchy of the health care system impacts the team and the self-understanding of the team. (7) The meeting with researchers has been challenging because of the confrontation with new ways of practicing treatment and new communicative practices. Further, the researchers have introduced new tools to assess the process from intervention to outcomes. (8) The practitioners were frustrated about whether and when they had sufficient knowledge about the other disciplines represented on the team.
- *The practitioners' experiences with developing an integrative treatment approach to PwMS.* One prerequisite for developing this approach is the development of a team identity. It is a challenge to 'think as a team' and to be patient-centered. The driving force is the practitioners' recognition

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that an interdisciplinary approach is a realistic opportunity to explore new pathways to improve the treatment outcomes of PwMS. In this interdisciplinary approach, important mutual concepts are formulated such as symptom levels, symptom images and core symptoms. Some of the desired improvements in treatment expressed by practitioners on the team are: Being able to differentiate between symptoms resulting from the disease MS and other kinds of symptoms; the opportunity to postpone drug treatment when this is medically safe; the need to incorporate broader diagnoses than given by a bio-medical frame of reference; exploring the opportunity to initiate healing processes; developing mutual professional communication skills; formulating mutual criteria for treatment success (regarding processes and outcomes). and being able to communicate what the adverse effects of a treatment are as well as what the expected reactions to a treatment are. As all of this indicates, building a professional team identity takes time.

- *Standards of professional and personal competences.* The practitioners considered both professional and personal competences to be important, and, in fact, these competences overlap**.** The core competences are: being open**,** having the intention to cooperate, being explorative and curious, having confidence and respect in the practitioners' different professional capabilities, possessing the willingness to develop a team approach and a team attitude, and being aware of one's own and the other practitioners' strengths and limitations.

2. How do the practitioners assess practitioner-researcher seminars as a tool for developing bridge building and an integrative treatment approach to people with MS?

- The practitioners assessed that the preparatory phase containing four practitioner-researcher seminars at the MS hospital was essential; although several practitioners felt that more time could have been allotted to this phase. The ultimate strength of the seminars was the establishment of a 'free zone'; an atmosphere of trust with open lines of communication that challenged and exposed the practitioners' 'tacit knowledge'.

5. Discussion and conclusion

5.1 Theoretical considerations

According to learning theories, innovation and change are promoted by staging a context that legitimizes and further invites and encourages confrontations. In this

project, the means for promoting innovation and change was four practitioner-researcher seminars held at the MS hospital, each lasting six hours.

The practitioners attached importance to the seminars, their structure and content, and found them to be an essential preparatory phase in the approach to develop bridge building and a bridge-building discourse. However, in this approach, the practitioners and the researchers had to acknowledge that the hierarchy of health professions and the medical doctor's overall responsibility for treatment also impacted the team's possibility to change conventional medical treatment.

The learning theories used as a frame of reference to set up a team of conventional and alternative practitioners were useful. Before starting the project, the researchers' focus was on facilitating bridge building between the two landscapes: the conventional practitioners within the landscape of the health care system on one hand, and the alternative practitioners from the landscape outside the health care system on the other. We quickly realized that we were facing ten landscapes, not two, between which we had to facilitate bridge building. Differences and similarities in frames of reference were seen between and across the conventional and alternative practitioners. Some of the conventional practitioners felt more in line with some of the alternative practitioners in their patient-centered and 'holistic' approach to patients, and in their focus on strengthening the patients' self-healing capabilities. The alternative practitioners perceived the conventional practitioners' extensive experience and knowledge based on previous treatment of PwMS as very beneficial.

Learning theories were used to focus on the differences as a base for initiating transcending learning processes among the practitioners. To make the differences visible, we worked with conceptualizing the practitioners' different treatment models. The concept 'treatment model' refers to the practitioners' perceptions of their understandings of MS, their diagnostic systems, their treatment methods and their experience with and expectations of outcomes (Launsø and Rieper 2005). Common to the practitioners was the understanding of a treatment model as a socially constructed phenomenon that may undergo re-assessment and change. This understanding may be an essential prerequisite for transcending learning to take place.

'Transcending learning' is a concept playing a central role in the literature of organizational learning and organizational development (Pawlowsky et al. 2003:77). It is also called double-loop learning (Argyris 1991, 1992), which refers to the process whereby persons transcend their professional paradigms by reflectively scrutinizing own norms, conventional thinking and prejudices. This reflective scrutinizing characterizes the process team practitioners are undergoing in the project.

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5.2 The results of the project compared to a newly published study

When we had finished collecting our data, a qualitative study was published on the experience of 16 members of a health care team who worked at a comprehensive integrative care clinic in Vancouver for five years (Mulkins et al. 2005). The objective of this study was to assess what factors the practitioners had identified as supports and barriers to providing care within an integrative health care setting. The study (ibid.) shows the following supports and barriers: (1) effective communication tools (weekly team meetings; common patient charts; standardized procedures to avoid conflicting patient information; an environment that supports informal communication); (2) personal attributes (enthusiasm about the integrative care model; being a team player and a change agent); (3) satisfactory compensation and (4) a supportive organizational structure not based on a conventional medical clinical model (as was the case). The practitioners found that the conventional medical model inhibited patients and practitioners from experiencing the integrative care model.

Our study supports these findings. We decided to incorporate the preparatory phase of the project in order to formulate and address potential barriers before initiating the treatment of patients. The practitioners pointed out that the responsibility of the medical doctor for the treatment of patients was a factor that potentially inhibited the access and possible effects of other practitioners' treatments. There was agreement among the practitioners to work on this issue and discuss it as an important item on the agenda at the seminars.

Our project differentiates from Mulkins et al.'s study (2005) in terms of the researchers' role. Mulkins et al. write that the desire of practitioners and researchers to work more closely together was never fully realized (Mulkins et al. 2005:116). However, the nature of the cooperation is not described in the article. In our study, the researchers played a very active role in creating the structure and content of the treatment project in ongoing dialogue with the practitioners. As the quotes in this article illustrate, the practitioners experience the exchange of knowledge between practitioners and researchers as a process ranging from frustration to recognition and acceptance of the learning potential in this exchange. The research facilitates a level of meta-reflection on the strengths and limitations of the practitioners' treatment models and clinical practice. Thinking as a team is facilitated by the practitioners' ability to reflect on a meta-level.

An integrative treatment model was not 'handed over' to practitioners. On the contrary, they have had to create visions, goals and procedures to develop integrative treatment approaches. The practitioners are expected to revise these approaches in response to current feedback from the evaluation research in the

second phase of the project, and by discussing worst and best patient-cases at future practitioner-researcher seminars.

5.3 Quality criteria

We tested the 'validity' of the knowledge generated in the study in a dialogue with team members. The team members received a report on the quotes and interpretations, and they assessed that the knowledge presented was trustworthy and reflected their opinions and experiences. In relation to the quality criterion 'transferability', the theories applied in the study make it possible to assume that the findings can be transferred to bridge-building activities between alternative and conventional therapists trying to develop integrative approaches within the health care system to patients with other chronic diseases.

5.4 Conclusion

The present study of a preparatory phase of an integrative treatment project points to a number of important factors in facilitating bridge building. It is important to underscore that our project is ongoing, and thus our knowledge will be deeper at later stages. However, as of now we find it crucial to:

- Create a social 'free zone' within the health care system. The hospital setting gives the project a formal status and legitimacy, which is essential for both the conventional and alternative practitioners
- Create mutually accepted norms for communication practice among the practitioners, between practitioners and patients and between practitioners and researchers
- Facilitate a meta-level for practitioners' communication about strengths and limitations of treatment practice when developing integrative treatment approaches
- Provide insight into the differences and similarities between the practitioners' treatment models at the very beginning of bridge building, and perceive the differences as challenges that can nourish team collaboration
- Develop team-based criteria of treatment success (processes and endpoints) in dialogue with the practitioners
- Develop research data collection instruments in dialogue with the practitioners to ensure clinical relevance of the research results, thereby optimizing external validity.

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