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TOWARD A CLINICAL FRAMEWORK FOR COLLABORATION BETWEEN GENERAL AND COMPLEMENTARY PRACTITIONERS

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The Marylebone Health Centre (MHC) was established in 1987 as a general practice within the NHS aiming to develop and assess innovative approaches to primary health care. Among the principles developed as part of the "Marylebone Model" is the commitment to offer patients a wide range of approaches to health care, including both educative strategies and treatment by disciplines which may be described as "complementary" to general practice. At MHC these include homeopathy, traditional Chinese Medicine (TCM), osteopathy, counselling, and therapeutic massage.

Over the years multidisciplinary practice at MHC has taken several different forms. Complementary practitioners have held sessions there, seeing patients referred by general practitioners and taking part in the development of the Marylebone practice, and the centre established a multidisciplinary clinic1. The Marylebone practitioners have a degree of familiarity with each others' disciplines through working together over several years, and also usually have some experience and competence in a range of complementary and orthodox healing practices: thus for example the osteopath is also a general practitioner, and the TCM practitioner a family therapist.

In the Autumn of 1989 a new multidisciplinary clinic, the MHC Research clinic, the subject of this paper, was established.

The problem

A central question in all of these collaborative endeavours concerns the nature of multidisciplinary practice. What is involved when practitioners with very different assumptions and practices try to work together? In particular what kind of clinical models should inform such practice? Another concern was to explore the balance between expert knowledge and patient empowerment, and the extent to which patients might chose between different approaches to treatment.

The MHC Research Clinic was established to explore these issues of multidisciplinary practice. At this clinic patients, referred by their GP, were seen for individual assessment by each complementary practitioner. Following the assessment each patient met with the clinical team, with their GP in the role of advocate, to hear feedback from the practitioners and jointly to agree a management plan.

It was decided that this clinic should also be explored by the clinicians involved using co-operative inquiry, in order to identify and learn from the opportunities and problems of clinical practice facing such a venture. It was also to be the subject of a clinical trial in order to determine its impact on practice issues such as attendance at the Centre and prescription rates, as well as on patient well-being2.

Co-operative inquiry

In traditional research, the roles of researcher and subject are mutually exclusive. The researcher contributes all the thinking that goes into the project, while the subject contributes the action being studied. In the co-operative inquiry[3,4] these mutually exclusive roles give way to a co-operative relationship with bilateral initiative and control, so that all those involved work together as co-researchers and as co-subjects. As co-researchers they participate in the thinking that goes into the research -- framing the questions to be explored, agreeing on the methods to be employed, and together making sense of their experiences. As co-subjects they participate in the action being studied. The co-researchers engage in cycles of action and reflection: in the action phases they experiment with new forms of practice; in the reflection stages they reflect on and explore their experience critically, learn from their successes and failures, and develop theoretical perspectives which guide and inform their work.

Ideally in co-operative inquiry there is full reciprocity, with each person's agency, their potential to act as self-directing persons, fundamentally honoured both in the exchange of ideas and in the action. This strongly contrasts with traditional approaches in which all agency is held by the researcher, and the subjects of the inquiry are treated as objects.

The inquiry team for this research consisted of the three practice GPs and the four complementary practitioners, with the Director of Clinical Research as facilitator. The inquiry engaged in five cycles of action and reflection between November 1989 and June 1990. Each action phase consisted of two or three clinics attended by up to four patients; each reflection stage consisted of a three hour meeting at which the experience of the previous clinics, and the experience of the whole venture to date, was discussed in detail. The meeting with the patients in the clinic itself and the reflection meetings were all tape-recorded and the transcripts circulated to the clinical staff involved in the clinic, who were thereby able to reflect more thoroughly on their experience.

It is important to note that the patients who attended the clinic were involved only minimally in the inquiry, although without them the inquiry could not have taken place. They were involved with their GP in agreeing their expectations for the clinic and in making a joint assessment of their health both before and after the clinic.

Among the guiding assumptions of co-operative inquiry is that valid knowledge is formed in action and for action[4,5,6]. It follows that the outcomes of the inquiry importantly include the group members' experiential or tacit understanding of the process of multidisciplinary practice; their individual and collective practical knowledge, which include the skills of collaborative practice developed together; and also the conceptual or propositional knowledge of the issues involved in this multidisciplinary process. All these forms of knowledge are valuable and important outcomes of the co-operative inquiry process. A written article can only address the last of these three forms of knowing.

An overview of the whole inquiry has been provided in a working paper[7], and an exploration of issues of power and conflict in the clinic in a separate article[8]. The present article describes a clinical model for the kind of multidisciplinary work which was developed in the course of the inquiry. The ideas in the paper evolved during the inquiry process: the first draft was written at the end of the inquiry proper, and was refined in several later meetings. Thus the clinical model presented here is based on the experience of the group, but has not been critically tested in action as thoroughly as a fully rigourous application of the co-operative inquiry method would demand. For a fuller discussions of issues of validity in co-operative inquiry the reader is referred to the working paper.

Variety Of Clinical Models

At the start it seemed, on the surface, that there was a relatively clear and shared idea of what the

clinical team were setting out to do and how this was to be accomplished. It soon became evident, however, that there were many different models for the clinic in team members' minds, some quite explicit, some tacit; some widely shared, and others more idiosyncratic.

For example, in one view the clinic was based on a multidisciplinary model of practice, and its purpose was to extend the treatment available to patients to include appropriate complementary therapies. Another view was that while the complementary viewpoints were important, the key process of the clinic was the empowerment of the patient to take charge of their own health.

Thus there was a degree of initial confusion, with different team members, unwittingly, operating with different objectives and from different assumptions. Through the research process the inquiry group clarified the different models which were being used, and with a developing sophistication explored their interrelationships.

Thus a first and maybe most important finding of the inquiry is that any multidisciplinary team involving general and complementary practitioners needs to work very hard in the initial stages to agree what it is setting out to accomplish and to find ways to explore and understand the different models and assumptions its members bring to any joint exercise. In our experience this is more problematic and requires more attention than may at first appear.

A model for multidisciplinary practice

There appear to be three arenas of concern and attention in the consultation between a practitioner and a patient in which some kind of a assessment may be made. It is necessary for the purposes of discussion to consider these separately, which is of course artificial since they must be integrated in practice.

First there is a specialist diagnosis from the perspective of the practitioner's chosen discipline, made with the authority of their expertise: the bio-medic may diagnose in terms of disease entity, the osteopath in terms of body structure, the acupuncturist in terms of energy, and so on. Each practice has a unique perspective on the problem, elicits a different set of signs and symptoms, and has its own particular way of investigating and understanding them.

The second arena for attention is the psychosocial context in which the symptoms occur -- the patient's current predicament and response to it, mediated as it will be by their individual and cultural history. Thus there may be a current problem of housing, of poor relationships, of unemployment; and these may be exacerbated by a history of physical abuse or psychological neglect which may make the patient particularly vulnerable to these circumstances.

While in this arena there is more likely to be general agreement concerning the issues which need attention, practitioners with different personal experiences or political perspectives are likely to identify or emphasise different issues: a woman might be seen as clinically depressed by a male GP but as suffering from oppressive male domination from a feminist perspective; an unemployed black youth might be seen as malingering and delinquent from a right wing viewpoint, but as severely under-privileged from a liberal perspective. The issue here is what meaning is placed on the patient's life, and by whom[9].

The third arena for concern is the relationship between practitioner and client, which is critical in influencing the extent to which any clinical intervention is likely to be successful. This relationship is also important in its own right, since practitioners may wish to influence it in particular directions. Several issues may need consideration, for example:

the extent to which the practitioner is willing and able to develop a close and empathic relationship;

the patient's belief systems concerning health and illness;

the practitioner's intention and skills in relinquishing control and empowering the patient; and the patient's intent and capacity to take power;

the patient's physical and mental condition -- there are occasions when a patient may be quite appropriately dependent on the practitioner for life-sustaining intervention or containment of distress;

the manner in which the relationship is influenced by earlier and childhood experiences (although an in-depth treatment of these issues would most likely fall within the expert realm of a psychotherapist).

In conventional one-to-one practice, be it orthodox medical or complementary, all these factors may be taken into account by the practitioner and to some extent by the patient. The diagnosis, or "knowing through", is (or should be) the synthesis of the three perspectives. In multidisciplinary practice the same diagnostic concerns are present but with in greater variety and richness of alternatives. Some of these issues are addressed in the remainder of this paper.

Perspectives from different disciplines

A multidisciplinary practitioner group will have available a much wider range of resources than a single practitioner, and is thus faced with the challenge of how to use them. There is a wide variety of possibilities, some of which are identified as follows.

a) It may be possible to make a "match" between patient condition and therapy; to say, for example, that conditions of menopausal imbalance are best treated with homeopathy. Some such matches are beginning to emerge in practice, although much more research is needed before such statements can be made with confidence.

b) Treatment by one discipline may be supplemented and supported by treatment by a second. On occasion in the MHC clinic homeopathy was twinned with osteopathy, the homeopathy (for example Rhus tox and Bryonia, low potency) aiming to help with fibromyalgia and myofascial pain; similarly homeopathy was used to support counselling, with Natrum muriaticum being used to help a patient in counselling let down their defences. And all the complementary disciplines were used at times in conjunction with more orthodox general practice approaches.

c) The involvement of several experienced clinicians working from quite different perspectives may enable all the practitioners, and thus potentially the patient, to deepen their understanding of the patient's condition. This may result in more effective long term treatment of a patient with a chronic condition:

> A patient was seen in the clinic with a variety of physical symptoms and a fear that she had MS. A history of debilitating childhood illnesses including meningitis and rheumatic fever, of physical and psychological abuse, and physical injury combined with very poor housing conditions resulted in an experience of physical pain, exhaustion, and deep seated anxiety. Some of the physical pain was diagnosed osteopathically, and treatment relieved one layer of the pain symptoms.
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> However further reflection in later inquiry sessions suggested that long term treatment was required and that, while held and supported by her general practitioner, this patient would ideally receive care and attention over

several years, with treatment probably including psychotherapy, maybe family therapy, acupuncture, and further osteopathy. All this would need to be carefully orchestrated to meet her life situation and ability to respond and change.

It was not possible to design such a programme within the limitations of the Research Clinic, although the patient continues to see her general practitioner, whose understanding of her condition has been deepened, and who has access to the wide range of resources of the Marylebone Health Centre (for a fuller description see Reference 7).

d) The clinicians are able to use their colleagues' differing clinical expertise in order to support, inform and develop their own expert judgement.

On the other hand there are possible negative consequences of the multidisciplinary model, the most likely one being that instead of developing a creative synergy between the different disciplines, difficulties of communication and understanding cause the team to dilute the skills of its practitioners to conform to some lowest common denominator and the particular differences of the different disciplines get lost. In the Marylebone experience it proved very difficult fully to appreciate and integrate the clinical skills and experience of the different practitioners: we simply did not have the concepts or the language. In consequence every practitioner felt that they were educating their colleagues at the same time as trying to understand the patient, and that they had greatly to simplify their technical explanations in order to be understood.

Because of these difficulties of communication across professional disciplines, there was also a tendency to discuss the patients in terms of their psycho-social predicament (because that was the arena of most shared understanding) to the detriment of careful diagnosis from the perspective of the different disciplines. And there was at times a feeling that the general practitioners in particular did not appreciate the distinctive expertise and clinical contributions of the complementary practitioners, especially of the homeopath and TCM practitioner. As one of these practitioners reflected toward the end of the inquiry, the implication was that their approach could not have any *medical* validity, but what it could have was psycho-social validity.

Psycho-social issues

There is likely to be a greater uniformity of understanding and perspective in this area, and less likely to be differential expertise to contribute to the diagnosis (although a systemic family therapist might well have a professionally informed opinion). However, the collaboration of practitioners as individuals with different life perspectives may make possible a much deeper understanding of the patient's predicament. As pointed out above the danger appears to be that, just because this is an arena of common understanding, it will come to dominate discussion.

Relationship issues

Relationship issues are greatly complicated by multidisciplinary practice, certainly in the form of the Marylebone Research Clinic, involving as it did the meeting between the patient and a group of practitioners. In addition to issues in the relationship between individual clinician and patient, there is the broader question of the management of the relationship between the patient and the team as a whole, and also between the clinicians themselves.

First, patient-clinician relationships now take place in the context of the multidisciplinary clinic. Thus the traditional personal relationship between GP and patient may be disturbed. While the positive side is that the patient may be supported by more people, one danger is that they may get "lost", with no

one clinician taking responsibility for overall care; another is that the patient may (consciously or unconsciously) play one clinician off against another.

Second, it is important to manage the meeting between patient and team with utmost care, because it is clearly much more complex to establish a healing relationship between one patient and a group of practitioners than it is one to one. The patient is confronted by a possibly overwhelming array of clinicians, each with their different clinical perspective, and the danger is that they will in some way compete to "sort out" the patient.

The initial view of the meeting with the patient which followed the assessment interviews was that the patient, having heard from the clinicians, would make their own choice of treatment. This was an attempt to guard against the danger that the clinicians would in some sense "take over". However, this rather simplistic notion confused patients and sent the clinicians into turmoil. A new more business-like and problem-solving structure for the meeting was then adopted: each clinician in turn would report from their perspective, and then the GP orchestrated a decision, with the team making great efforts to include the patient as an equal partner in the decision process. This format was acceptable for a while, but its limitations became apparent: it was a compromise, and more seriously a defense against the anxiety of uncertainty, of working together in a new way.

It is evident that a completely new language is needed if the clinicians are to be able meet the patient as a group and work together with her or him in the room. While the inquiry team was not able to explore this with any degree of rigour, it does appeal as a possible focus for future inquiry. Such a new language might look to ceremonial and ritual processes for inspiration, creating what might be termed a transitional space or an alchemical vessel[10]. It might mean drawing on the thread of clinical work which comes from models of brief psychotherapy, family therapy and systems thinking[11,12,13,14]. It would mean much more careful strategic planning of the meeting as an intervention by the practitioners.

The third relationship question concerns the clinicians themselves and their capacity for creative collaboration. Certainly in the early days of this clinic the team really did not know how to work together: there was the inevitable awkwardness of people working together in a new and challenging situation and this was compounded by the absence of a clear and shared model of practice, and compounded again by the failure to realize the extent of this absence. The establishment of the Clinic within a framework of co-operative inquiry, with its phases of systematic reflection, enabled the team to identify these problems and work toward their resolution. One outcome of the inquiry is the clinical model described in this paper.

Healing relationships: who has the "juice"?

The multidisciplinary model as described so far is a useful logical and analytical tool. However, careful diagnosis and analysis need to be linked to subjective considerations which the team encapsulated in the question, "Who has the juice for this patient?". This notion of *juice* is not just about having the most appropriate treatment, or about empathic relationships and a good bedside manner. It is about a personal integration of the specialised skills of a discipline with an understanding of the patient's predicament and containing these within a healing relationship, so that empathy and personal expression are channelled through the healing discipline.

Summary

A creative and effective multidisciplinary practice would work together to integrate these arenas in its work It would develop an expertise in collaboration over and above the separate expertise of the individual clinicians. It would take time to educate itself in some depth into the perspectives of each of its specialised disciplines, and in discussion of each patient would allow adequate time for each clinician's viewpoint to be fully developed. This would lead to a joint "expert" choice of appropriate treatment (or combination of treatments). This judgement would be integrated with a psycho-social diagnosis and with an assessment of which clinician is best suited to develop a healing relationship with the patient.

The co-operative inquiry described in this paper has laid a firm foundation for further work to develop the understanding and skills required for this kind of multidisciplinary practice. The following questions in particular merit further consideration:

a) What steps can a multidisciplinary team take to deepen members' understanding of the diverse clinical practices of its members, and of the manner in which these are expressed by each practitioner? Clearly some of this can be accomplished in a straightforward manner through reading and discussion; however we suspect that the more subjective aspects of these healing skills are more difficult to communicate and can only be learned through extended and sympathetic collaboration.

b) How can a multidisciplinary team as a whole best relate to a patient? Are there therapeutic practices outside primary health care -- in systemic family therapy or group psychotherapy, for example -- on which a team could draw?