Author's response to reviews

Title: CAM practitioners in the Australian health workforce: an underutilized resource

Authors:

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Author's response to reviews: see over
Dear Executive Editor,

Thank you for the opportunity to revise my Debate paper entitled CAM practitioners in the Australian health workforce: An underutilized resource. I have addressed all reviewers’ comments in the revised paper (see highlighted text).

Reviewer 2’s comment

I had suggested to include an international perspective. The author has included some points with regard to education now. However, the international perspective would be most interesting with regard to the question how to integrate CAM practitioners in "normal" the health care system. The revised passage, however, does not include this perspective.

I have added the following passage on p10-11 in the section entitled New models of delivery. It presents a brief summary of two dominant models of integrating CAM and conventional medicine that appear in the international literature:

- New models of delivery. The literature presents various ways in which CAM and conventional medicine can be integrated and it appears that strategies can be successfully developed to facilitate integration. Two dominant models of integration are described in the literature:

  (1) Selective fusion of the most effective elements of both CAM and conventional medicine based on health outcomes. This is the ideal model described by Lewith and Bensoussan [49]. Both biomedical evidence and clinical efficacy are valued. CAM and conventional medicine are complementary to each other and CAM practitioners
and members of the medical profession are co-workers with equal input and standing. The Birkenholm Centre in Denmark was established as such a model [50] as was the Marylebone Health Centre in London, in which condition-based guidelines (as opposed to individualised care plans) were used for CAM service delivery [51].

(2) Selective incorporation of some elements of CAM into conventional medicine. This model may involve initially directing patients to members of the medical profession for conventional medical assessment. If referral to a CAM practitioner is required it is carried out under the aegis of medical practitioners [52-57]. The Australian Government’s Medicare rebate system exemplifies this model in relation to subsidising chiropractic, podiatry, psychology and other allied health treatments for patients with chronic diseases. Subsidies are available only if the services are part of enhanced care plans and are supervised by general medical practitioners [58].

On p 14-15 I have expanded the discussion on re-designing roles for CAM practitioners to embrace a more international perspective.

Re-designing roles of CAM practitioners: Professions have always responded to new ways of perceiving health and illness, new technologies, innovations in education and new regulation, and have always had changing roles and status in society [80]. Professional boundaries are dynamic and change according to such pressures as workforce shortages, performance-based management principles and consumer preference. According to Nancarrow and Borthwick [80], a workforce can change within a single discipline through diversification and specialisation, and/or can undergo vertical and horizontal substitution, which occur when a discipline moves outside its traditional boundaries. There are opportunities to review current roles of CAM practitioners in the workforce with a view to re-designing roles, including performance in multidisciplinary teams (diversification and specialisation), especially
in identified areas of need (e.g. prevention, treatment and management of chronic conditions, obesity, rural and remote community health). The CAM practitioner role could be legislated in a similar fashion to that of nurse practitioners who conduct autonomous and collaborative nursing practice in an advanced and extended clinical role (vertical substitution).

I have also added the following at the end of p13 to the discussion about potential disadvantages:

- Shuval and Mizrachi [77] found that CAM gained legitimacy when they worked collaboratively in practices with general medical practitioners but that they did not have the same status as other health care providers in these practices. That CAM runs the risk of being subsumed under conventional medicine is borne out by the experience of several clinics where CAM and conventional medicine practitioners practice together [30, 78, 79].

**Reviewer 2’s comment**

I appreciate the inclusion of "potential disadvantages". However, I see some more possible disadvantages e.g. delayed therapy or complete lack of adequate conventional therapy. This is a major problem for patient safety.

I thank the review for suggesting this point be made more explicit. I have adopted their suggestions, as indicated in the paragraph below:

- Delayed diagnosis and therapy. Greater utilisation of CAM practitioners by government agencies and medical and other health practitioners could promote CAM practitioners’ primary contact role in health care. Concerns have been raised about the competence of some CAM practitioners to adequately fulfil this role [67]. A lack of such competence could mean an incorrect or delayed diagnosis, delayed therapy or absence of adequate conventional therapy, less than optimal health outcomes, and a waste of money and time.
Reviewer 2’s comment

Legislat ing CAM practitioners in a similar fashion to that of nurse practitioners would lead to more interfaces of care with known consequences. In case of ordering diagnostic interventions by CAM practitioners there would be a risk of oversupply with diagnostics and over-diagnosing.

I have acknowledged this possibility in the text on p.16:

Such opposition might raise objections concerning over-prescribing and over-diagnosing.

Reviewer 2’s comment

Furthermore, following the description in the manuscript I would see a problem in the distinction between the role of nurse practitioners and CAM practitioners.

In the paper I suggest that CAM practitioners and nurse practitioners may both have an expanded role that includes prescribing medication and ordering diagnostic tests without referral to a general medical practitioner. However, their roles are distinguished by their core practices and philosophies. Inclusion of the two sentences beginning “CAM practitioners are already ... treatment approaches” clarifies the distinction between the roles of nurse practitioners and CAM practitioners (see text on p.15 which is reproduced below):

Nurse practitioners’ tasks include prescribing medication, ordering diagnostic investigations, and referral to other health care practitioners. CAM practitioners already provide a valuable service in both community and private settings. Their particular strengths would be their focus on lifestyle medicine, health promotion and chronic disease management using simple, non-invasive and often inexpensive treatment approaches.

Reviewer 2’s comment

I agree with the earlier criticism of reviewer 3 that it would be favorable to consider registered and non-registered practitioners separately. But this is important not only for the description of the work practices but also for the implications (which means for the debate part of the article). Describing the sociodemographics of osteopaths in this context makes no sense to me.

I agree that the reason for inclusion of the socioeconomic data of registered professions was not clear. My aim is to compare socioeconomic data on registered and non-registered CAM professions (as suggested by one of the other reviewers) in order to strengthen the arguments for registration that occur later in the paper on p14. In the text on p4 I have made the sociodemographic data of
registered and non-registered professions more compatible by including a statement on income for the registered practitioners.

Chiropractic and osteopathic businesses operating at 30 June, 2010 generated an average income of $232,100 per business. Fee for service income earned per practitioner was $108,500 [16].

I have also connected the sociodemographic data on p4 with the registration argument to follow on p14 by including the highlighted text at the end of p4:

It appears that many CAM practitioners were underutilised in terms of their potential client reach and that the effects of statutory registration on the workforce may extend beyond conformity of training to enhancing the prospect of a secure and viable income.

I trust that I have satisfactorily addressed the reviewer’s concerns. I am happy to make any further changes that you might require.

Yours sincerely,

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