

Changing the Global Health Care Landscape—Proceedings of a “Glocal” Symposium*

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Background: This glocal (global knowledge with local action) symposium was convened by a professional therapeutic massage bodywork professional organization to bring together the fields of economics, politics, and traditional and complementary and alternative medicine (TCAM) to begin development of effective TCAM advocacy worldwide. The symposium addressed the core question, “What information will be needed to address issues that will arise as TCAM practitioners advocate for a respectful and equal-footing access to health care provision, public and private, worldwide?”

Participants and Setting: The 35 international participants convened in a Victoria, Canada hotel. They were selectively invited to provide expertise in: advocacy, politics, public policy, economics, TCAM practice, integrative practice, sociology and TCAM research, education, media and language framing, psychology, and mediation.

Methods: The two-day symposium used a facilitated dialogue and knowledge-sharing design process geared to achieving group-supported recommendations. Invited panelists discussed each agenda topic, followed by facilitated discussion with the entire group.

Results: In general, participants agreed that advocacy from a TCAM perspective is needed. Additionally, more research should use methods with more relevance to everyday health care provision and health care costs such as effectiveness comparative trials and cost effectiveness studies. A number of specific advocacy steps were recommended. Most focused on developing local support for better access and equity regarding TCAM within local health care systems and advocacy work, which needs to both understand and

engage the local TCAM practitioners and those using the TCAM services.

Conclusions: The increasing awareness of TCAM and advancement toward integrative medicine—including traditional medicines and perspectives—are themes currently in development worldwide. Now is a good time for TCAM practitioners to open dialogue to develop better partnerships in health care. Such dialogue is facilitated when diverse people at the health care table understand each other’s perspectives. More discussions like this, with diverse people across more disciplines, need to occur worldwide.

KEYWORDS: congresses, consumer advocacy, delivery of health care – integrated, complementary therapies, holistic health, economics, organizing, financing, policy

INTRODUCTION

The Natural Health Practitioners of Canada (NHPC) association sponsored this traditional/indigenous healing and complementary and alternative medicine (TCAM) symposium on TCAM advocacy, on October 27th and 28th, 2010. This unique international event on health was developed to create and share a multidisciplinary dialogue of health and non-health specialists, engaging sociology and TCAM researchers, scholars, First Nations healers, CAM practitioners and CAM organization representatives, advocacy consultants, educators, and policy-makers from around the world. The focus was to create shared understandings regarding political and sociological views on different health care systems, and develop plans for advocating for a more collaborative integrative medicine between TCAM and biomedicine. The vision was for an increased and more respectful support for TCAM paradigms within the biomedical system. Given the current paradigm dominance and political power of the biomedical

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system, the need for a proactive approach was identified by the participants.

The host of the symposium, the NHPC, is a Canadian CAM practitioner professional organization established in 1988, with over 6500 members nationally. The symposium developed in response to international interest in the NHPC's advocacy project, the Natural Health Knowledge Dialogue (NHKD). The NHKD was formed to study and address facilitators and barriers to inclusion of complementary and alternative medicine (CAM) into public and private health care plans, particularly the therapeutic massage bodywork and energy work therapies of its members. The NHKD team was reviewing the interlinked dynamics of economics (especially of the benefits industry and health care economics), the possible cost-effectiveness of TCAM interventions, the established and growing public use or desire for TCAM, and the developing momentum of "integrative medicine" as conceived from a biomedical paradigm. Many people need to be involved in dialogue that can bridge these many issues from a TCAM—not biomedical—perspective if decisions about TCAM are to be made with TCAM representatives and knowledge at the decision-making table. Therefore, the NHKD planned this global symposium to gather solutions to these dilemmas, both because the issues are relevant to many countries, and because several countries have solutions to specific components of these concerns but little international engagement about their solutions. As many of the issues arise regardless of the TCAM involved, the NHPC desired many TCAM perspectives and other relevant expertise as part of the dialogue.

As a pilot symposium, the agenda outlined a list of task areas, avoiding questions surrounding natural health products and legal or law considerations vis-à-vis TCAM and citizens' rights to the medical treatment of their choice, to be considered in another iteration of this symposium group. Note that throughout this manuscript, the acronym TCAM is used when appropriate rather than just CAM (complementary and alternative medicine) to ensure that native/aboriginal peoples feel included in this material, as the traditional medicine perspectives of CAM are sometimes subsumed or lost in discussions regarding CAM.

PARTICIPANTS AND METHODS

The selection of participants was a multipronged approach. Based on the NHKD's internally developed environmental scan of TCAM integration and policies within health care systems worldwide, specific categories of knowledge and specific perspectives were identified as important to this symposium. One or two experts were invited for each category: economic, political, policy, consumer, reconciliation, language framing, research, education, biomedicine, traditional

medicine practice, complementary and alternative medicine/health care practice, integrative medicine practice, sociology, and communication. A broad sampling of country participation was also desired, though communication in English was an acknowledged limitation. Potential symposium members were carefully selected by the symposium committee based on their published work (peer reviewed and lay literature, books, and video) that established their vision, knowledge, and expertise in their respective fields. Contacted experts who were interested in the symposium but unable to attend suggested alternative participants. Potential organizations who would be able to test-implement advocacy recommendations were also invited, including several who had specifically approached the NHPC regarding participating in its NHKD program. More people and TCAM professional bodies (national and international) were invited than could attend, and many potentially valuable resource people were not invited due to the constraints of keeping the discussion-based symposium small—after one or two positions were filled for each category, recruitment for that category was stopped—providing participants the opportunity to become acquainted and engage fully with each other. Representative members of the symposium were able to attend from Switzerland, Canada, the U.S.A., New Zealand, Australia, and the Peoples' Republic of China. TCAM practitioner association representatives, those expected to undertake the advocacy, came from Canada, the U.S.A., New Zealand, and Australia. The list of participants is found in Appendix 1.

The symposium took place in the Membership Lounge of the Platinum-LEED certified Parkside Resort in Victoria, British Columbia, the key in-kind sponsor of the symposium. Two days of facilitated dialogues included topics designed to develop a unified background in diverse areas of knowledge (as noted above) that would build on each others' expertise and experience as the process moved toward creating action steps that addressed barriers identified through the dialogue process. The itinerary (Appendix 2) began, on the first day, with broad overviews of the concepts that were to be brought together, as well as specific issues and knowledge in the field: where TCAM is located politically and sociologically, and the components that affect its standing in various global societies. The second day continued with advocacy issues—what skills or information would be needed, and how to best frame the advocacy work—and finished with brainstorming methods to develop specific ideas for moving the discussions into action steps. The format was adapted from the Structured Dialogic DesignSM for achieving group intelligence (see www.globalagoras.org), in which a "group of experts sequentially clarifies meanings, explores similarities among ideas, and identifies relationships between ideas". Informal seating led to encouragement of interaction among delegates. Prior to meeting,

the participants read a number of materials provided by each other to prepare them for the context of the meeting (Appendix 3).

Meal and refreshment breaks offered a time for networking and further dialogue.

Many proceedings documents are listings of the abstracts of the individual symposium presentations, selected for presentation by a peer-review committee. This symposium had no such abstracts, as the entire process was a preplanned two-day discussion topic progression. Single discussion panels are often published as verbatim transcripts, but a two-day meeting of 34 participants is not conducive to verbatim publication. Therefore, these proceedings results are summaries, predominantly highlights of the key points, of the material (statements, discussions, sketches) presented by the panelists and the concurrent/subsequent discussions. The participants made many authoritative statements. As experienced representatives of their fields, we assume they have the knowledge and experience to substantively back up those statements; we report those statements when they were key components of the discussions but perforce do not have the participants' sources to substantiate those statements. Each Results subsection will summarize each new topic as it occurred in sequence in the Symposium program as listed in Appendix 2. After the final session, *What Comes Next?*, one further section has been added to capture some of the non-topic discussions occurring during breaks, with the title of *Informal Discussions*.

RESULTS

The symposium began with Aboriginal Healer Antoine's offering of food—the same breakfast as enjoyed by the symposium participants—to the Coast Salish Ancestors on whose land the meeting hotel is situated.

Advocacy Methods

Panelists: May, Stüdeli, Teklu, Tipene, Hymel, Epstein, Bell

These panelists all have experience in different areas (politics, human rights, health policy, integrative medicine), in which they successfully overcame political and professional barriers to achieve specific advocacy goals. Some key issues can be summarized from their experiences:

- 1) A coordinated strategy addressing interrelated stakeholders must be developed:
 - a. Develop supporters from all sides of the political spectrum.
 - b. Build commonalities—in health care, all people are patients at some point

- c. Develop a relationship of trust with stakeholders
- d. Educate on the value that the desired change will bring, recognizing that the advocate must also have nimbleness to change.
- e. Consider diversity a strength, not a problem.

- 2) At the policy and political levels efficacy evidence may not be that useful.
- 3) Healing is not just physical. Just as healing is about making connections and integrating the person (body, mind, and spirit), so too must advocacy heal in a similar fashion.
- 4) Perseverance and group expertise are fundamental for success.

The Status of TCAM Globally Today

Panelists: Hollenberg, St. George, Tipene, Xu, Stüdeli, White, Graff

The political status of TCAM can be found in many governmental and organizational documents; many research articles and the World Health Organization approach to TCAM, can be found on the Internet. These documents, however, may not elicit understanding of the local zeitgeist, nor how the information fits into the broader cultural and sociopolitical environment. The panelists described how TCAM is still used by a majority of peoples around the world because it is readily available, frequently inexpensive to access, and usually community-based. Panelists also provided perspectives on the meaning and value of its status within communities. Perhaps the most critical point made was that using non-biomedical medicines and therapies refutes the mind–body split of Descartes, as well as supports the mind–body–spirit concept.

All healing has sociocultural context, with its meaning rooted in community and culture, and based on shared knowledge. It often links spiritual and physical health. It is therefore an essential cultural resource. Historically, colonizers, as part of the colonization process, have devalued the conquered, and as part of this process, devalued local healing traditions. Biomedicine continues with this attitude, even in “integrative” or “traditional-medicine” supportive environments, where biomedical forms of evidence are required for TCAM to be “valued” and then integrated into and co-opted by “medicine” (see for example, Hollenberg and Muzzin, 2010, in Appendix 3). Many biomedically-dominated areas are experiencing pushback, with local healers and communities renewing dedication to the knowledge base of their local healing traditions through such channels as the support of local healers and the use of personal herb gardens. There is a desire to see the local traditions regain their status, alongside or equal to biomedicine, as an essential health service. The local people are taking back their power and their own approaches to healing, desiring to use the best of the available health

systems, with respect, not antagonism, between these systems. The wrap-up of this section included insight into some glocal (global knowledge with local action) healing knowledge: if mind and body are not to be split, we must: (1) “be careful” in that words and language are imbued with power and so we must be aware that our language be neutral and not energy- or emotion-laden; (2) “make our minds strong” for protection and strength; and (3) “establish a middle ground”, like “zhong” (中) in Chinese: to be giving and receiving at the same time.

Futurist Visions? Outside Views of Biomedicine?

Panelists: Porcino, White and Antoine, Hollenberg, Xu, Armstrong, Davis, Epstein, Hymel, Bell

Views, stories, and ideas in this section ranged widely but are summarized into two themes: (1) creating the context for resolving differences between TCAM and biomedicine; and (2) addressing the social effect of personal/community disconnect on the person, and a vision for that change. Many spoke using the idea of balance or fulcrum, using it to describe the current health care systems in place, and then trying to find the counterbalance in the patient’s individual health choices and values and those of his or her community. Respect, then, must encompass and accommodate different beliefs, hopes, paradigms, and the right to be wrong when it comes to autonomy over one’s body, such as a desire for noninvasive or non-pharmaceutical options. That balance must be found, too, in personal healing, which can be enabled and supported from the outside, but must be found within and cultured by the individual. Biomedicine may not value this personal process as an important part of treatment, perhaps thereby failing for healing other than for infection management, acute care, and emergency care. Change to the biomedical vision will not likely follow the common management process described by mission, vision, and values, but rather will come from paradigm and vision challenges creating shift to a new equilibrium. One of those challenges right now is “integrative medicine”—itself now being challenged because of its biomedical bias—which may ultimately give way to a new and more respectful balance of medical pluralism.

Two symbolic examples were presented during this topic that were referred to throughout the symposium. One was an African proverb, “when one hand is sick, the other hand suffers”. The second was the reduction in language that occurred when the traditional Chinese sinograph (logogram) for “doctor” became the simplified form in the 1960s in the People’s Republic of China. The original configuration, Figure 1, included many aspects of healing in a person in the different parts (radicals) of the first of the two components; whereas in the newer version, Figure 2, the first component now simply represents “medicine”.

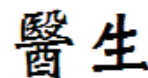


FIGURE 1. Original sinograph.

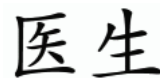


FIGURE 2. Simplified sinograph.

The inherent loss of meaning seems to coincide with a reduction in the social valuing of the multifaceted nature of healing.

Glossary and Language

Porcino opened this section with a brief review of the glossary in the prereading taxonomy (Porcino, 2009, Appendix 3). The first point of discussion he brought up was the problematic conflation of “medicine” and “health care”, which can have different meanings to different people, professions, or cultures. The participants agreed that while they would continue to use the language they were most familiar with, they would be clear as to the scope of the meaning they were invoking when using words such as “medicine”, “practitioner”, or “healer”. The second point was that through our language, we privilege or put down systems of healing outside of our own, and that there may be power differentials invoked by our language.

Finally, Porcino opened the discussion on integrative medicine, pointing out that while sounding like it is bringing people together, “integrative” is usually from the perspective of the biomedical paradigm, setting the limits on who, what, and how TCAM therapies are to be considered complementary to the primary treatments of biomedicine. Thus integrative medicine is the incorporation of *complementary* medicine into biomedicine. This perspective discounts the TCAM alternative(s) (as in complementary and *alternative* medicine) that may be the choice of, or reflect the values of, an individual. It thus prevents genuine integration or respect of individuals’ voices about their own bodies and the totality of their healing choices, effectively silencing the persons. The perspective also discounts the possibility that TCAM alternative(s) may be the primary care available in some regions (see for example the W.H.O. documents on TCAM). There is no easy solution to the definition of the totality of therapies and systems that make up TCAM, but if those who practice TCAM cannot agree on their language and definitions, then policy makers and legislators are unlikely to implement proactive change. Definitions would continue to be discussed, recognizing that the symposium group was too small to effectively take on developing new language in the immediate future.

An Introduction to Economics and Health Insurance: How should they be included in the process? How do we interact with them?

Panelists: Emery, Armstrong, Church

Economic considerations can touch on many different areas, and this discussion passionately brought together many interests of the all the symposium guests. Regarding health care economics, the patient's needs are often secondary to the health costs, which are deployed often to the benefit of the health care providers and insurers. This is true for all health care, regardless of how the money is paid, as the patient is exchanging money for some form of health benefit. Public health care in many countries is built around, and often controlled by, one type of provider, which may be difficult to undo. The financial stakes are high—for example, in Canada, an average 39.2% of current government expenditure. By the same token, local TCAM and folk CAM are often employed when biomedical costs are too high for the patient. Additionally, CAM and genetic testing are seen as the money-makers driving private medical and “integrated” clinics—which is not surprising, given that innovation and expansion in health care is usually driven by profit. Many people desire TCAM and so its provision and products can comprise a lucrative business, often with low service-delivery costs. For this reason, there is notable current consumer and government interest regarding whether TCAM may save money compared to the costs of biomedicine. Access to private insurance, one of the primary sources of support for many biomedical health benefits, as well as some CAM services, is shrinking as those plans are linked to the shrinking pool of employees in companies that provide health benefits insurance plans.

Economic studies of TCAM should include the cost benefits of the delivery of TCAM, but should also encourage studies of the costs of the harms from the biomedical system and the combinations of drugs people are on. Studies of environmental costs and environmental footprints should be part of the evaluations. A generally held belief is that TCAM costs are lower than biomedicine and have a smaller ecological footprint, an assumption that should be verified. Economic evaluations can include a broad range of outcomes, such as subjective patient measures including quality of life outcomes. For politicians, efficacy evidence is not paramount for acceptance—TCAM advocates must make clear that treatments must be put into the contexts of the local social milieu, perceived needs, and other political pressures. Politicians may not be the primary targets for decision-making advocacy, but they and their various ministry workers may be affected by lobbying from pharmaceutical companies and others. These lobbying interests may find it expedient to support TCAM as long as the financial loss from TCAM is not significant and supporting it could be in their interest in other ways.

Regulation and Credentialing

Panelists: Porcino, MacDougall, Bell, St. George, Tipene, Blatman

Much has been published elsewhere about the politics and process of regulation, self-regulation, and credentialing, and their effects on a profession. These topics were discussed throughout this section. The opportunities and problems that regulatory and credentialing processes provide took some time to identify. This occurred because the three distinctly different, critically important stakeholders—patients, health care professionals, and insurance companies—each hold different reasons for desiring regulation or credentialing.

Independent credentialing bodies with defensible standards are important as they can help set the scope of practice, provide a degree of assurance and independent proof of ability to provide a service, and can act to help a member of the public or revoke a membership if such professional action is required. Providing a legitimate independent recognition process for credentialing bodies, such as was initiated in British Columbia for the shiatsu and aromatherapy bodies through Occupational Title Protection, is an effective non-regulatory option that is also cheaper and quicker. Finding these kinds of “legitimizing” options is important if TCAM is to be brought into more equal footing in any healthcare system.

Several concerns articulated about the credentialing and regulating of traditional/aboriginal medicine systems can be generally valid for many TCAM therapies, and include: (1) a standardizing process will fragment the integrity of practice (force a compartmentalization of parts); (2) traditional medicine systems do not have a closed body of knowledge; they are adapted to an area and open to “whatever works” and should be recognized as such, just as in biomedical practice; and (3) documenting traditional medicine will enable appropriation of parts of the system.

Reconciliation: Are Biomedicine, TCAM, and Traditional Medicines Three Solitudes? How Do we Move Forward?

Panelists: Teklu, Hollenberg, Stüdeli, St. George, Bell, Blatman, Xu, Davies, Epstein, Tipene

Teklu began this session with the Ethiopian story comparing a beautiful but controlled, yellow-flowered garden to a multicolored flower garden. It represents the understanding that diversity enriches society. This includes the field of medicine, optimally through collaboration and reconciliation, not by making only one option tenable or only choosing more of “the same”. This acknowledges that biomedicine is not “wrong”; nor are TCAMs. Rather, the users of health care need to start focusing on the additive strengths, for example, including the TCAM allowance for session

time or working with the mind–body connection. There was concern expressed about the appropriation of TCAM components without accepting the “primitive” holistic perceptions on which the therapies are based; while they may be effective, equally, a therapy is often dissociated, and then the individual parts fail, allowing a claim that the therapy is worthless. As well, the commodifying of a health care system moves the drivers to profit rather than care—an issue that affects all types of health care.

While the topic was reconciliation, most of the discussion focused on advocacy, particularly from a TCAM perspective. One of the barriers identified during this particular discussion was that people in leadership positions are aware that changes in health care funding are needed, but are afraid to move forward because of divisive issues, including funding allocation and opposing paradigms (biomedicine and TCAM). The advocacy themes fell into three areas, described below: (1) the need for education and outreach; (2) “the current funding crisis opens opportunity for change”; and (3) TCAM practitioners must unite if they are to succeed.

- 1) Public/consumer awareness, through education and involvement, is important for developing support for a more collaborative health care environment. Ideas on where to look included: (a) countries such as New Zealand, China, Japan, and India, and hospitals where collaboration is already happening; (b) the language of promotion and prevention currently being leveraged by marketing; and (c) the strength, courage, and methods used for campaigns regarding pesticides, acid rain, cigarettes, and the reclaiming of rights of first nations cultures.
- 2) Further, the high costs of biomedicine, and its weakness particularly in dealing with chronic conditions, creates a situation where TCAM providers are optimally placed to collaboratively create new solutions.
- 3) As well, TCAM practitioners must mobilize and come together, in a vision of co-empowerment and collaboration. Their actions must focus on the destination, developing and using their passion for their vision of healing. The steps will then become clearer and the support will develop. Gaining an equal control with biomedicine in the integration process is key as to how equitable it will be. Therefore TCAM needs a unifying direction for advocacy and action. Small changes can lead to big policy shifts. Finally, TCAM practitioners need to call upon and support CAM and TCAM-informed biomedical health care providers in coming out of the TCAM “closet” (i.e. be willing to identify themselves to their colleagues as TCAM-friendly or as TCAM practitioners) so that they can more effectively work also on creating change.

Discussion: “Evidence-based” What Will Be Needed for the Next Steps?

Panelists: Blatman, Bell, St. George, Church.

The issue of the “evidence” for TCAM often arises when the issue of integration or inclusion of TCAM into health care is discussed. The issue of evidence for biomedicine is rarely discussed during integration discussions. As has been documented extensively elsewhere, there is on-going debate regarding the validity of traditional evidential standards and methods for many TCAM situations and the different epistemologies behind the TCAMs, different meanings and values of evidences, and whether biomedicine is as research-evidence based as the expectation is for TCAM. One of the primary messages from this section, however, was that during the development of public policy, often scientific evidence will not be the most important factor. There is recognition that evidence can be used to sway policy for political or financial gain.

In terms of what would be needed for moving forward, it was felt that evidence must include three voices, that of science/research, that of the clinician, and that of the patients’ values and opinions. Practice-based evidence has a place in the application of evidence-based medicine, especially when appropriately conducted studies are not yet conclusive and cannot cover all possibilities. While research underscores biomedicine, not all is supported by empirical evidence. Some is anecdotal, or based on collective experience. Not all possible variations will ever be studied, and physicians can have difficulty navigating the “forest” of evidence available, especially given time constraints. It will be important to incorporate the language of patients, including their needs and experiences into any TCAM research project consideration. Individual stories and case studies are often the real drivers of health care, and they get lost in many research programs. Some peer-reviewed research journals have stopped publishing case studies in their exclusive focus on empirical evidence. Notably, the value of case studies has entered the evidence discourse, with some journals revisiting the value of narrative medicine in developing group understanding and expertise. TCAM would do well to bring this material forward in many situations regarding the topic of evidence.

Future Global and Local Advocacy

Panelists: May, Stüdeli, Graff, Teklu, Tipene, Armstrong, Hymel

Given that many of the sessions had already started developing this subject and the day’s previous discussions had continued longer than expected, this session was omitted.

Framing Advocacy: Creating Successful Advocacy Messages and Methods

Panelists: Weeks, May, Cienski, Epstein, St. George, Bell, Stüdeli

The idea of “framing” has been used in several ways, given that the word is often loosely used in marketing and communication. This session, therefore, started with a discussion on the meaning and implication of framing: the organizing principle through which the thought or message is given or interpreted. A common example is the “war on cancer”, which shapes the common language around the approach to cancer treatment. The frame that is created is critical to the long-term message. The “controversy” frame is one of the most commonly used frames of TCAM in media, but for TCAM that frame will not be useful, pitting TCAM against biomedicine rather than developing a co-existence or collaborative message. If an “integration” frame were used, optimally it would include exemplar depictions of successes, patient-centered and holistic metaphors, and values of respect and collaboration. The message and approach for each language/culture/country will need to be framed locally.

Once the answer to the question, “for whom do you advocate?” has been discerned, development of an advocacy program should start with a consideration of four areas: (1) how will the advocacy be done?; (2) who is the audience?; (3) where is the powerbase that will make the decisions?; and (4) why do we believe we need to do this? Issues for consideration include:

- Media as a primary source for TCAM information;
- People have a strong sense of justice and injustice, and many want TCAM to be accessible;
- The public—the users of health care and TCAM—is an important audience, therefore consumer surveys of TCAM issues are needed;
- Clearly articulate an advocacy program’s goals early on—they should not change. But be prepared to adapt your methods and message to current circumstances to keep on track of your goals and to manage the message;
- The message should include how to locate bona fide practitioners (linked to the earlier credentialing/regulation discussion); and
- Advocacy is expensive, so building the relationships within the sectors you are lobbying within and through is key.

What Comes Next? Refining the Vision, Goals, Key Content and Strategies

Group discussion

This brainstorming session needed more time than was available. Even so, many ideas came forward and were developed into a cohesive, glocal whole. A

clear advocacy and development plan was not developed. The following are many of the ideas brought forward from separate small group discussions that relate directly to the discussions as described above. Some are ideals; others are concrete steps that particular persons or groups want to take to begin the process of creating glocal change as expressed by the suggestions and conclusions in the previous discussions. Many are direct transcriptions while others are summaries, yet all indicate steps that can be taken by any group in any appropriate environment (local, regional, national, etc.).

- 1) Expand Canadian / Australian / Chinese / New Zealand / Swiss health acts to include all therapies and interventions with demonstrable potential to reduce the human and economic burden of the chronic and acute effects of illness and injury.
- 2) Advocate for equitable and universal access to health care, including TCAM.
- 3) Use appropriate social media to educate the public on how TCAM therapies can help achieve a better quality of life.
- 4) Enable multidisciplinary and multicultural services of choice.
- 5) Change the language away from “prevention” to something clearer; engage a marketing strategist.
- 6) Plan new messages for holistic health policies for election(s).
- 7) Honor the commonality of intent across health care providers in order to build an inclusive health care community.
- 8) Establish equitable, ethical principles for collaborative health care plurality.
- 9) Develop providers/practitioners who have access to intergenerational and multicultural practitioners and elders.
- 10) Create a bidirectional educational process for the community at large and its individual members regarding the new health care vision.
- 11) Learn from TCAM users not just why they use TCAM, but how it is helping them. Include the patients’ opinions of the economic value of TCAM to them and their health care.
- 12) Develop a collaborative consistent communication strategy that educates and informs practitioners and the public on how to be a movement for natural health change.
- 13) Identify the key principles of each culture and work in community to harmonize diversity (of health care).
- 14) Present media with framed information that inspires/supports TCAM.
- 15) Define ethical principles that respect the harmonizing of our natural environment and human resources. (Consider the broader context of the environment and culture through which health care is delivered, and its link to related issues affecting the rights, health and lives of the people.)

- 16) Support the development of systems of quality assurance with each professional TCAM modality to ensure minimum standards of competence.

Participants and groups with distinct interests committed to undertaking the following direct actions:

- 1) Submit a proceedings document of the symposium to the IJTMB.
- 2) Communicate to all NHPC members the potential value to them of this recently concluded symposium that they sponsored.
- 3) Contact, inform, and educate the members of all professional associations in Canada represented by the 66 modalities included under NHPC about the results from this symposium.
- 4) Publish a post-symposium journal-specific report in the *NHPC magazine*.
- 5) Include Item 10 above in the NHPC's survey of members' clients.

One proposal that was put forward and agreed upon consensually was for any resultant materials arising from the Symposium to be "creative commons", allowing for equal sharing of the ideas and material, but not supporting quotation out of context. Therefore, this is the de facto status of the Symposium material. This will help prevent the work of the Symposium from being controlled or used by any single group, and honors the intent and integrity of the Symposium and its participants.

Informal Discussions

Topics such as future meetings and possible actions to disseminate the Symposium knowledge were discussed informally during breaks and at the concluding dinner. Collaborative suggestions were numerous, including an offer of facilities to "camp out" at a North Island Maori community in the near future. Action ideas included smaller groups appearing at local and international conferences to agitate for change by holding a separate meeting as a kind of Salon des Refusés, or even trying to negotiate a space in another organization's conference, for example at any biomedical or health research, insurance, or professional regulatory association conference. Many methods were discussed to maintain the cohesiveness of the group.

As a pro-active public relations suggestion for the future, it was proposed to hold public sessions using the skills of the invited experts in panel discussion. This would highlight the outcomes of the work, as well as advertise the intent to proceed with action.

Also of interest were the future directions and health care practices for the role of integrative medicine and TCAM in medical education and health care practices, an area that many participants want to address more fully.

Finally, while the participants were very pleased with the results of the symposium, they also repeatedly expressed strong enthusiasm over the format and cross section of expertise present, as it afforded an opportunity for extended engagement with many peers that, while staying focused to the topic, allowed for extensive creative process and open-ended dialogue.

DISCUSSION

The symposium was initiated with the expectation that a supportive and dynamic group would evolve. It afforded participant-collaborators the opportunity to contribute within an intimate atmosphere that encouraged partnership and collaboration in planning the future of an integrated health care across disciplines, across languages, and across practitioner modalities. The symposium did evolve and most participants remain an enthusiastic group of international, interdisciplinary, intergenerational members who want the informal and proactive group to continue. This is a critical, highly significant outcome. Many of the visions, goals, key content, and strategies (last section of Results), as well as material from the previous discussions, will be useful for developing localized plans of advocacy action.

Our experience had confirmed that there are better proactive approaches available—as in this Symposium's format—when thinking is centered around reconciliation rather than debate, when the fruitfulness of interdisciplinary gatherings are exploited. Consensus was achieved on many issues in the agenda that can propel constructive action forward. A number of useful, concrete steps were identified that can be pursued further. Some difficulties arose due to the ambitious nature of the symposium, particularly time allocation, and as a result of having to deal with some persons who were not participating in good faith within the unusual format of the symposium. Authors Graff and Porcino, of the planning committee, can be contacted for further dialogue should others wish to undertake a symposium of similar format.

While the symposium managed to achieve the developing/voicing/presenting personal ideas as summarized in the visions, goals, key content and strategies section above, the final discussions to synthesize a collaborative plan of local, related goals focusing on changing the global health care landscape did not occur at the end of the final day due to time constraints.

Furthermore, though they were on the facilitator's agenda, no time was spent on:

- 1) Privacy and confidentiality as it related to the sharing of participants' contact information;
- 2) Managing communication about the Symposium results and next steps; and

3) Format(s) for continuing the dialogue and coordinating work on the (undecided) action plan(s).

As these issues are important for sharing the results and moving the agenda forward, they are to be addressed using Internet meeting strategies and other live, discipline-specific gatherings of various symposium participants.

To Be Addressed in Future Meetings

More agenda items will be added in future gatherings, particularly herbal supplements in the TCAM realm, the use of law and pro-active litigation to create change, and the discussion material included in the additional, non-planned discussion material section of the results. Online monitoring and coordination of advocacy efforts and changes to the legal standing of TCAM will need to be explored. The question of when and how additional members to the group are brought in—there is significant interest—must be developed. Finally, the question of whether specific areas of interest may require coordinated subgroups will need to be addressed if the number of participants becomes too large, or the group begins naturally splitting into specific areas of interest.

CONCLUSION

The Symposium development outlined some very specific goals, most of which were achieved. The NHPC can be very proud of the results from the innovative symposium that it undertook. It was a learning experience that brought together a number of key international stakeholders and innovative thinkers in TCAM, particularly if the secondary links and network of influential persons of the participants are considered. The team was cohesive and collaborative, and wants to continue to work together on the Symposium material. The next steps are to finish the incomplete work of the Symposium, and establish an ongoing community of collaborative activism that will manifest these first steps as envisioned in the discussions of Changing the Global Health Care Landscape.

LIST OF ABBREVIATIONS

CAM: complementary and alternative medicine
IJTMB: International Journal of Therapeutic Massage and Bodywork

LEED: Leadership in Energy and Environmental Design
NHPC: Natural Health Practitioners of Canada
TCAM: traditional healthcare systems and complementary and alternative medicine

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CONFLICT OF INTEREST NOTIFICATION

While Porcino and Graff were employed by the Symposium sponsor (Natural Health Practitioners of Canada, NHPC) to develop and implement the Symposium, this manuscript was written independently of that employment, and no remuneration was received for work on the manuscript. The NHPC had no involvement in the production of this manuscript. Hollenberg and Hymel have no conflicts of interest to report.

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APPENDIX 2: THE SYMPOSIUM PROGRAM

Wednesday, October 27, 2010

8:45 Breakfast Meal for the Coast Salish Ancestors Healer Antoine, assisted by White and NHPC representatives

9:00 Welcoming and Opening Remarks

9:15 Advocacy Successes

Panelists: May, Stüdeli, Teklu, Tipene, Hymel, Epstein, Bell

Purpose: Present a variety of effective advocacy experiences from social, policy, and government perspectives

9:45 The Status of TCAM Globally Today

Panelists: Hollenberg, St. George, Tipene, Xu, Stüdeli, White, Graff

Purpose: Review of the current political and financial status of TCAM globally

10:30 BREAK

11:00 Open-floor Discussion of Previous Panel

Purpose: discuss specific pressures on the use and integration of TCAM globally

11:45 Futurist visions? Outside views of biomedicine?

Panelists: Porcino, White and Antoine, Hollenberg, Xu, Armstrong, Davis, Epstein, Hymel, Bell

Purpose: Explore visions of a cohesive plurality of medicine, and how that can interact with the economic and sociological landscapes. Discuss the value of integrative care.

12:15 LUNCH

13:00 Glossary and Language

Panelist: Porcino

Purpose: Discuss unified language and meaning in TCAM

13:10 An Introduction to Economics and Health Insurance: How should they be included in the process? How do we interact with them?

Panelists: Emery, Armstrong, Church

Purpose: to understand the needs and drivers of these two areas of healthcare, and consider how advocacy goals must accommodate those needs and drivers

14:00 Open-floor discussion on previous topic

14:45 BREAK

15:15 Regulation and Credentialing

Panelists: Porcino, MacDougall, Bell, St. George, Tipene, Blatman

Purpose: Globally and nationally, regulation and credentialing are far from being uniform or standardized. Are they important? What are the impacts of them in terms of service availability, provision, and cost?

16:30 Wrap up, summarizing the day's topics and placing them into context for second day.

16:45 BREAK

18:00 DINNER

20:00 PechaKuchas [Abbreviated PechaKucha PowerPoint presentations of only ten slides of 20 seconds duration each rather than the usual 20 slides of 20 seconds duration (for more on PechaKuchas, see www.pecha-kucha.org). These were to give symposium participants an opportunity to learn more about fellow participants' particular areas of interest.]

Thursday, October 28, 2010

8:45 Reconvene, recap the previous day, and set the day's intention.

9:00 Reconciliation: Are biomedicine, CAM, and traditional medicines three solitudes? How do we move forward?

Panelists: Teklu, Hollenberg, Stüdeli, St. George, Bell, Blatman, Xu, Davies, Epstein, Tipene

Purpose: Developing the advocacy perspectives of reconciliation, collaboration, and respect.

10:00 Discussion and group brainstorming

10:30 BREAK

11:00 Discussion: "Evidence-based." What will be needed for the next steps?

Panelists: Blatman, Bell, St. George, Church

Purpose: Frame out the possible research needs (randomized controlled studies, economic evaluations, other research designs) and advocacy approaches (lobbying, actions, legal approaches)

11:30 Future Global and Local Advocacy

Panelists: May, Stüdeli, Graff, Teklu, Tipene, Armstrong, Hymel

Purpose: Develop perspectives on how to move things forward from an advocacy perspective. Identify: where does change need to occur and how is it brought forward?

12:00 Open floor discussion on previous topic

12:30 LUNCH

13:20 Framing Advocacy: Creating successful advocacy messages and methods

Panelists: Weeks, May, Cienski, Epstein, St. George, Bell, Stüdeli

Purpose: Creating successful advocacy messages and methods for different audiences (including the public, governments, TCAM industry stakeholders)

14:50 BREAK

15:20 What Comes Next? Refining the vision, goals, key content and strategies

Group discussion

16:45 Final discussions, looking to the future

17:00 BREAK

18:30 Closing Reception

APPENDIX 3: PARTICIPANTS' PRE-CONFERENCE READING LIST

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