

Online Appendix

**SECTION A**

**Study Setting: Integrative Medicine**

The logics of conventional and IM are summarized in Table 1, using dimensions offered by Thornton and Ocasio (2008). The table shows, in ideal-typical form, the principles of conventional and IM logics that are found in the discourse of these professional communities, as well as central practices.

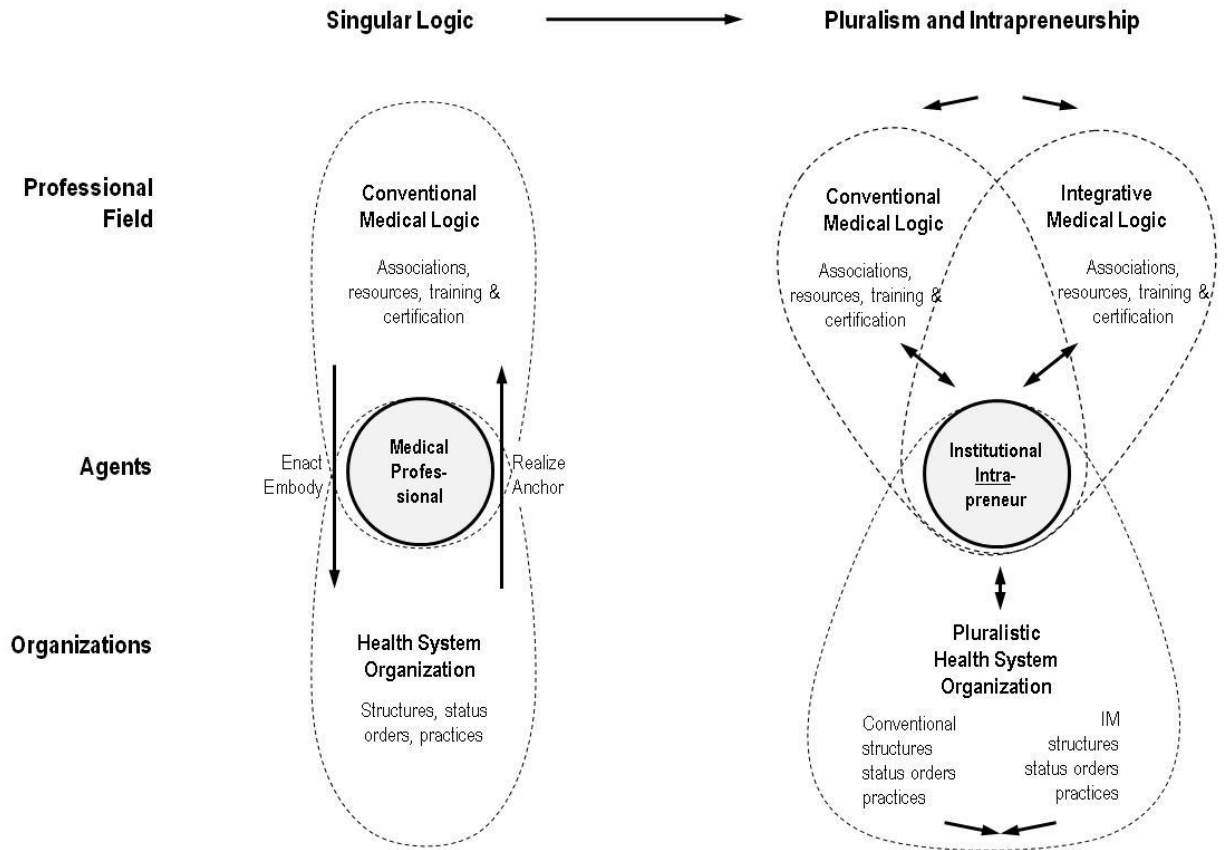
**Table A1. Ideal Types of Institutional Logics in Medicine**

<i>Dimensions of Logic</i>	<b>Conventional Medicine</b>		<b>Integrative Medicine</b>
<i>Economic system</i>	Reward units of service	↔	Reward outcomes, prevention, integration
<i>Sources of identity</i>	Physician as medical expert	↔	Physician as guide, role model, and mentor
<i>Sources of legitimacy</i>	Efficiency, scientific evidence	↔	Holistic, backed by scientific evidence
	Credentials of MDs		MDs training in conventional medicine and CAM
<i>Sources of authority</i>	Professional associations	↔	Professional boards, elite IM programs
	Government regulations		Government centers
<i>Basis of mission</i>	Build reputation of expertise	↔	Help patients achieve optimal health
			Build evidence-base, knowledge around IM
<i>Basis of attention</i>	Biological	↔	Biological, psycho social, and spiritual
<i>Basis of strategy</i>	Cure disease	↔	Offer holistic, individualized care
<i>Institutional entrepreneurs</i>	Professional associations	↔	Heads of integrative programs
<i>Logic of investment</i>	Greater scientific, tech innovations	↔	More holistic, integrated, prevention-focused care
<i>Structural overlap</i>	Providers: MDs, Nurses	↔	Providers: MDs, DOs, a variety of CAM practitioners
<i>Practices</i>	Medical toolkit	↔	Expand toolkit: comp histories; refer CAM providers
			self care, complementary healing practices

**Table A2. Timeline of Rise of Integrative Medicine**

Approx. Years	Stage	Field Level Events	Organization Level Events
Early to Mid 1990s	Uncoordinated activities around emerging logic, consumer demand increasing	34% of consumers use some form of CAM, landmark study finds (1993)	Ad-hoc practices, interest groups
		Office of Alternative Medicine formed (1993)	
		80% of Family Practice physicians interested in CAM training, study finds (1995)	
Mid to Late 1990s	Formation of field level organizations to research, theorize, and promote logic	American Board of Integrative Holistic Medicine formed (ABIHM, 1996)	
		National Center for Complementary and Alternative Medicine established as part of NIH (NCCAM, 1998)	Three IM/CAM research centers at elite academic institutions created and supported with NCCAM funding (\$5 million, 1998)
		First meeting of the Consortium of Academic Health Centers for Integrative Medicine (CAHCIM, 1999)	Representatives of 8 institutions participate in the CAHCIM (1999)
Late 1990s to Early 2000s	Early formalization of organizational activities around new logic with creation of first programs and centers	ABIHM offers first national conference (1999)	5 health professions schools receive NCCAM funding for education (2000); 2 institutions receive funding for cancer centers
		NCCAM begins issuing R25 grants to institutions to incorporate CAM education; fund cancer center research (2000)	5 more health professions schools receive NCCAM funding for education (2001)
			Study finds 27 hospitals in US have integrative medicine clinics (2001)
		Formalization of the CAHCIM (2002)	5 more health professions schools receive NCCAM funding education (2002-2003)
Mid 2000s to Early 2010s	Broader awareness of, and resistance to, new logic in the conventional field; Growth of organizational centers/programs	<i>Academic Medicine</i> publishes special issue on experiences of NCCAM grant recipient institutions (2007)	In <i>Academic Medicine</i> special issue, NCCAM grant recipient institutions report organizational resistance, barriers, and best practices (2007)
		Washington Post article: "Scientists Speak out Against Federal Funds for Research on Alternative Medicine" (2009)	More health care systems establish IM programs and centers
		Institutes of Medicine (IOM) hosts summit on Integrative Medicine and the Public Health (2009)	
		Forbes article: "Why Medical Schools Should Not Teach Integrative Medicine" (2011)	
Early 2010s-present	Early stabilization, increased legitimacy of new logic with conventional community	American Board of Physician Specialties begins accrediting doctors in Integrative Medicine (2014)	CAHCIM now 57 members (2014)
		The American Holistic Medical Association and the ABIHM unite under one Academy of Integrative Health and Medicine (AIHM) 2014	

**Figure A1. Relationships between Field, Organization and Actor**



## SECTION B

### Data and Method

#### Research Sites and Data

*Site 1: Program Blue.* Program Blue was situated within a large academic health care system in the Midwestern U.S. The lead intrapreneur at Blue was the founder and director (“Beth”); she was trained as a conventional family physician, and for years studied herbal medicine, and other indigenous practices and philosophies with a Native American healer. She also helped found an IM board and society, speaks at national conferences, and authored books and articles on IM. Her efforts to introduce IM to the organization began soon after she joined the health system as an assistant professor of family medicine. Data collection on Program Blue included 19 semi-structured interviews with 15 different individuals, including the director, all other affiliated faculty, most community facilitators, and administrators of the medical school who had been involved in aspects of decision-making around the program. The interviewees were identified by the key informant - , who is also the director of the program. Most interviews lasted about one hour, ranging from 40 minutes to 2 hours, and were tape recorded. Interviews started by asking individuals to recount their journey to IM and their current roles and positions. The interviews then asked the interviewee to describe in detail the origins and evolution of the IM program, including critical episodes. In addition, we conducted 50 hours of observation of planning, curriculum, and facilitator meetings and student and faculty courses. These data provided insights into situational tactics and influence strategies as well as the scope of the program independent of interview accounts. Finally, we collected archival documents dating back to the beginning of the IM program. These documents include email correspondence between faculty and administrators; planning documents and templates from other programs; surveys that were developed and administered to students about their knowledge and acceptability of the material; and syllabi and curricula.

*Site 2: Program Red.* Program Red is similarly situated within an academic health system in a different city from Program Blue. The founder and director of the Red program (“John”) completed an intensive two year fellowship in IM at the premier program in the U.S., after completing his training as a conventional physician. He is the author of a leading IM book and served in leadership roles of IM associations. Like the founder of Program Blue, the director of Red was a beginning assistant professor of family medicine during the creation of the program. We interviewed all faculty and administrators involved with the IM program for a total of 12 interviews with 10 individuals, using a similar protocol as at Blue. We interviewed the founder and director, fellows, other IM physician faculty, three program administrators, and two CAM practitioners who are fulltime staff of the hospital. We also obtained archival documents including teaching curriculums, program descriptions, and had access to online course modules and videos.

*Field-Level Data.* In addition to the in-depth studies of the two programs, we collected data at the field level to understand the institutional context in which organizational and individual activity is embedded. In addition to collecting secondary data on the field, we conducted 45 hours of observations of two large professional meetings: the Institutes of Medicine Summit on Integrative Medicine and the Public Health, and the North American Research Conference on Complementary and Integrative Medicine. These meetings brought together practitioners from the conventional and CAM communities, including the leaders of the IM programs at our case sites, as well as scholars, government figures, and heads of key national professional associations. Finally, we conducted seven interviews with leaders of other IM programs and projects. Understandings that emerged from our review of this data about the institutional logics served as the basis for Table 1.

## SECTION C

### Findings

**Table C1. Vignettes by Site, Description and Tactics**

ID	Site	Description	Tactics Used				
			Status	Juris. Resource	Trading Spaces	Pipeline	Exper.
B1	Blue	Developing IM Medical School Course					x
B2	Blue	Inserting IM Content into Med School Curriculum					x
B3	Blue	Forming IM Medical Student Curriculum		x			x
B4	Blue	Forming Integrative Medicine Program	x	x			
B5	Blue	Losing Integrative Medicine Courses		lack of		lack of	
B6	Blue	Forming Faculty Education Program		x		x	x
B7	Blue	Managing Membership of IM Board			x	x	
B8	Blue	Building Support for the IM Program			x		
B9	Blue	Recruiting, Training Course Facilitators			x	x	
B10	Blue	Securing Grants	x	x			
B11	Blue	Managing Success of IM Clinic		x	x		
R1	Red	Proposing Integrative Medicine Program	x	x			
R2	Red	Creating Integrative Residency Curriculum				x	x
R3	Red	Opening Grand Rounds and Outreach Education			x		
R4	Red	Forming of IM Fellowship				x	
R5	Red	Forming and Growing Mindfulness Program	x	x			
R6	Red	Forming Massage Clinical Services		x			
R7	Red	Formation of Integrative Medicine Program	x	x			
R8	Red	Recruiting Supporters Within the Healthsystem		x	x		
R9	Red	Recruiting Community Practitioners			x	x	
R10	Red	Growing the Integrative Medicine Program		x			x
R11	Red	Expanding the IM Clinic		x			x
R12	Red	Managing Timing of Change	x		x		
R13	Red	Securing Grants	x	x			