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Abstract: The use of complementary and alternative medicines (CAM) is growing rapidly within the western world and the nexus with conventional health care services is expanding. Many nurses and other conventional health care providers are not only using CAM themselves but see many of their clients using these medicines and therapies. The attitudes to CAM can influence client satisfaction and client use of different therapies and many practitioners of conventional health care are seeking education and information to enhance their knowledge and use of CAM. This paper reflects on the attitudes to CAM and the education needs and services in the field of CAM as identified by western health care providers, in particular nurses.

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COMPLEMENTARY AND ALTERNATIVE MEDICINE AND THE SEARCH FOR KNOWLEDGE BY CONVENTIONAL HEALTH CARE PRACTITIONERS

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ABSTRACT

The use of complementary and alternative medicines (CAM) is growing rapidly within the western world and the nexus with conventional health care services is expanding. Many nurses and other conventional health care providers are not only using CAM themselves but see many of their clients using these medicines and therapies. The attitudes to CAM can influence client satisfaction and client use of different therapies and many practitioners of conventional health care are seeking education and information to enhance their knowledge and use of CAM. This paper reflects on the attitudes to CAM and the education needs and services in the field of CAM as identified by western health care providers, in particular nurses.

KEY WORDS: complementary, alternative, CAM, education, attitudes

Introduction

Complementary and alternative medicines (CAM) have been identified as being widely used both as a supplement to conventional or mainstream health care and as part of traditional health care systems and practices (Bodeker et al. 2005). Australian data, published in 2007, reported that 69% of the population has used one or more forms of CAM in the past 12 months. However, the use of CAM varied with age, health and a range of other factors (Xue et al. 2007). Those with chronic health issues, cancer and/or chronic pain in particular have been found to have higher use of CAM (Saydah & Eberhardt 2006). Exact estimates of spending on CAM have been difficult to determine accurately,

however there is little doubt about the magnitude of spending. For example, in 2000 it was estimated that AUD 2.3 billion was spent on CAM (MacLennan, Wilson & Taylor 2002) and Blackmores, a company with a 21.8% market share of Australian vitamin, mineral and herbal products, reported sales of AUD 171.1 million for 2007 (Blackmores 2007).

With the use of CAM by such a large proportion of the population there is a need for conventional health care professionals within these western markets to be knowledgeable about these treatments in order to assess and advise those clients who chose to use CAM. Whilst nurses and midwives may not be directly involved in prescribing medicines to treat patients, nevertheless they, like doctors, are in a unique position to offer support and advice on health issues. In addition nurses have been shown to have high use of CAM and to be open to its holistic nature (Wilkinson & Simpson 2002).

In light of this, the attitude of health care providers to the use of complementary therapies, and exposure of health care providers to education about CAM, is an important consideration in contemporary health care in the western world.

What is CAM?

The notion of what is thought to be conventional health care varies between countries and changes over time and thus, what is thought to be CAM must also vary across cultures, geographies and time (Bodeker et al. 2005; Zollman & Vickers 1999). This variance also means that the boundary between CAM and conventional medicine is blurred and constantly shifting. Baer (2008) believed this blurring and blending gave rise to the integrative medicine movement which aims to use the best of both CAM and conventional care. The definition of what is CAM therefore changes and those therapy and practice types that are called CAM become difficult to limit to a universally accepted listing. One of the most widely used definition is that of the US National Institutes of Health (NIH) National Centre for Complementary and Alternative Medicine (NCCAM): 'CAM is a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine'. The NCCAM also note that –

> *The list of what is considered to be CAM changes continually, as those therapies that are proven to be safe and effective become adopted into conventional health care and as new approaches to health care emerge*. (National Center for Complementary & Alternative Medicine [NCCAM] 2007)

Zollman and Vickers (1999) referred to CAM as a group of therapeutic and diagnostic fields that in the main exist outside those institutions where conventional health care is taught and practiced. They noted that in the 1970s and 1980s these fields of practice were provided as an alternative and became known as ‘alternative medicine’. The term ‘complementary medicine’ was asserted by Zollman and

Vickers to have arisen out of a growth in the acceptance and use of alternative therapies to complement other health care practices; and the use of the term has grown from describing the 'complementary' relationship of health care practices to describing the non-conventional therapy group. Another significant differentiating factor noted by Zollman and Vickers was that the public sector has supported the education, regulation, research and practice of conventional health care practices; however similar activities in respect of CAM have been undertaken in the private sector. They particularly note that there was a limited academic infrastructure supporting CAM.

CAM is typically divided into a number sub-groups, for example, alternative medical systems (e.g. naturopathy, traditional Chinese medicine), mind-body interventions, biologically based treatments, body and tactile therapies and energy therapies (NCCAM 2007). However, the division is somewhat artificial and a given CAM may cover more than one sub-division and other classification schemes exist which divide CAMs differently. Tataryn (2002) suggested that a better framework was one based on underlying philosophies of health and disease and which covered both CAM and conventional medicine:

1. Body paradigm e.g. diets and supplements, physical manipulation, surgery
2. Mind-body paradigm e.g. meditation, counselling, hypnosis
3. Body-energy paradigm e.g. acupressure, Chinese medicine, therapeutic touch
4. Body-spirit paradigm e.g. faith healing, spiritual health, shamanic healing

Termed the four paradigms of health they provide an integrated means of thinking about approaches to health and disease and perhaps reflect the current move to integrative health practices rather than distinct CAM and conventional practices.

Conventional health care providers and CAM

Some CAM therapies are now covered by health insurance, delivered in conventional medicine environments, incorporated into hospital services and taught in medical, nursing and other health professional training programs and this mixing is stimulating changing attitudes to CAM within the ranks of those who deliver conventional medicine. With an increasing use of CAM reflecting changing patient attitudes to CAM, there is recognition of a need to identify practitioner attitudes to these therapies (House of Lords 2000; Milden & Stokols 2004) and to consider how contemporary health care professionals might be better educated to meet the community's desire for CAM (Gaylord & Mann 2007). Most research on the attitudes of health professionals to CAM and its use have focused on general and specialist medical practitioners, followed by research focused on nurses and, to a much lesser extent, pharmacists.

It is also important to note that while there are many reasons that individual may seek CAM, the idea prevalent a decade ago that the main reason was dissatisfaction with conventional care is not

reflective of the results of current research. Rather, current research points to a desire for greater personal involvement in health maintenance, holistic health beliefs and, for those with chronic conditions, an active coping mechanism (Bishop, Yardley & Lewith 2007; Sollner et al. 2000). However, it has also been shown that lack of adequate access to health care services and ready access to CAM services influence use of CAM (Moga, Mowery & Gieb 2008; Ritchie, Gohmann & McKinney 2005). In addition, there has been a desire demonstrated by consumers for provision of conventional and CAM services within the one site (Ben-Arye et al. 2008; Frenkel et al. 2008), further highlighting the need for an understanding of how nurses regard CAM and their knowledge of these therapies, and providing education opportunities to ensure that practitioners can clarify and work within their limits of CAM competence.

Various aspects of medical practitioners' use and attitudes towards CAM have been explored by a series of researchers (Ben-Arye et al. 2008; Cohen et al. 2005; Milden and Stokols 2004; Owen, Lewith & Stephens 2001; Roberts et al. 2005; Schofield, Juraskova & Butow 2003). Hospital based practitioners and older members of the medical profession were identified by Zollman and Vickers (1999) as being less accepting and more skeptical of complementary therapies. This skepticism can be identified in a submission to the White House Commission on Complementary and Alternative Medicine Policy (Low Dog & Fins 2002) and was deemed to have been based on concerns about the unproven and unvalidated nature of many CAM therapies. Giannelli et al. (2007) reported that 42% of Italian general practitioners did not recommend CAM due to concerns about lack of data on proven efficacy. However other studies have shown that general practitioners and specialists are more open to CAM than this research suggests. Cohen et al. (2005) found that Australian general practitioners (GP) believed that a number of complementary therapies such as chiropractic and herbal treatments, yoga and acupuncture are moderately or highly effective; however this was coupled with concerns that some therapies had a high potential for harm. Similarly, Pirotta et al. (2000) reported widespread acceptance of CAM among Australian GPs. In Germany and Russia studies of doctors show high adoption of CAM within conventional practice (Brown 2008; Joos et al. 2008) and Wahner-Roedler et al. (2006) found that physicians at a US academic medical center saw a benefit in CAM and 44% would refer to CAM practitioners. Despite these mixed reports there is a nevertheless a constant theme in many of these studies about the lack of availability of information on proven efficacy, lack of an adequate knowledge base in CAM from which to advise patients and concern about possible herb-drug interactions.

As with the data from studies of medical practitioners those examining use of and attitudes towards CAM by nurses are variable. Several studies have shown that the nurses are open to CAM from both a personal and professional perspective (Chu &Wallis 2007; Halcon et al. 2003; Wilkinson 2005; Zanini et al. 2008) yet other studies have shown more mixed responses suggest that factors such as

institutional policies, patient experiences and personal knowledge and experience of the therapies influence use (Rankin-Box 1997; Wang & Yates 2006). It has also been suggested that the holistic model of care promoted and adopted within the nursing profession provides for openness to CAM philosophies. Irrespective of individual nurses views on CAM the nursing professional as a whole does appear to have recognized the role that CAM can play in nursing and the congruence of CAM and nursing philosophies. For example, the Australia Nursing Federation guidelines on complementary therapies in nursing states –

> *Various forms of healing, such as massage, relaxation, meditation, visualisation, and environment manipulation (eg the use of colour, music, quiet, aroma) have always been a part of nursing practice. Other complementary therapies (eg reflexology, iridology, yoga, kinesiology) may be incorporated by nurses as part of their holistic approach to nursing practice.* (Australian Nursing Federation 2008).

Similar sentiments are contained within statements issued by both Australian and international nursing organisations (College and Association of Registered Nurses of Alberta 2006; Nurses and Midwives Board of New South Wales 2006; Nursing Board of Tasmania 2005; Royal College of Nursing 2004). In addition to recognizing the value of CAM there has been identified an active push to provide CAM education within undergraduate curricula as a means of providing both a return to nursing's holistic roots and to ensure that nurses can provide appropriate and knowledgeable advice to their patients (Fenton & Morris 2003; Halcon et al. 2003; Helms 2006).

CAM learning by conventional medicine practitioners

Recognition that patients are accessing CAM in increasing numbers has prompted many health care providers who work within the conventional health care fields to seek education in CAM (Berman 1998; Ching 1998; Gaylord & Mann 2007). Stevenson (1997) further linked the introduction of an understanding of complementary therapy to the 'care enhancement and patient family and client support' criteria in the professional development categories of The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and in doing so formalised a relationship that had developed out of a recognition of patients driving practitioners to improve their knowledge and skills. This notion of linking education to care standards was also reflected in the various nursing organization position statements on CAM. Taylor (2002) also reminded practitioners that the adoption of CAM practices does not automatically result in holistic nursing care and that systemic and continual reflection on practice is critical to successful incorporation of CAM into nursing care.

The need for nursing education institutions to introduce courses in CAM, as a response to interest in complementary therapy, was presented by Nicoll (1995) when discussing the models of such teaching

using either external experts or in-house nursing experts. The credibility of the qualifications of the educator was raised as crucial to the integration of complementary therapies into accepted nursing education. As with the rise in acceptance of CAM, education has been in a state of rapid growth with courses across a wide range of qualification levels and therapy type. Courses range from short weekend and Continuing Professional Education workshops to formal qualifications (e.g. Diploma or Graduate Certificate) in one or more CAM modalities and can aim to either provide a general working knowledge of the therapies or training as a CAM practitioner. Courses targeting particular professional groups have been identified. Stevenson (1997) did note, however, that within those courses identified, there were no programs specifically tailored for community health nurses. In addition Owen et al. (2001) noted that elective modules in CAM have been created and structured into undergraduate medical programs. Stevenson (1997) considered that a generalised program relating to the introduction of CAM was a valuable precursor to specialised training in a particular therapy, thus setting up a generalised knowledge base that could be enhanced by specialist training.

Ching (1998) suggested that some nurses are not prepared to integrate CAM into their practice because of a lack of understanding and knowledge due to the diversity of therapies and lack of education opportunities. Ching further elaborated that there are no minimal education requirements for CAM nurse therapists and identified a need for research, education and policy development. While these sentiments were published a decade ago there appears to have been little progress on particularly these later two issues in nursing (Helms 2006). Owen et al. (2001) identified that the interest in education in CAM is stimulated in undergraduate medical students because they identified that many patients were initiating treatments that had not been recommended by doctors and this could lead to possible conflict in treatment regimes. The students also demonstrated a concern about the regulation and control of the CAM providers and wanted to know about regulation and standards. Similar data has also been found when examining nursing students (Halcon et al. 2003). In recognition of this, recommendations made at a 1995 United Kingdom national conference on CAM education were that nursing and medical education should include coverage of CAM (Berman 2001). In 1997, 60% of 125 surveyed medical schools in the United States of America offered some form of education in CAM; Berman (2001) pointed to the funding initiatives made by the NCCAM National Institutes of Health to develop teaching in CAM in medical, dental and nursing education programs as being evidence of increasing provision of educational opportunities in CAM. The NCCAM now offers an on-line continuing medical education series to meet this need (see http://nccam.nih.gov/videolectures/). Berman described the content of educational programs at the University of Maryland as addressing efficacy and treatment options but also awareness of cultural influences and beliefs, he noted that most courses available at the time of his writing addressed an overview of CAM but did not teach clinical skills in prescribing. Berman's reflections on the need to achieve a general consensus on the requirements of a core curriculum which focuses on knowledge and an ability to refer patients to

CAM practitioners is an extension of the comments made by Ching (1998) in her call for further research and policy development. Health care professionals, patients and the health care system can only benefit if medical and nursing education bridges the gap with CAM.

Although position statements and guidelines from Australian nurses' associations and registration boards promote the need for education in CAM there is little information in the actual level of coverage of CAM topics within undergraduate curricula. Duffy (1995), in her discussion of the educational perspectives of CAM in nursing, identified that there were only a very small number of institutions offering discrete units of study in complementary therapies to nursing students or graduates. More than ten years on there does not appear to any increase in CAM in undergraduate education with only a few institutions offering compulsory or elective study in CAM. However this information is based on course information provided on university internet sites for prospective and current students and does not take into account incorporation of studies on CAM into other nursing subjects such as community and preventative health and clinical nursing. At the undergraduate and post-graduate level several universities within Australia offer courses in CAM, either as a discrete area of study or as part of study into preventive health. In addition there are a large number of award and non-award courses offered by private CAM colleges and TAFEs (see for example http://www.atms.com.au/colleges/index.asp) for those that wish to be trained as a CAM practitioner.

Despite the availability of training opportunities the needs of health professionals, and nurses in particular, with respect to the scope and depth of information about CAM, and the relationship to current scopes of practice, remains under-researched. The question also arises whether the of these programs is to create conventional health care professionals with sufficient knowledge and understanding of CAM philosophies and practice to provide high quality, evidence based advise to patients, or should conventional health care professionals be actively incorporating CAM such as massage therapy and aromatherapy into their scope of practice? This also opens discussions of the best way and place (e.g. undergraduate or postgraduate) to incorporate training in CAM such that practitioners are reflective, holistic and working from an evidence base. These issues remain at the core of CAM and the search for knowledge by conventional health care practitioners.

Conclusion

The rapid growth in the western world in use in CAM has been mirrored by a growth in the search for information and skills in CAM practice and prescription by those practitioners whose core training has been in the conventional medical fields. This desire for information has been stimulated by patients who are already using CAM and increasing demand for health care which integrates CAM and conventional practices. There has been a demonstrated use of CAM in their personal health care

practices by the practitioners of conventional medicine and this has further enhanced the acceptance of CAM by the traditional medical providers. This demand for knowledge has in turn influenced the supply of educational programs and the rising use of CAM has motivated investigation of regulation and control and the need to support practice with evidence through research. The current literature reflects this growth in the search for knowledge and skills, the provision of educational programs and research and the development of regulatory frameworks surrounding CAM particularly where they intersect with conventional health care practice. It is evident that models of integration, the identification of critical issues that nurses need to know about and the standard of knowledge in CAM needed to practice have not yet been covered in a meaningful way in the literature. These are outstanding issues upon which the profession needs to decide.

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