

Learning In Practice: Experiences Of Integrative Medicine Practitioners

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Abstract

The increasing public use of complementary and alternative medicine (CAM) has led to calls for members of the medical profession to acquaint themselves with both the efficacy and safety of CAM. CAM training for medical practitioners now appears in medical schools and continuing education programs. However, medical practitioners also learn about CAM in their practices from their colleagues and patients. The aim of this study was to explore integrative medicine (IM) practices (i.e. combined GP and CAM practices) as a learning environment for CAM.

Method: This study adopted a hermeneutic phenomenological approach as an appropriate methodology to reveal the meanings and significance people attach to their everyday experiences, of IM in this case, practitioners' interpretations of their learning experiences in IM clinics. Data collection consisted of semi-structured interviews, focus groups and observation. Interview transcripts and field notes were transcribed and repeatedly reviewed and compared until conceptual patterns and themes emerged from the data.

Results: Participants in this study found that IM practice provided a fertile learning environment for CAM. Not only did practitioners learn interdisciplinary ways of practising, such as new ways of combining and sequencing CAM and mainstream medical treatments, but also how to develop their practices through interdisciplinary collaborations, reflection and critical self evaluation.

1. INTRODUCTION

Growth in the use of complementary and alternative medicine (CAM) has been called "one of the most important health consumer trends of the 20th century" [1]. This growth has been observed in many developed countries, including Australia. In 2004, 52.2% of respondents (n=3015) to a South Australian survey had ingested at least one complementary medicine product in the previous year and 26.5% had visited a CAM practitioner [2]. Longitudinal comparisons with a representative population survey of South Australians showed that the extrapolated Australian expenditure for CAM practitioners and products of \$930 million in 1993 had risen to \$1802 million in 2004 [2, 3]. In recent years members of the medical profession have encountered CAM use by their patients more frequently in their daily practices. There is also a growing acceptance of CAM practices underpinned by an increasing biomedical evidence-base [4]. The Cochrane Complementary Medicine Field listed over 7000 clinical trials showing an increasing amount of empirical evidence for CAM [5]. An increasingly positive attitude towards CAM is also apparent in the number of continuing education programs on CAM available to members of the medical profession and in the willingness of general medical practitioners (GPs) to share their premises with CAM practitioners [6-8]. Australian GPs have also demonstrated an increasing willingness to refer patients for CAM. Pirotta [9] found that over 80% of GPs in Victoria had referred clients for CAM in the previous year.

Given the degree of public demand for CAM, the need to more fully inform members of the medical

profession about it has often been acknowledged [10-14]. Hopper and Cohen [15] conducted a survey of 1097 first, third and fifth year Australian medical students on their attitudes towards complementary therapies; 56% reported having no knowledge of the principles of complementary medicine. To address similar knowledge gaps in medical students and other health care practitioners in other countries a number of CAM courses have been incorporated into medical and other health professional training programs, both in undergraduate training [16-20] and in post-graduate training and continuing professional education programs [21, 22]. In one American study of 117 medical schools, 64% offered some type of CAM instruction [23]. These courses have tended to include only biomedical evidence-based aspects of CAM [24] and have been introduced as short familiarisation courses or electives [25-27]. Where CAM electives have been offered, they appear to have been well received by medical students and students in other health professions [28].

Taking courses and participating in practice both provide opportunities for learning. Much has been written about learning through engagement with the communities in which people work [29-32]. The complexities and uncertainties of modern professional practice provide rich "sources of knowledgeability" [33], including interactions in the clinic itself and the influences of diverse educational backgrounds, current research, professional associations and regulating bodies. In this complex landscape, both patients and practitioners can learn. This paper focuses on practitioners' learning in the clinical environment. Listening to patients' reports of experiences with CAM, or of research they found on

the internet, and reviewing patients' responses to CAM treatments with colleagues, for example, all contribute to practitioners' knowledge about CAM. Clinical environments also provide opportunities for "reflection, theorisation and research to critique, refine and generate practice knowledge which can contribute to public knowledge available for use by their profession" [34].

Integrative medicine (IM) that combines CAM and mainstream medicine has emerged largely on account of demand from consumers who, for one reason or another, are disenchanted with mainstream medicine [35-38] or are looking for a new kind of medicine that is more in tune with a holistic conception of health [39-41]. IM practices where non-medically trained CAM practitioners and mainstream medical practitioners are co-located provide a unique opportunity for learning about CAM and about the way that learning occurs in an interdisciplinary practice. The aim of this research was to explore IM practice as a learning environment for CAM.

2. METHOD

This study adopted a hermeneutic phenomenological approach as an appropriate method for uncovering practitioners' experiences of IM as a learning environment. Hermeneutic phenomenology combines a descriptive and interpretive approach to studying lived experiences [42]. Observing participants in their everyday world and asking questions that prompt recall of their immediate responses, their feelings and thoughts, are effective tools for exploring lived experiences as a source of meaning. In assigning words or language to any experience or phenomenon an interpretation has already been made. Hermeneutics is based on the premise that descriptions of people's experiences are already meaningfully interpreted and that each interpretation potentially offers deeper or richer layers of meaning. Moreover, meanings can only be interpreted from some perspective or standpoint. Hermeneutic researchers aim to explore interactions (*fusion of horizons*) between their own personal historical context and that of their participants [43].

This research involved three overlapping phases. The number of participants was not predetermined, and evolved in response to the quality and extent of repetition of information collected. Interviews and focus groups continued until no new information emerged from the data. In the first phase, cumulative case studies were used to combine data derived from three IM clinics, selected to maximise variation in a range of dimensions including number of practitioners in the practice, diversity of CAM services offered and ratio of GP to CAM practitioners. Data were collected by direct observation of the daily operations of each clinic for

up to 10 days and semi-structured interviews with 11 practitioners.

In the second phase, four focus groups (two groups of CAM practitioners, one group of GPs and one group of both CAM practitioners and GPs) provided an opportunity for more in-depth discussion of issues raised in interviews, to incorporate new perspectives on IM as a learning environment, and to test the credibility of emerging findings. Participants were recruited from advertisements disseminated via four seminars and from five IM practices, two of which were not involved in the case study phase. Each focus group had between 5 and 10 participants and lasted for one to two hours.

In the final phase, in-depth interviews were conducted with six key informants (three GPs and three CAM practitioners) who were selected on account of their standing as IM experts based on publications, conference presentations, and clinical experience in IM. This series of interviews provided an opportunity for the interviewees to express a wide range of personal insights about IM and to examine in depth emerging findings of the research.

Data analysis was conducted concurrently with data collection, so that questioning and observation were progressively guided by the data. Interviews were audiotaped and transcribed with participants' consent. Data analysis consisted of repeatedly reviewing transcripts and field notes to identify key concepts. A key feature of the analysis process was constant comparison to identify conceptual similarities and themes in the data [44, 45]. Emerging themes were refined, expanded, or discarded throughout the data analysis process. Ultimately a set of metathemes emerged from the combined findings from all phases of the research. Throughout all phases of the research, the researchers acknowledged and reflected on their own contexts in interpreting the results [46]. Triangulation [47] (using several data collection methods, participants with different perspectives, multiple data analysis reviewers, regular peer review) was used to reduce the possibility of misinterpretation. This research was approved by Sydney University's Human Research Ethics Committee.

3. RESULTS

The IM clinics in this research were fertile learning environments for practitioners. Practitioners learned new approaches to practice that combined CAM and mainstream medicine. They also learned ways to developing their practices through interdisciplinary collaborations, reflection and critical self evaluation.

3.1 Learning new approaches to practice

Learning how to integrate CAM and mainstream medicine was promoted by the diversity of practitioners' training and experience and the

information sharing among practitioners that takes place in these clinics.

Every GP in this project had some degree of CAM education before joining the IM practice. One practitioner who had studied at a medical school in Europe had received CAM training as part of her medical training. For the Australian trained GPs, however, this opportunity had not been available. In 2008 only three (15.9%) medical schools in Australia included CAM education in core or elective units (see Table 1). Of the remaining 16 schools (84.1%), 11 (57.8%) reported that CAM was not included in their programs. Five schools (26.3%) reported minimal or incidental CAM training. The Australian GPs in the study had undertaken post-graduate CAM courses provided by universities, private colleges and external courses, such as those offered by the Australasian College of Nutritional and Environmental Medicine [48]. Many had also undertaken CAM training through continuing education programs. Table 2 summarises the range of CAM modalities offered to patients by practitioners in the three IM clinics used in the cumulative case study phase of the research.

Both CAM practitioners and GPs reported that most of their learning about the integration of CAM and mainstream medicine occurred in practice. Cases dealt with in IM clinics potentially provide unique sets of combinative treatment approaches. In the course of this research many instances of positive health outcomes of clinical applications of CAM and IM were reported. Some key learning areas included:

i) the wide range of diagnostic and treatment options (including mainstream medicine, CAM and self-management), particular combinations of these options and the effects of varying their sequence.

ii) patient outcomes from traditional uses of CAM. One GP was keen to pass on results from the use of grape seed extract in the treatment of cataracts (one of its traditional uses) to a mainstream medical colleague. (This is also an instance of information becoming disseminated beyond the IM clinic.)

*I spoke to an ophthalmologist recently. I was getting people's cataracts to reverse by using grape seed extract - in a month gone. Their whole cataracts completely cleared and I spoke to this ophthalmologist and said, "This is fantastic. You should be using it for your patients."*¹ GP 1

iii) preference for using simple and non-invasive CAM treatments before mainstream medical ones. The following excerpt is an example of this approach.

We might refer to CAM practitioners for different things to do with gaps in our knowledge. I generally tend to refer younger women, for example, who come in for hormone balance when it's not really appropriate for them to go on HRT I'm definitely not keen to give oestrogen to a pre-menopausal woman. So I'd refer to ... [CAM practitioner] to give her acupuncture or herbs to boost her own oestrogen. GP 2

iv) serendipitous IM treatments, for example, treatments that emerged from patients disclosed revelations of previous and current treatments.

v) treatment protocols that were established by the practice for clients seeking healthy ageing, detoxification, and management of chronic fatigue, obesity, osteoporosis, diabetes and cancer. Protocols usually resulted from formal interprofessional collaboration and conferred several advantages including the efficient use of clinic resources, particularly the inclusion of CAM practitioners within the programs, and standardisation of treatment.

Dr ... and I are formulating a program at the moment. It will be a 3-month program that we're putting together for weight management ... In our approach we can touch on emotional issues because I think that is really important. Without looking at emotional issues with things like weight management you're not going to get the source of the problem. I've put together a network of other practitioners and health clubs, personal trainers and other people in our area that we can work with. Patients will get an information pack at the beginning and then they'll come in each fortnight to get weighed and measured to keep their motivation up and make sure everything's going as it should be. Then they get the following fortnight's diet diaries. It's really handy working with ... [GP] because he can determine whether there's any pathological problem behind the weight gain as well. The idea is that, to begin with, patients will go to see ... [GP] and have a complete medical check-up so we can look at all aspects of their health and whatever comes up can be addressed through the weight management program. CAM practitioner 1

3.2 Learning ways to develop practice

According to the practitioners in this research, communicating with practitioners from other disciplines (including discussions arising from shared patients and discussions about recent research and other issues related to CAM and IM) was a driver for learning. Shared space within the clinic and shared client files provided frequent opportunities for informal exchanges about clients' care. The thrust of

¹ Italics indicates quote from research participant

the following comment relating to this issue was widespread among participants.

One of the things I liked about working with doctors was the learning experience. I could ask them questions about patients or conditions and I had the opportunity to learn from that. The doctors were usually very willing to talk to me when I asked them questions. It was an informal thing. I'd see them out in the corridor and ask them questions.

CAM practitioner 2

Interprofessional collaborations were also beneficial for GPs. CAM practitioners sometimes assumed the roles of teacher and advisor to GPs, particularly for GPs who were relatively inexperienced in clinical applications of CAM.

The doctors would ask questions that might have to do with what herb would work here, what nutritional approach would work here. Do you think that this therapy or that therapy is of any use in this kind of condition?

CAM practitioner 2

I have Dr ... next door who will pop her head in and ask my advice, you know, "I've got this patient and this problem. Is there anything you can offer?"

CAM practitioner 3

Each clinic also held formal practice meetings where cases of interest were discussed and analysed. Taking time out from busy practice schedules gave practitioners opportunities to reflect on and critically self evaluate the contribution of their own discipline to patients' health care and their personal knowledge bases. They could examine and question their own assumptions and be opened up to experiences and suggestions of others. These events developed the practices of individuals, enhanced the resources of the clinics, and carried the potential to contribute more widely to the professional knowledge base of IM.

4. DISCUSSION AND CONCLUSION

The *learning in practice* model evident in this research is underpinned by social constructivist learning theory that holds that individuals continually construct and reconstruct knowledge and have the potential to learn beyond their current knowledge under the guidance of experienced peers or mentors [49]. Although mentors were not specifically identified in this research, it is not hard to conceive of such a role emerging for the most senior or highly qualified practitioners in the course of the developing relationships among clinicians.

The IM clinics in this research were hubs of continuing education for both CAM practitioners and mainstream medical practitioners. Practitioners learned from each other through ongoing informal

conversation, shared client files, formal practice meetings, and treatment protocols. They extended their knowledge bases into areas that their formal education had not canvassed but that were important to their patients. Many practitioners encountered new diagnostic and treatment options (including combining and sequencing CAM and mainstream medicine) which challenged their personal knowledge. According to Fish and Coles [50], practitioners are more able to develop their practices when they have questioned and reflected on their own personal knowledge. Interprofessional collaboration was facilitated by shared practice spaces and the time that was allocated to formal interdisciplinary encounters in practice meetings. Practitioners could discuss cases, see new perspectives and make connections between individual cases. They could articulate critical moments (i.e. moments that were significant for practitioners' learning) and underlying assumptions and values. However, time pressures in practice often inhibit formal strategies that encourage critical reflection, such as practice meetings and writing journals. Fook and Gardner [51] suggest that practitioners aim to use critical reflection informally or implicitly, that is, as part of what they do all the time using appropriate questions as prompts. Questions such as, "What does my account of my critical incident imply about my basic ideals or values, my beliefs about power, my view of myself and other people?" and "What do I believe about professionalism?" could be used to promote critical self reflection. There is also a call for practitioners to take opportunities to go beyond reflection and critical self-evaluation and to become "conscious investigators" of their own practices [52], that is, conduct research on the basis of cases within their own practice. For this to occur, organisational and management approaches need to be supportive of the kinds of communities of practice that could generate research. IM clinics where CAM and mainstream medical practitioners are co-located are a potentially rich source of interdisciplinary collaboration and research activities.

Hermeneutic phenomenology is an effective way of mining the depths of knowledge and wisdom that accumulate in any practice through its exploration of the lived experiences of practitioners and patients. It opens up possibilities of deeper understanding for readers. One of the challenges of this approach is acknowledging one's own standpoint and maintaining an attitude throughout the research that is open to others' interpretations of their experiences. In qualitative research, findings relate to particular contexts at particular times and cannot be generalised, although practitioners may transfer relevant findings to their own health care settings. Furthermore, the findings may serve to generate

topics for wider consideration and stimulate further research, both of which could enhance practice.

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Table 1: CAM Education in Australian medical schools

CAM education in Australian Medical Schools	Number	Percentage
Core in undergraduate program; CAM electives in post-graduate program	1	5.3
CAM electives in undergraduate program	1	5.3
Core in post-graduate program	1	5.3
CAM taught incidentally in problem-based learning sessions	3	15.7
Some herbal medicine taught in pharmacology	1	5.3
One lecture in Year 2	1	5.3
No CAM taught	11	57.8
Total	19	100.0

Table 2: Diversity of CAM in three IM clinics in Sydney

	General medical practitioners	CAM practitioners
Clinic 1	GP1: WM*, acupuncture, nutritional medicine GP2: WM, acupuncture, herbal medicine, nutritional medicine, homoeopathy GP3: WM, anthroposophical medicine, herbal medicine, nutritional medicine GP4: WM, homoeopathy GP5: WM, herbal medicine, nutritional medicine	CAM1: psychotherapy CAM2: naturopathy CAM3: naturopathy CAM4: naturopathy CAM5: naturopathy
Clinic 2	GP1: WM, acupuncture, herbal medicine, nutritional medicine	CAM1: naturopathy CAM2: naturopathy CAM3: naturopathy CAM4: naturopathy CAM5: Reiki CAM6: remedial massage
Clinic 3	GP1: WM, nutritional medicine, counselling GP2: WM, nutritional medicine, environmental medicine, herbal medicine, acupuncture GP3: WM, environmental medicine, nutritional medicine, allergy testing GP4: WM, environmental medicine, naturopathy GP5: WM, nutritional medicine, environmental medicine GP6: WM, bio-energetic medicine, acupuncture, homoeopathy, nutritional medicine, parasitology GP7: WM, homoeopathy GP8: WM, environmental medicine, nutritional medicine	CAM1: naturopathy CAM2: acupuncture, traditional Chinese medicine CAM3: chiropractic CAM4: chiropractic

* WM = Western medicine