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Personal and professional influences on practitioners' attitudes to traditional and complementary approaches to health in the UK

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Abstract *Objective:* To explore primary care practitioners' personal and professional beliefs about traditional and complementary approaches (TCA) to health and the influence of professional socialization in the UK.
Methods: As part of a larger study on child TCA use in a multi ethnic community, semi-structured, one on one, face-to-face interviews with 30 primary care practitioners (GPs, nurses and health visitors) explored experience, knowledge and attitudes regarding TCA. Framework analysis was used. This paper explores the key emergent issues of personal and professional beliefs and professional socialization resulting from the qualitative data obtained during the interviews.
Results: Personal factors (ethnicity and personal use) influence attitudes, but professional factors appear to dominate, including biomedical theory, evidence based medicine, safety and treatment choice. Curbing of personal views and experience may be due to caution and conformity from increasing regulatory power. Inter- and intra-professional group differences also emerged, likely due to variation in training, status and professional role.
Conclusions: Practitioners need to understand patients' diverse health beliefs and practices and discuss TCA with families, despite regulatory and organizational constraints, to fulfil their professional duty to patients, particularly regarding safety. Further research is needed to verify the professional socialization process and the influence of specific regulation on training.

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Introduction

Complementary and alternative medicine, 'diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine'[1] is used by between 10% and 69% of the population in the West.[2–4] Many families use traditional approaches; 'folk' medicine, culture specific traditional medicine (e.g. Chinese medicine, Ayurveda), ethnomedicine or home remedies.[5] The term TCA, traditional and complementary health care approaches, is used in this study to capture both.

In the UK most TCA is accessed outside the National Health Service (NHS), often as self-care.[6] Up to 80% of conventional practitioners report discussing CAM with patients,[7] over half recommend,[8] and up to 95% refer.[9]

Attitudes of practitioners influence communication about TCA.[10,11] Practitioner attitudes to TCA vary; most are ambivalent or neutral[12–15]; some are overtly negative.[13–16] Attitudes are influenced by personal and professional factors.[11–15,17–19]

Practitioners more likely to accept and discuss TCA are younger and female,[12,14,19–22] and personally use or practice TCA.[12,17,22–24] Personal use of TCA may not correlate with consultation behaviour.[17,25] Cultural or religious beliefs may also influence TCA discussion.[26] Practitioner ethnicity results are disparate: Black or African–American practitioners may have greater belief in religious TCA[19,26] but Asian doctors in America perceived TCA as less legitimate than White or African Americans.[19] Amster[27] found no difference in TCA attitudes between racial/ethnic groups. Attitudes to traditional medicines may be part of cultural origin[28] or 'personal philosophy about health'.[24]

Professional influences on attitudes to TCA include professional grouping (general practitioner (GP), nurse, midwife), setting, status and specialization.[18,25,29] Compared with doctors, nurses are more positive about TCA and likely to discuss and recommend TCA.[8,17,30] Practitioners with a closer relationship to the patient are likely to be more positive.[25,29,31] A hierarchy of TCA views and behaviour shows midwives as most positive, referred and more likely to discuss, followed by nurses, then doctors. Few studies include more than one professional group.[31] Clinical experience[11] and evidence are also important.[21,32]

Hirschkorn and Bourgeault[33] assimilated the (largely theoretical) literature, using Tovey and Adams' framework[34] which divides factors influencing practitioners' CAM decisions into five categories; practitioner factors (including personal and professional characteristics), patient factors, TCA modality, structure (setting and organizational structure) and context.[33] They compared different provider groups (doctors, nurses and midwives).[35]

There is a need for theory based research to investigate the relative influence of personal and professional influences on attitudes to TCA.

Methods

The themes in this paper arose from the second phase of a study reported previously.[36–42] The first phase used parent focus groups and questionnaires to explore child TCA use.[42] The second phase, interviews with primary care practitioners, investigated parent's consultation behaviour regarding TCA. Parents' and practitioners' disparate views of TCA have been discussed elsewhere.[41] This paper focuses on practitioners' attitudes to TCA and the emergent theme of personal and professional influences.

Interviews were semi-structured, one on one, face-to-face, with primary care practitioners: GPs (general practitioners); nurses (including nurse practitioners – nurses with additional specialist training); health visitors (HVs (nurses with specialist community health qualifications)); and midwives. GP practices in Brent and Harrow, London (an ethnically diverse area, 48% non-white) were invited, and individual practitioners volunteered. Sampling was purposive, theory-based and iterative, based on ethnicity, profession and GP practice location. Payment was offered to cover costs of a locum.

Qualitative methods were used to understand complexity, detail and diversity, and for long-standing, ingrained and possibly even unconscious beliefs.[43] Digitally-recorded interviews were at the practitioner's workplace and lasted thirty- sixty minutes. Questions and prompts covered practitioner's knowledge of TCA, awareness of patient use, professional training, attitudes and beliefs about TCA, personal use, influence of personal factors (including ethnicity and family), perceived relative impact of factors, and clinical behaviour regarding TCA. Attentive listening was important, interpretation was avoided during interviews, non-verbal behaviour was noted, to ensure dependability.[44]

Recordings were transcribed verbatim into Atlas.ti. Framework Analysis was used, a highly structured, systematic, transparent method.[43,45] Frameworks with cases (individuals) in rows and themes in columns allowed for searches within and between groups, identifying shared understanding. Structure and rigor promoted reflexivity. Key stages were: familiarization, identifying a framework, indexing, charting and mapping.[45] The first four are mainly data management strategies; mapping identifies patterns and explanatory accounts to access individual meaning and interpretation and enable categorization[45,46] The credibility of explanatory accounts was by 'weighting' themes according to: frequency, specificity, intensity, disconfirming evidence and reflections.

Harrow NHS research ethics committee approved the study, reference 06/Q0405/92. TCA was not considered sensitive; no concerning ethical issues arose. Potentially sensitive personal topics may arise, but discussion was not required.

Results

Thirty interviews were conducted: thirteen GPs, nine HVs, six nurses, one medical student and one midwife. Eleven were White, eleven Asian, three Black, one Chinese and one 'Other'.

Practitioner factors- professional

Professional experience and philosophy seemed more important to practitioners' attitudes to TCA than personal factors. However, separation was difficult and potentially biased by not disclosing personal issues within a professional setting. Six key professional influences were identified.