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The clinical reasoning of Western herbal practitioners: A qualitative feasibility study

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ABSTRACT

Aims: A literature search found no research into the clinical reasoning of Western herbal practitioners. This study aims to address this gap in knowledge by investigating practitioners' clinical reasoning when designing individualised herbal prescriptions.

Design and methods: A qualitative feasibility study using case study methodology and framework analysis was conducted in the UK. Think-aloud technique enabled capture of the thinking of 5 herbal practitioners when designing prescriptions. Themes emerging from the recordings were explored further during semi-structured interviews.

Findings: This study found that Western herbal practitioners use hypothetico-deductive reasoning, intuition and pattern recognition when designing prescriptions. The findings were consistent with dual-process theory in that both analytical and non-analytical thinking were used. Furthermore, the concept of tacit knowledge was useful in exploring the meaning of intuition.

Conclusions: Herbal practitioners design individualised prescriptions using complex decision-making processes, which can be analysed with models of clinical reasoning used in other healthcare professions.

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1. Introduction

Most published research into herbal medicine examines single herbal medicinal products; however, Western herbal practitioners (WHPs) prescribe combinations of herbs using non-standardised preparations which are selected for individual patients (Nissen and Evans, 2012). A pilot randomised controlled trial by Green et al. (2007) showed that individualised care from WHPs improved menopausal symptoms. However, the study lacked external validity as it was not known whether the 3 WHPs involved were representative of the profession in the United Kingdom (UK). Denham et al. (2011), reporting on the prescriptions and advice given in this study to these 35 women during the menopause, flagged up the need to understand the clinical reasoning of herbal practitioners.

Clinical reasoning is an essential aspect of professional practice, and encompasses 'the sum of thinking and decision-making processes associated with clinical practice' (Higgs and Jones, 2008,

p.4) which enable the practitioner to make clinical judgements (Eva et al., 2007; Higgs and Jones, 2008). Clinical reasoning has been studied in other healthcare professions such as physiotherapy and nursing (Edwards et al., 2004; Jones, 2006; Simmons et al., 2003), but little is known about it in the context of Western herbal medicine. A recent report on the regulation of herbal medicines and practitioners prepared for the Department of Health highlighted the lack of high quality evidence for the effectiveness of the practice of herbal medicine (Walker, 2015). Studying the phenomenon of the clinical reasoning of herbal practitioners will start to address a gap in the literature and inform future studies. The aim of this study was to use the concepts discussed in this literature to learn more about how WHPs make decisions when designing herbal prescriptions.

The literature on clinical reasoning emerges from different philosophical approaches and this is reflected in the language used within the different models. Each approach incorporates both conscious (analytical) and subconscious (non-analytical) thinking. A component of each approach is the conscious or analytical cognitive process of reasoning. This is sometimes described as hypothetico-deductive, whereby an initial hypothesis is tested against the findings of the clinical history, examinations and investigations and published reference sources such as guidelines (Marcum, 2012; Pelaccia et al., 2011). However, many aspects of

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clinical reasoning are subconscious and are described in various ways including as intuitive or non-analytical (Higgs and Jones, 2008; Mattingly, 1991). The term pattern recognition is used to describe the way in which a practitioner accesses previous knowledge instantaneously without being able to fully articulate the process (Shiralker, 2011). This is more commonly seen in expert practitioners, who can recognise cues and match them to similar past situations or conditions (Ajjawi, 2009). Pattern recognition is therefore significant in the literature on diagnostic expertise which explores how novices can develop the skills of experts. Intuition is another recognised aspect of clinical reasoning in conventional healthcare (Bhugra et al., 2011; Lee et al., 2006; Shiralker, 2011; Stolper et al., 2011), and is also considered to help practitioners deal with complex situations (Stolper et al., 2011). However, intuition in the literature is not clearly defined and neither is the relationship between intuition and conscious or analytical reasoning (Brien et al., 2011; Ruth-Sahd, 2004). In some cases, the term intuition is used interchangeably with tacit knowledge (Marcum, 2012). Tacit knowledge, a recognised aspect of clinical reasoning, shares many characteristics with intuition, in that it is defined as personal know-how that is used without requiring a conscious process (Henry, 2010). Tacit knowledge is defined as clearly contextualised in practice and is thus an experiential process (Polanyi and Sen, 2009; Fleming and Mattingly, 2008; Henry, 2010; Welsh and Lyons, 2001; Sternberg, 1999).

Dual-process theory proposes that there are two cognitive processes: non-analytical and analytical thinking. Depending on the situation one process may be relied upon, or they may be used in combination (Evans, 2006; Marcum, 2012; Pelaccia et al., 2011). The non-analytical process, sometimes known as System 1, is described in the literature as intuitive, subconscious and fast. It is also described as tacit and experiential (Marcum, 2012; Pelaccia et al., 2011), with intuition and pattern recognition falling into this category (Pirret, 2016). The analytical process, sometimes known as System 2, is described as a conscious process which is more likely to be used in complex situations, when there is uncertainty, when the stakes are high and where more time is available (Pelaccia et al., 2011; Pirret, 2016). These theories are presented in different ways and can be contested, but these debates are not explored here (Osman, 2004; Evans and Stanovich, 2013).

2. Methodology

To investigate the complex phenomena of clinical reasoning in its real-life context, a qualitative study using case study methodology was conducted (Baxter and Jack, 2008). The case was defined as experienced WHPs operating within their normal clinical setting. Framework analysis was chosen for examining the data as it is both deductive and inductive (Pope et al., 2000). This dual approach is appropriate as clinical reasoning models have been identified in other healthcare professions, but theory building needs to be conducted in the realm of Western herbal medicine. A literature review highlighted the paucity of knowledge regarding the clinical reasoning of WHPs. The literature was reviewed to identify the main clinical reasoning models used by healthcare professionals and incorporated these into the framework analysis.

The practitioners were registered with the National Institute of Medical Herbalists [NIMH] which is the main UK professional association. Practitioners either hold an accredited BSc degree in herbal medicine or equivalent. Registrants must abide by the Code of Ethics and Code of Practice, be fully insured and fit to practice, and undertake mandatory continuing professional development (NIMH, n.d.).

WHPs conduct personal consultations usually lasting an hour in which they explore current health issues, take a comprehensive medical history and perform any clinical examinations necessary

(Casey et al., 2007; Conway, 2011; NIMH, n.d.). Prescriptions are individually designed for the patient using a combination of herbs, and are usually accompanied by dietary and lifestyle advice (Casey et al., 2007; Denham et al., 2011). The choice of herbs in any prescription relies on both traditional and scientific knowledge, alongside the practitioner's consulting style and relationship with the patient. Furthermore, the vernacular of herbal practitioners consists of a mixture of conventional terminology and that specific to herbal medicine. The researchers are WHPs which enabled an easier discussion of decision-making processes used by the herbal practitioners when designing prescriptions.

2.1. Subject participants

Ethical approval was obtained from the School of Health Peer Review panel of the University of Central Lancashire. All NIMH herbal practitioners in Lancashire and the South Lakes area ($n = 28$) were invited to take part in the study. Due to low recruitment the catchment area was expanded to include Cheshire and Merseyside ($n = 14$). An information pack consisting of an invitation letter, information sheet, consent form and a stamped addressed envelope were posted out. Practitioners were then sent an email reminder with the letter attached.

Five qualified herbal practitioners ($n = 5$), each having a minimum of 3 years' clinical practice were recruited to be included in the study. The herbal practitioners also needed to be in a position where they could formulate a prescription immediately after a consultation. Written consent was obtained from the herbal practitioners in the study.

Their patients were not classed as participants. However, written consent was obtained from each patient because their health conditions were discussed on the recordings and during interviews. Practitioners were requested not to include personal information about the patients on the recording. Prior to consulting with a new patient the herbal practitioner introduced them to the study, and gave them an information sheet, informed consent form and stamped addressed envelope with which to return the consent form to the main researcher. Patients under the age of 18 years were excluded.

2.2. Data collection

In line with case study methodology, data from different sources was collected: think-aloud digital voice recordings, field notes (gathered during a pre-study telephone conversation with the participants and when collecting the recorders from the practitioners' clinics), and interview transcripts (Baxter and Jack, 2008). The study ran from 17 February 2014 until 23 June 2014.

Think aloud, a technique of describing cognitive processes using verbalisation whilst undertaking a task (Arocha and Patel, 2008; Ericsson and Simon, 1980), was used to capture the herbal practitioners' immediate thinking whilst designing prescriptions. The herbal practitioners reported everything they were thinking onto a digital voice recorder, as it occurred, for any new patient seen within the 6 week timeframe (see Table 2). Concurrent think aloud was chosen over retrospective, as the latter runs the risk of the participants reconstructing or misremembering their thinking (Unsworth, 2008). Given that clinical reasoning is context-dependent (Higgs and Jones, 2008) the thinking aloud was for a real patient and took place within their practice setting. The original intention was for the herbal practitioners to design their prescriptions away from the patient – this would allow them to talk freely. However, this was not always possible without adversely affecting the herbal practitioners' normal practice (as some prescribe with their patients present). Therefore the study design was amended to accommodate this, providing they had

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