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Complementary medicine teaching in Australian medical curricula: The student perspective

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ABSTRACT

Background: Use of complementary medicine in Australia is increasing. Despite documented high use, however, perspectives of complementary medicine teaching inclusion within health professions education are poorly documented and understood.
Aim: This paper explores medical students' perspectives of complementary medicine teaching from the curriculum of Australian medical programs.
Methods: A constructivist grounded theory methodological approach was used to generate, construct, and analyse data. Thirty second-year to final-year medical students from 10 medical school education faculties in Australian universities participated in semi-structured interviews over a five-month period in 2013.
Findings: Students from all represented medical schools highlighted perspectives of complementary medicine offerings in both the preclinical and clinical curriculum. Across the curriculum, a wide range of perspectives were related to both complementary medicine teaching and learning aspects incorporating social and ethical issues, evidence of clinical efficacy and safety, and evidence-based principles involving critical application and appraisal.
Discussion: The findings demonstrate diverse perspectives of complementary medicine teaching not necessarily synonymous with learning. While all students highlighted some form of complementary medicine teaching and/or learning, perspectives varied between schools and across jurisdictions in terms of context and content. Clinical exposure to informal complementary medicine learning in clerkship was extensive relative to formal didactic teaching in the preclinical curriculum. Educational exposure to complementary medicine was shown to positively affect medical student attitudes towards complementary medicine.
Conclusion: A coordinated policy towards integration of complementary medicine teaching in Australian medical curricula is recommended. Impetus for open debate regarding what level of complementary medicine teaching and/or learning is sufficient in medical and other health professions education is required.

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1. Introduction

Global use and prevalence of complementary medicine (CM) as a component of healthcare is widespread (Harris, Cooper, Relton, & Thomas, 2012). Concurrently, prevalent issues such as self-prescribed CM use (Mathew et al., 2013; Reid, Steel, Wardle, Trubody, & Adams, 2016) and potential for adverse events and interactions with pharmaceutical medicines (Izzo & Ernst, 2009; Tsai, Lin, Pickard, Tsai, & Mahady, 2012) indicates that appropriate guidance from health professionals is needed. Taking into account such issues, this study focused on enhancing safe and appropriate use of these medicines and utilised the Therapeutic Goods Administration regulatory definition of CM, which differentiates medicinal products from physical therapies. Within this definition, CMs may include herbal medicines, vitamin and mineral supplements, nutritional supplements, traditional medicines (Ayurvedic medicines and traditional Chinese medicines), homoeopathic medicines,

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Statement of Relevance

Problem

Little is known about the context of complementary medicine (CM) teaching in Australian health professions education and medical students' perspectives regarding CM teaching in medical programs.

What is Already Known

Educators globally have recognised the need for CM teaching in health professions education. Medical students require basic competency in CM to prepare for their role in primary care.

What this Paper Adds

Evidence that perspectives of medical students regarding CM teaching in Australian medical programs appear positive, yet heterogeneous, due to a lack of stringent educational guidelines. In addition, disparate requirements for CM teaching demonstrates inequities in educational experiences among medical students.

and certain therapeutic aromatherapy preparations (Therapeutic Goods Administration, 2013).

There is growing interest towards CM in health professions education (Kreitzer, Kligler, & Meeker, 2009). Literature on gauging students' attitudes towards, knowledge of and interest in, learning more about CM in several countries unanimously shows a high level of desire to learn about CM (Adib-Hajbaghery & Hoseinian, 2014; James, Bah, & Kondorvoh, 2016). In such studies, health professions students have shown positive attitudes towards CM training and recognised the need for open communication about CM and therapeutic guidance available to patients. Within this landscape, previous studies of medical students have focused mainly on attitudes towards CM and CM training, factors influencing such attitudes, own use of CM, the likelihood of recommending CM to patients, and perceived importance of CM in the curriculum (DeSylvia, Stuber, Fung, Bazargan-Hejazi, & Cooper, 2011; Joyce, Wardle, & Zaslawski, 2016; Quartey, Ma, Chung, & Griffiths, 2012). In contrast, there is a paucity of literature specifically describing medical student perspectives of CM teaching experiences. This dearth is even more pronounced in the Australian context where such data and meaningful educational policy are lacking on a national level.

Increasing popularity and use of CM has stimulated the need for curricula reform within health professions education (Frenkel, Ben-Arye, & Hermoni, 2004; Kreitzer et al., 2009). This need has been increasingly addressed by select health professions schools internationally through incorporation of CM teaching in education programs (Al-Rukban et al., 2012; Nicolao, Täuber, Marian, & Heusser, 2010; Pearson & Chesney, 2007). In contrast, Australian educators have been slower to act, in particular, incorporating CM teaching into medical programs (Pierantozzi, Steel, & Seleem, 2013; Pirotta, Hassed, Kotsirilos, Rawlin, & Sali, 2007). In healthcare, what potentially defines a core CM curriculum has been proposed in the literature (Pearson & Chesney, 2007; Pirotta et al., 2007; Wetzel, Kaptchuk, Haramati, & Eisenberg, 2003). Yet, little is known about a core CM curriculum in medical programs, much less in the Australian context. While the Australian Medical Council (2012) outlines guidance on requirements for medical programs and curriculum design it does not detail information on CM teaching or learning activity. More importantly, it does not stipulate the context in which such information is delivered.

The purpose for this paper was to explore and elicit student perspectives of CM teaching in Australian medical programs, and importantly, to capture the context in which CM offerings were taught. In exploring medical student perspectives of CM teaching, this paper draws on a larger study into exploration of CM education development in Australian medical curricula. Understanding student perspectives in this context may assist educators, curriculum developers, and national standards bodies across the health professions to identify educational gaps and core teaching needs for CM curricula development.

Table 1
Medical student demographics.

Characteristics	Number (n = 30)	Percentage
Gender		
Male	15	50%
Female	15	50%
Age range		
21–30 years	18	60%
31–45 years	12	40%
Medical course		
Undergraduate (MBBS)	10	33%
Undergraduate (graduate-entry) (MBBS/BMed)	17	57%
Graduate-entry postgraduate (MD)	3	10%
Year level (u/grad + postgrad)		
Second year	6	20%
Third year	11	37%
Fourth year/final year	13	43%
Ethnicity (n = 17)		
Asia	4	24%
Indigenous/Maori	3	18%
European/middle eastern	5	30%
Indian subcontinent	5	30%
Other expertise		
Curriculum committees	12	40%
Professional bodies (e.g. medical board)	4	13%
Professional (e.g. pharmacy)	11	37%
Academic (e.g. researcher)	5	17%
Undergraduate qualification (n = 20)		
Pharmacy	4	20%
Dentistry	2	10%
Science	6	30%
Medical science	7	35%
Law	1	5%
Arts	1	5%

2. Methods

Little is known about CM teaching in Australian medical programs from perspectives of medical students. The study utilised constructivist grounded theory method (CGTM) to explore this issue. CGTM, as described by Charmaz (2006), draws on a social constructivist paradigm where the research process is constructed from interaction between investigator and participant, acknowledging each reflexive position. Tenets of CGTM involved constant comparison of data, reflexive memoing, theoretical sensitivity, and theoretical sampling (Birks & Mills, 2011; Charmaz, 2006). The study was approved by Monash University Standing Committee on Ethics in Research.

2.1. Participant recruitment

Thirty medical students (Table 1) from 10 university medical school institutions across five Australian states and one territory were recruited (National School Network, 2008). Following ethics approval, flyers were distributed via each university medical student society inviting students from second year onwards to participate. As part of the inclusion criteria, students were required to have completed at least one year of medical education to enable exposure to some form of CM teaching in the curriculum and appropriate reflection on such experiences. Students brought perspectives throughout the passage of their medical education (first to final years; preclinical and clinical curriculum). Repre-

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