Perceptions and attitudes of New Zealand Plunket nurses toward the use of complementary and alternative medicine in children

Stephanie Lai Ha Lo

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Abstract

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Background: Studies suggest that the use of complementary and alternative medicine (CAM) is high in New Zealand children. Plunket nurses are primary child health care providers who play a significant role in assisting parents in making informed decisions. Their perceptions and attitudes toward CAM are important as they can influence their clinical approach to health issues. This study examines New Zealand Plunket nurses’ perceptions and attitudes toward CAM use in child health and explores factors that might affect the nurses’ clinical practice related to CAM issues.

Method: This is a qualitative study using focus group method to collect data. A total of five Plunket nurses participated in the study. Data were analyzed using an interpretative description framework.

Findings: Four key themes emerged from the data. They were “organisational policy constraints”, “ambivalence about being an organisation employee and independent health professional”, “fear of liability” and “desire for knowledge and resources”. The findings aid understanding of New Zealand Plunket nurses’ perceptions and clinical responses toward CAM practices.

Conclusions: Participants have ambiguous feelings toward the organisational policy of not endorsing or recommending any type of CAM in response to CAM enquiries. While feeling restricted by the policy, participants were concerned about the confusion among staff and the possible liability in engaging with CAM issues if the existing policy was not in place. All participants reported a desire to have more updated knowledge and in-service education about CAM to assist parents and caregivers in their choices of CAM care. This study highlights the need for further research to explore the current status of CAM use in New Zealand children and the strategies needed for the health care policy makers to respond appropriately.

Keywords: CAM, paediatrics, Plunket nurses, health professionals, attitudes, perceptions
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Dedication

I dedicate this thesis to Royal Plunket Society New Zealand. They offered me a wonderful opportunity to serve families and children in New Zealand. The contribution of this organisation to the community is enormous with their honourable spirit to offer their best service to the community. I enjoyed the time working for Plunket and offer my best wishes for them to continue providing excellent care to the families and children of New Zealand.
Abbreviations

CAM       Complementary and Alternative Medicine
GP        General Practitioner
MACCAH    Ministerial Advisory Committee on Complementary and Alternative Health
NCCAM     National Center for Complementary and Alternative Medicine
NZ        New Zealand
NZCOM     New Zealand College of Midwives
NZMC      New Zealand Medical Council
NZNO      New Zealand Nurses Organisation
PN        Plunket Nurse
RNZPS     Royal New Zealand Plunket Society
TCM       Traditional Chinese Medicine
UREC      Unitec Research Ethics Committee
WHO       World Health Organisation
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1.0 INTRODUCTION

1.1 INTRODUCTION

The topic of the study is ‘Perceptions and attitudes of New Zealand Plunket nurses toward the use of complementary and alternative medicine in children”. In this chapter, the background of the development of the study is presented. The Plunket nurses (PNs) and the Royal New Zealand Plunket Society (RNZPS) which is the employer of PNs are introduced. A brief description of the researcher’s background is given in an attempt to give readers a better understanding of her position in relation to the study. The aims and purposes of the study are then stated and finally an overview of the thesis is given.

1.2 BACKGROUND IN DEVELOPING THE STUDY

Complementary and Alternative Medicine (CAM) refers to a group of diverse medical and health care systems, practice, and products outside conventional medicine (National Center for Complementary and Alternative Medicine [NCCAM], 2008). In recent decades, interest in and use of CAM in the public has increased worldwide and as have CAM related studies. Most of these studies focus on adults (Barnes, Bloom, & Nahin, 2008; Ernst, 2000; Harris & Rees, 2000; Hunt et al., 2006; MacLennan, Myers, & Taylor, 2006; MacLennan, Wilson, & Taylor, 1996; Xue, Zhang, Lin, DaCosta, & Story, 2007). Although fewer studies have been conducted in children, the prevalence of CAM for children has been shown to be high as well, following the trend for adults (Barnes, et al., 2008; Cuzzolin et al., 2003; Ernst, 1999; Simpson & Roman, 2001; Smith & Eckert, 2006; Zuzak et al., 2013). Locally in New Zealand (NZ), the prevalence of CAM use in adults and children is also found to be high, in line with the global trend (Armishaw & Grant, 1999; Ministry of Health [MOH], 2008; Nicholson, 2006; Wilson, Dowson, & Mangin, 2007).

However, despite the prevalence of CAM use, many studies revealed that majority of parents did not disclose the use of CAM in their children to their health care providers (Eisenberg et al.,
1998; Lim, Cranswick, & South, 2011; Ottolini et al., 2001; Robinson & McGrail, 2004; Sewitch, Cepoiu, Rigillo, & Sproule, 2008; Sibinga, Ottolini, Duggan, & Wilson, 2004; Sidora-Arcoleo, Yoos, Kitzman, McMullen, & Anson, 2008). The non-disclosure rate is even more pronounced in NZ compared to that of other countries (Wilson, et al., 2007). These studies highlight that it is essential for all health care providers to explicitly ask their patients or parents about the use of CAM to safeguard their patients’ health considering that many CAM modalities still require evidence to prove their safety and efficacy, Children are not small adults. Their immune and nervous systems are not fully developed and they may respond differently to CAM treatments. Communication with young children’s parents is even more significant as young children cannot speak for themselves but rely on their adult parents or family members to make decisions for them. As South and Lim (2003) state the topic of CAM use in children is so important that it should not be ignored by health care providers. With effective communication, health care providers can assist parents in interpreting which CAM therapies may or may not be beneficial to their children. The perceptions and attitudes of health professionals towards CAM are important as these will affect their clinical approach and their communication with parents. There is still a huge gap in literature related to CAM use in children and the perceptions of the health professionals working with children (Fearon, 2003).

The study is conducted primarily with NZ Plunket nurses (PNs) who are child health nurses working in the community with regular contact with children and their families. Their perceptions and attitudes may influence parents’ consideration of and decisions on health choices for their children. This study investigates their perceptions and attitudes toward CAM use in children. It also explores factors that may influence the nurses’ clinical practice related to CAM issues.

The majority of existing studies that have been conducted to study the perceptions and attitudes of health professionals toward CAM are surveys using questionnaires in a quantitative approach. They are generic and do not appear to be very relevant to PNs whom this study focuses on. Moreover, no study associated with PNs and CAM has previously been conducted. Hence, a qualitative approach using interpretative description as its framework, and the focus group method to collect data has been selected to be used to gain insights into PNs’ perceptions and attitudes regarding the topic. In identifying whether there are any potential factors that may
influence PN-parent communication regarding CAM use, recommendations and improvements can be made accordingly to optimize the health outcome of children.

1.2.1 ROYAL NEW ZEALAND PLUNKET SOCIETY AND PLUNKET NURSES

Plunket nurses (PNs) are nurses registered with the Nursing Council of New Zealand. They are employed by the Royal New Zealand Plunket Society (RNZPS) which is the largest Well Child Health care provider in New Zealand funded by the government. The organisation offers nationwide well child services to families with babies and preschool children from newborn to five years old. Over 90% of babies born in New Zealand have been registered with the organisation and visited by PNs (RNZPS, 2012, p. 14). Nurses form the largest group of primary health care providers working with young children in NZ. PNs have specialized postgraduate education in child health and work with families in the community. They make regular contact with parents and young children through home and clinic visits offering free child development assessments, health advice and support to families with regard to child health and development. It is likely that parents or family members would seek information and advice from PNs regarding their consideration and use of CAM in their children. PNs play a significant role in assisting parents in making informed decisions. Thus their perceptions and attitudes toward CAM are important as these can influence their interaction and communication with parents on the issue.

Despite this, no study has been done to identify the perceptions and attitudes of PNs toward CAM or how comfortable and competent PNs are to discuss the use of CAM with families who may wish to use it for their children. This gap in literature is particularly significant in light of the fact that mainstream health care providers are often reluctant or incompetent in discussing and examining the use of CAM and hence safety, efficacy and practicality issues may be overlooked (Sewitch, et al., 2008). Moreover, PNs’ information and advice are provided from a strong mainstream medical perspective and the guiding principle underpinning Plunket Well Child services strongly emphasizes the use of standard guidelines founded on evidence-based best practice (RNZPS, 2012, p. 5). Thus, it will be useful to know how PNs communicate with parents in their daily practice; also what are the factors that may influence PNs’ clinical behaviours related to CAM issues.
In conducting a qualitative study and managing its data, some scholars emphasize that the researcher should de-centre or suspend herself from her knowledge, experience or belief on the topic to avoid the influences of them on her own objectivity in the study. However, taking the interpretative approach, Thorne (2008) argues that identification of one’s beliefs, assumptions and preconceptions about the research topic through self reflection is more important than trying to avoid it. In fact, it is almost unavoidable that the background of the researcher would have an influence on her choice of study. Actually the researcher would naturally utilize her knowledge and experience in the interpretation of the study.

I am conducting this study for the partial fulfilment of the requirement for the degree of the Master of Osteopathy. While I am currently a full time osteopathic student, I have experience of being a Plunket nurse for five years. With this background, I have a basic understanding about the role of a Plunket nurse as a mainstream child health care provider and I can identify with the PNs easily during the process of the study. Becoming an osteopathic student, I am trained in a profession which is considered under the umbrella of CAM by most mainstream health care providers and among the public. However, many osteopaths categorise themselves as primary health care providers under Allied Health \(^1\) as the profession is regulated by the government and governed by the Osteopathic Council of New Zealand. The progression from a mainstream health care provider to a CAM learner is a journey of discordance and reconciliation for me. I recognize that the holistic philosophy of osteopathy is not only in line with many other CAM practices but also in congruence with the principles of nursing care. My background explains why I am interested in the topic and how I developed the study.

My cultural background plays a role in the developing of the study as well. I am an immigrant from Hong Kong. I was brought up in an environment where there was a mix of oriental and western cultures. While western medicine was the mainstream health system in Hong Kong’s

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\(^1\) Allied Health is all health professions other than medicine, nursing and pharmacy that require a tertiary degree to practice, and who form part of the public health system.
colonial era and my nursing training was entirely oriented in a biomedical model, Chinese Traditional Medicine (TCM) and remedies were common and a norm in people’s everyday life. Through reflection, I recognize that my career and cultural backgrounds could be a strength of the study in embracing different perspectives. Nevertheless, it is possible that others may consider them potential limitations. Constant awareness of these factors was maintained throughout the research process and strategies have been taken to maintain the rigour and credibility of the study.

1.3 AIMS OF THE STUDY

This study has two primary aims:

- To investigate the perceptions and attitudes of New Zealand PNs toward the use of CAM in children
- To explore the factors that might influence their communication and clinical practice related to CAM

1.4 OVERVIEW OF THE THESIS

The study investigates the perceptions and attitudes of PNs toward CAM use in children. Including this chapter, the thesis has been written in six chapters. The first chapter here describes the background in developing the study and that of the researcher. The Plunket nurses and New Zealand Plunket Society are introduced, followed by the rationale and the aims of the study. The second chapter is a review of literature including the definitions of CAM, the prevalence of it in adults and children, the situation of CAM use in New Zealand context, the common CAM practices used in children, the reasons for parents choosing CAM care for their children, and the perceptions and attitudes of health professionals toward CAM. Chapter three describes the methodology and method used in the study. The processes of recruiting participants, the focus group discussion and data analysis are outlined. The ethical considerations and strategies of
maintaining the rigour and credibility of the study are stated. Chapter four is a presentation of the findings from the focus group data which has been categorized into themes and subthemes. Chapter five is a discussion of the key findings of the study in relation to literature. Chapter six is the concluding chapter which gives a summary of the key findings and discussion. Implications and recommendations to mainstream health care providers, CAM practitioners and the coordination between the two are then given. Future research is recommended and the limitations and strengths of the study are reviewed. Finally, the concluding thoughts of the researcher are presented.
2.0 LITERATURE REVIEW

2.1 INTRODUCTION

In responding to the increasing popularity of CAM with the public, the number of studies related to CAM continues to expand. The majority of which have been focused on adults. As the prevalence of CAM use in children is also shown to be high, studies associated with CAM use in children have been growing but are still fewer than those in adults. This chapter covers the literature review on CAM with a focus on its use in children. Different definitions of CAM including traditional medicine are given. The prevalence of CAM use and the types of CAM commonly being used for children are discussed. The reasons why parents choose CAM care for their children are explained. The general findings and recommendations from current literature on health professionals’ perceptions and attitudes toward CAM are summarized. The current status of CAM in New Zealand is briefly discussed.

The review of literature was conducted through internet, database, specific journal and bibliographical searches. The primary search engine used for the internet searches was provided by ‘Google’ at http://www.google.com. The primary databases used were PubMed, Science Direct, EBSCOhost and CINAHL. Specific journals included the New Zealand Medical Journal, International Journal of Osteopathic Medicine and Complementary Therapies in Medicine. A comprehensive list of keywords were used separately and in combination in the search including ‘complementary’, ‘alternative medicine’, ‘traditional medicine’, ‘Plunket nurses’, ‘New Zealand’, ‘perceptions’, ‘attitudes’, ‘health professionals’, ‘prevalence’, ‘communication’, ‘safety’, ‘efficacy’, ‘reactions’, ‘non-disclosure’ and ‘children/paediatric’. The reference sections of the articles which have been retrieved were reviewed for related literature to expand the search. The years of literature searched were set from 1988-2013.
2.2 DEFINITION OF CAM

The field of CAM is very broad term which is not easy to define. The US National Center for Complementary and Alternative Medicine [NCCAM] (2008) defines it as a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine.

A more comprehensive definition which has been adopted by the Cochrane Collaboration and the New Zealand Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH, 2004) is as follows:

Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. (p. 1)

In some countries, the term ‘traditional medicine’ is used interchangeably with “complementary medicine" or "alternative medicine”. Traditional medicine often includes self care approaches, for examples home remedies, soups and traditional practices for wound healing such as boiled eggs for bruises. The World Health Organisation (WHO, 2013) refers to traditional medicine as:

The sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.

Other terms may be used to describe CAM including ‘natural medicine’, ‘non-conventional medicine’ or ‘holistic medicine’. The term ‘complementary’ and ‘alternative’ may also be used interchangeably, yet complementary therapies usually refer to therapies that supplement western biomedical treatment and/or complement the needs of the patient, and alternative medicine
generally means the use of therapies outside of the biomedical model (MACCAH, 2002, pp. 2-3).

NCCAM (2008) further classifies CAM into five categories. They include: 1) alternative medical systems such as naturopathic medicine, Ayurvedic medicine, homeopathy and traditional Chinese medicine; 2) mind-body interventions such as meditation, hypnotherapy, yoga, Tai Chi, music therapy; 3) biologically based therapies including food, herbs, natural remedies and aromatherapy; 4) manipulative and body-based methods such as chiropractic, osteopathy and massage; 5) energy therapies such as Gi Gong, therapeutic touch and magnet therapy.

2.3 PREVALENCE OF CAM USE IN ADULTS AND CHILDREN

Worldwide, the number of people using CAM has increased significantly in the past few decades. A national survey in the USA showed that almost 4 out of 10 American adults used CAM therapies in the year of 2007 (Barnes, et al., 2008). Going further back, a national survey in the general population of the USA concluded that the use of alternatives therapies by adults increased substantially between the 1990 to 1997 (33.8% to 42.1%) (Eisenberg, et al., 1998). National population-based surveys completed in England (Hunt, et al., 2006) and Australia (MacLennan, et al., 1996; Xue, et al., 2007) yielded similar findings, as did a review of twelve studies across Australia, Canada, Finland, Israel, the UK, and the USA (Harris & Rees, 2000).

In relation to children, a systematic review done by Ernest (1999) found that the prevalence of CAM was generally high with figures varying from 9% to 50% and the high variability was due to the difference in the study populations. A population-based study in United Kingdom reported 17.9% of children under 16 years of age used CAM at least once in the year of 2001 (Simpson & Roman, 2001) and figure was higher (37%) in study done in a paediatric outpatient clinic (Robinson et al., 2008). In the United States, the national survey conducted in 2007 revealed that 12% of children had used CAM (Barnes, et al., 2008). In Australia, CAM prevalence in the paediatric population varied from 11% to 68% (Kukuruzovic, 2005; Lim, Cranswick, Skull, & South, 2005).
According to the most recent New Zealand Health Survey during the period of 2006 - 2007, nearly one in five adults (18.2%) reported that they had seen a complementary or alternative health care provider, with the number of women being significantly more than men. Over half of them saw a massage therapist, one in four saw a homeopath or naturopath, and one in five saw an acupuncturist (Ministry of Health [MOH], 2008, pp. 299-302). A survey undertaken in the emergency department of a large tertiary hospital (Waikato Hospital, Hamilton) reported that one in three (397 in 1043) people had used CAM, including 29 who had used a traditional Maori therapy\(^2\) (Nicholson, 2006). Whilst there is no national data available specifically on the prevalence of CAM use in children, some regional studies showed that there were a substantial proportion of New Zealand children using CAM treatments. A study done by Armishaw and Grant (1999) showed that 18% of the children who were admitted to the general paediatric service of a metropolitan children’s hospital in Auckland had received CAM treatments prior to hospital admission. Another study reported that a high prevalence of 70% of children who attended general practitioners in Christchurch had used one kind or another modality of CAM (Wilson, et al., 2007).

The prevalence of CAM use in children was shown to be considerably higher in certain study populations, for examples in paediatric clinics (21-53%) (Ottolini, et al., 2001; Sawni-Sikand, Schubiner, & Thomas, 2002), in emergency departments or hospital environment (Loman, 2003; Madsen et al., 2003; Nicholson, 2006) and in the intensive care unit of critically ill children (Moenkhoff, Baenziger, Fischer, & Fanconi, 1999). Use of CAM was also high among children with chronic illnesses or conditions where conventional treatments proved inadequate. Examples include those with autistic spectrum disorders (74-95%) (Hanson et al., 2007; Harrington, Rosen, Garnecho, & Patrick, 2006), attention deficit hyperactive disorder (67.6%) (Sinha & Efron, 2005), asthma (13-49%) (Orhan et al., 2003; Torres-Llenza, Bhogal, Davis, & Ducharme, 2010),

\(^2\)Maori therapy applies to the traditional medicine system defined by Maori people in New Zealand. The philosophy of it towards health is based on a wellness or holistic health model. Four cornerstones of health have been recognized: whānau (family health), tinana (physical health), hinengaro (mental health) and wairua (spiritual health) (Ministry of Health [MOH], 2013).
type 1 diabetes (19%) (Miller, Binns, & Brickman, 2008), juvenile idiopathic arthritis (33.9%) (Feldman et al., 2004), epilepsy (61.9%) (Post-White, Fitzgerald, Hageness, & Sencer, 2009), and cancer (35-59%) (Laengler et al., 2008; Martel et al., 2005; Post-White, et al., 2009).

2.4 COMMON CAM PRACTICES WITH CHILDREN

In the US National Health Interview Survey of 2007, the 10 most common CAM therapies used in children under 18 years of age were non-vitamin, non-mineral natural products (3.9%), chiropractic and osteopathic manipulation (2.8%), deep breathing, yoga, homeopathic treatment, traditional healers, massage meditation, diet-based therapies and progressive relaxation (Barnes, et al., 2008). Whilst in the UK, a cross-sectional population survey reported that homeopathy, baby massage, aromatherapy, herbal medicines, osteopathy including cranial osteopathy, reflexology, chiropractic and traditional Chinese medicine including acupuncture were the CAM most frequently used for children (Simpson & Roman, 2001). Smith and Eckert (2006) in their survey of Australian children found that ingestible therapies, chiropractic and massage were the commonest modalities being used. Whilst among children in Turkey, herbal therapies were predominant (77%) (Ozturk & Karayagiz, 2008).

The types of CAM used in children were varied in different countries which could be due to the availability of the therapies and cultural preferences. However, ingestible medicinal therapies appeared overall to be the most predominant and were always on the top of the list in many surveys. This was also supported by other studies performed more regionally. In a children’s hospital in Melbourne, Lim, Cranswick & South (2005) reported that multivitamins, vitamin C, herbal remedies and homeopathic treatments were used by 77% of the participants. Pitetti, Singh, Hornyak, Garcia, & Herr (2001) in their study conducted in an urban emergency department also found that homeopathic and naturopathic remedies were the most common CAM therapies used for children. As these medicinal therapies were often found to be taken alongside conventional prescribed medications, potential interactions between them has been a great concern for many mainstream health professionals working with the children (Cuzzolin, et al., 2003).
2.5 REASONS PARENTS CHOOSE CAM FOR THEIR CHILDREN

Studies have revealed that the use of CAM by parents or caregivers was the single best predictor of CAM use in children (Barnes, et al., 2008; Robinson, et al., 2008; Sawin-Sikand, et al., 2002). CAM use in children always reflects the beliefs and values of the parents or caregivers toward the meanings of illness and health which agree with the philosophies and theories of CAM. While conventional medicine aims to diagnose illness and alleviate symptoms, CAM practitioners consider that underlying factors such as genetic predisposition, environment and diet play an important role in personal health and illnesses and tackling these underlying factors is essential to restore health whereas relieving of symptoms is just a temporary measure. Therefore, the aim of CAM treatment is not only to relieve symptoms, but also assist the individual to maximize his own healing ability. Parents who chose CAM for their children prefer patient-centred consultation and have a more ‘holistic’ approach to health care (Cuzzelin, et al., 2003). Other reasons include dissatisfaction with conventional approaches, fear of side-effects of conventional medicines (Simpson & Roman, 2001; Yussman, Ryan, Auinger, & Weitzman, 2004), more personal attention and support given by the CAM therapists (Kemper, Vohra, & Walls, 2008), or because their children have a chronic illness or disability which cannot be resolved by conventional medicine (Fearon, 2005). CAM modalities are also found to be used as an adjunctive therapy to decrease complications of the disorders and improve overall health (Astin, 1998).

2.6 PERCEPTIONS OF HEALTH PROFESSIONALS TOWARD CAM

2.6.1. ATTITUDES AND USE OF CAM

A large number of studies have been conducted to examine health professionals’ attitudes and perceptions toward CAM. In a survey of faculty and students within medicine, nursing and pharmacy, Kreitzer, Mitten, Harris and Shandeling (2002) found that 90% of the respondents have favourable attitudes toward CAM. They also believed that a number of CAM approaches hold promise for treatment of symptoms and diseases and conventional medicine could benefit
from the ideas and methods of CAM. In a literature review that summarized 21 surveys of physicians, nurses, public health professionals, dieticians, social workers, medical and nursing faculty, and pharmacists, Sewitch et al. (2008) also conclude that overall health professionals have a positive attitude toward CAM. Despite these positive attitudes, referral or prescription of CAM among health professionals has been low. Moreover, though health professionals believed that they should take an active role in discussing CAM treatments with their patients, most of them were not comfortable in doing so. Perceived lack of knowledge about CAM and lack of evidence of CAM were the two major barriers that stopped their communication with patients or parents related to CAM (Kreitzer, et al., 2002; Sewitch, et al., 2008; Wahner-Roedler et al., 2006).

Overall, nurses were found to be more receptive to CAM compared to other health professionals. In a study of critical care nurses, Tracy et al. (2003) found that 88% of respondents were open or eager to use complementary therapies in their practice despite barriers including lack of knowledge, time, and training. Holroyd, Zhang, Suen and Xue’s study (2009) also found that 80% of nurses in Hong Kong used at least one form of CAM themselves and 41% of them recommended at least one type of CAM which they believed to be of benefit to their patients. The high percentage of CAM use among the nurses in this study might be due to the unique political environment in Hong Kong. Although Western medicine remains the dominant health system post-colonization by the British, it is likely that the nurses in Hong Kong may have been deeply influenced by their own Chinese background, as they are brought up in an environment in which traditional Chinese medicine practice is passed on from older Chinese generations. Moreover, in a recent survey done at five metropolitan hospitals in Adelaide of South Australia, Shorofi and Arbon (2010) concluded that more than 50% of the nurses had positive attitudes toward CAM and the same percentage of nurses used some types of CAM for their patients. Most nurses in these studies admitted that they had fair to limited knowledge about CAM and they were keen to have more knowledge about it. Furthermore, a study describing the knowledge and attitudes of graduate nurses toward CAM, Halcon, Chlan, Kreitzer and Leonard (2003) indicated that nursing education about CAM was lagging behind the high interest in CAM among nurses, thus the authors suggested the need for CAM to be integrated into nursing programmes at all levels.
Studies also demonstrated that CAM was widely used and recommended by midwives in their practice in the US (Hastings-Tolsma & Terada, 2009), Israel (Samuels et al., 2010), Canada and New Zealand (Harding & Foureur, 2009). Midwives considered that CAM played an important part in their practice in supporting normal birth. A literature review of 21 articles by Adams et al. (2011) examined the attitudes and referral practices of midwives and other maternity care professionals with regard to CAM and its use by pregnant women. It concluded that greater cooperation was needed between conventional and CAM practitioners.

Several NZ regional studies have been carried out examining general practitioners’ attitudes, use and referral pattern of CAM (Hadley, 1988; Marshall, Gee, & Israel, 1990; Taylor, 2003). The most recent survey carried out in 2005 involved GPs at a larger scale and a national level. It reported 20% of the respondents practiced and 95% referred their patients to some types of CAM (Poynton, Dowell, Dew, & Egan, 2006).

2.6.2 CONCERNS ABOUT CAM SAFETY AND EFFICACY

Concerns have been raised about the safety and efficacy of CAM. In a literature review of all the available literature derived from Medline and Cochrane library, Cuzzolin et al. (2003) summarized the known adverse effects, risk and interactions between CAM and conventional therapies in paediatrics. A detailed list of reports about the incidences is shown in the review. He emphasized that while many people consider CAM therapies to be “natural” and thus “safe”, this is untrue because they can be harmful just like any other medical treatment. Some reports given in the review relate to very young children: a six month-old infant suffered garlic burns when his father applied crushed garlic cloves to the wrists; a six year-old child developed a necrotic ulcer on her foot after her grandmother applied crushed garlic under a bandage as a remedy for a minor sore; two cases of serious or fatal toxicity have been described in two infants who had been given 90 to 120 ml of mint tea containing pennyroyal oil for colic and minor ailments. Studies also found that echinacea (root/rhizome) used together with acetaminophen (paracetamol) has been related to increased liver toxicity (Jacobsson, Jonsson, Gerden, & Hagg, 2009). These two substances are commonly used in children.

The potential direct harm of CAM to children could be the toxic effects, allergic reactions, lack of quality control, contaminations, and interactions with concomitant medications. Indirect
effects are missed diagnosis, disregarding contraindications, delaying more effective treatments and discontinuation of prescribed drugs. Cuzzolin et al. (2003) considered that these harmful effects are often derived from a lack of appropriate regulations in the providers or the products leading to uncorrected and uncontrolled use. While in some countries such as Germany, Switzerland, France and Austria, many CAM treatments are licensed and fully integrated into conventional medicine with education and training for physicians and pharmacists, in other countries such as the United Kingdom, United States and Canada, the majority of CAM are still not regulated by statute and providers are not necessarily medically qualified practitioners. Thus, users could not be informed in a reliable way about composition, instructions for use, storage and side-effects.

2.6.3 NON-DISCLOSURE PROBLEM

Despite the high prevalence of use of CAM, it was found that few patients (23-46%) would disclose their CAM use to their health care providers (Lim, et al., 2005; Ottolini, et al., 2001; Robinson & McGrail, 2004; Sidora-Arcoleo, et al., 2008), though a majority of them (81%) have the desire to do so (Ottolini, et al., 2001). Locally in New Zealand, Wilson et al. (2007) found that the non-disclosure rate by parents of CAM use in their children was found to be even more pronounced (77%) from interviews of 100 adults accompanying children under 12 years attending general practitioners and paediatricians in Christchurch.

Multiple reasons have been found to explain why patients did not inform their medical health care providers about CAM use. One reason was that the patients were actually unaware of the possible interaction between conventional medication and herbal supplements they were taking (Sidora-Arcoleo, et al., 2008). Other main reasons were concerns about being judged by the practitioners; the belief that the practitioner did not need to know about their CAM use; or simply because the practitioner did not ask (Robinson & McGrail, 2004; Sidora-Arcoleo, et al., 2008). Sometimes, parents would even intentionally lie to their doctors about their use of CAM for fear of being dismissed or disapproved of by them (Sibinga, et al., 2004).

Recommendations to improve patient–health professional communication have been made by many authors in order to encourage patients in disclosing the use of CAM to their health care providers (Ottolini, et al., 2001; Robinson & McGrail, 2004; Sewitch, et al., 2008; Sidora-
Arcoleo, et al., 2008). Health professionals were advised to ask the questions routinely, particularly in children with ongoing medical problems and those with parents or caregivers who use CAM for themselves (Ottolini, et al., 2001; Sawin-Sikand, et al., 2002). Mainstream health care professionals are also advised to respect patients’ belief and value systems and discuss these with patients in an open and non-judgemental manner (Robinson & McGrail, 2004).

A main reason for health practitioners not initiating questioning about CAM use is that the practitioners feel they lack knowledge about CAM. To improve this, suggestions have been made to increase health professionals’ knowledge of CAM in order to prepare them for engaging competently in dialogue with patients and answering patients’ enquiries on CAM. Suggestions include: self education, programmes to incorporate a CAM component into their training, availability of resources, updated information on CAM evidence and communication and coordination of services with CAM practitioners (Robinson, et al., 2008).

2.7 CAM USE IN NEW ZEALAND CONTEXT

In New Zealand, there is an estimate of 10,000 CAM practitioners in the country and some general practitioners (GPs) also practice CAM (MACCAH, 2004). Most CAM therapists operate privately outside the publically funded health system. The Accident Compensation Corporation (ACC) partly funds acupuncture, chiropractic manipulation and osteopathy for treatment of injuries resulting from accidents. A national survey shows that almost half of GPs regard these modalities as conventional rather than CAM and they are the most common CAM therapies which they referred their patients to for treatment (Poynton, et al., 2006).

The Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH) was established in 2001 to give advice to the Ministry of Health (MOH) on issues relating to complementary and alternative health focusing in areas of regulation, consumer information needs, research, and integration. In response to consumers’ need for information, a database was established to provide the New Zealand public with evidence-based information about the use of CAM therapies for particular medical conditions (MACCAH, 2004). Unfortunately, the MACCAH website was discontinued in 2006 as the priority of the government changed but the
public is still able to access the information through the MOH website. Moreover, through the MOH website, the public can also freely access the Cochrane library and BMJ Evidence websites for evidence on CAM therapies.

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### 2.7.1 REGULATION AND TRAINING

Many types of CAM therapies are currently practiced in New Zealand (Appendix G) and they are mostly unregulated (MACCAH, 2004). Chiropractic, osteopathy and acupuncture are a few among them which have been regulated under the Health Practitioner Competence Assurance Act 2003 (MOH, 2012). Traditional Chinese Medicine is being considered for regulation at the time of writing up this study. The practitioners regulated under the Act need to be appropriately qualified and registered with their relevant professional bodies. The purpose of the Act is to ensure the practitioners are competent and fit to practice and that they also work within their scope of practice in order to protect the safety of the public. Whether regulated or not, all CAM practitioners are subject to the Code of Health and Disability Consumers’ Rights, as are mainstream health care providers. Under the Code, patients have a legal right to be treated with respect and dignity, be given clear information, be given quality care and have the right to make a complaint if they think that any of their rights have been violated (Health and Disability Commissioner [HDC], 2012). All health care providers including CAM practitioners have a duty under the law to take actions in observing the rights of the consumers.

A range of recognized academic institutes offer formal training in various CAM modalities such as naturopathy, homeopathy, reflexology, aromatherapy and traditional Chinese medicine. There is little formal incorporation of education on CAM into the training of mainstream health professionals such as doctors and nurses. The two main medical schools in NZ have no formal modules educating undergraduate medical students about CAM. There is a small number of nursing schools that offer a formal CAM education component in their curriculum.
2.8 SUMMARY

CAM encompasses a large number of different types of health practices and products. Traditional medicine is also sometimes incorporated into it. The use of CAM has been increasing significantly worldwide including in NZ. Although fewer studies have been done in children, the existing figures show CAM use in children is high following the trend for adults. Parents have different reasons to seek CAM care for their children with the main reason being that they use CAM themselves; this is the single best predictor for CAM use in children. The increasing use raises some concerns among mainstream health professionals about the efficacy and safety of CAM. Of the different types of CAM used for children, ingestible medicinal CAM therapies were found to be most frequently used. As they are usually taken alongside conventional prescribed medications, interactions between them are a potential concern.

Despite most health professionals having positive or open attitudes toward CAM, the rate of referral to CAM is generally low. Many health professionals feel uncomfortable discussing issues related to CAM with parents due to perceived lack of knowledge about CAM. On the other hand, many parents do not inform their health care providers about CAM use in their children. Although many different modalities of CAM have been practiced in NZ, only a few are regulated by the government and governed by their own professional bodies. In addition, there is little formal CAM education in the training of mainstream health professionals such as doctors and nurses. The low disclosure rate by parents has been found to be more pronounced in NZ. The non-disclosure hinders the assessment and monitoring of the effects or adverse effects of CAM in children by their health care providers. There are many factors that explain why parents do not, or are unwilling to, inform their health care providers about CAM use. Practitioner-patient communication in relation to CAM issues stands out as fundamental. Thus health care providers were urged to improve communication with parents in order to safeguard the health of children. The perceptions and attitudes of health care professionals themselves toward CAM are important because they directly influence the way they communicate with parents about CAM use in their daily clinical practice.
3.0 METHODOLOGY AND METHOD

3.1 INTRODUCTION

This chapter describes the methodology and method used in the study. The qualitative approach and interpretive description as the methodology framework is briefly described and the reasons why they are adopted for the study is explained. Then, focus group as the data collection method is introduced. The process from recruiting participants, data collection, data transcribing to data analysis is then described. Finally, the considerations about ethical issues and steps taken to maintain the rigour and credibility of the study are reviewed.

3.2 RESEARCH DESIGN

The existing literature on perceptions and attitudes of health professionals toward CAM was found to be surveys mostly using questionnaires adopting a quantitative approach. The items used in those questionnaires were generic and did not seem to be very relevant to the PNs whose practice this study addressed. Moreover, there is a paucity of relevant information associated with PNs. Taking these factors into consideration, it was decided to use a qualitative approach for this study to gain a deeper insight into PNs’ perceptions and attitudes towards the use of CAM in children through their personal experiences.

Qualitative research seeks to identify knowledge about human phenomena. It recognizes the existence of multiple realities in the real world and focuses on describing phenomena through human experiences. It has been useful to reveal how people behave and what people actually mean when they describe their experiences, attitudes and behaviour (Pope & Mays, 1995). It was therefore appropriate to use a qualitative approach to answer the research question in exploring PNs’ perceptions and attitudes toward CAM specifically and uncovering any issues that might affect their clinical behaviours.

Interpretive description (ID) was employed as the methodological framework to guide the process of the study in recruiting participants, data collection and data analysis. ID was first
developed by Thorne and her colleagues as a non-categorical methodological approach to
develop better understanding of clinical phenomena relevant to nursing and other applied health
professions (Thorne, Kirkham, & MacDonald-Emes, 1997). It was designed as a method to study
problems originating from clinical needs and it is best used in investigating “a clinical
phenomenon of interest to the discipline for the purpose of capturing themes and patterns within
subjective perceptions and generating an interpretive description capable of informing clinical
understanding” (Thorne, 2008, p. 5). While valuing the experiences from the perspectives of the
study population, ID also accounts for the cultural and social forces that might have shaped their
perspectives. This matched the aim of the study to capture the themes and patterns of the
perceptions and attitudes of the Plunket nurses, and how these may affect their clinical practices
in communicating with parents or family members about the issue of CAM use in their children,
and thus it was employed to guide the study.

Focus group was selected as the method of data collection. Krueger and Casey (2000) describe
focus group as a "carefully planned discussion designed to obtain perceptions in a defined area of
interest in a permissive and non-threatening environment" (p.18). It has the benefit of bringing
people with similar experiences together to exchange ideas and uncover shared perspectives and
has been widely used in qualitative studies to review perceptions, opinions, attitudes and
behaviours on a particular issue within a target population (Kitzinger, 1995). The advantage of
using a focus group is that the atmosphere of the dynamic interaction among participants can
help to offer in-depth, authentic and quality data (Jamieson & Williams, 2003). Through
interaction, participants listen to each other’s experiences which stimulate memories and ideas.
Rich data can be gained through the group effect when the group members engage in a kind of
“chaining” or “cascading” effect (Lindolf & Taylor, 2010). Interpersonal and communication
skills are emphasized in PNs’ training and are applied in their daily work and PNs are perceived
to be verbally expressive in sharing thoughts and feelings, thus focus group method was
considered to be an excellent and appropriate technique to collect data where they could share
their personal and clinical experiences, and points of view related to the topic of the study.
There are weaknesses in using focus group method which the facilitator needs to be aware of.
According to Krueger (Krueger & Casey, 2000), the discussion can be dominated by one or two
participants, or participants may not express their own opinions but conform to a popular opinion
or submit to a particular group member.
3.3 RECRUITING PARTICIPANTS

After approval had been gained from Unitec Research Ethics Committee (Appendix D) and Plunket Ethics Committee (Appendix E), the clinical leader of the Plunket Waitemata district of Auckland region was contacted and the research project was introduced to her. Waitemata district covers areas with a range of socio-economic deciles. The district also included urban, suburban and rural areas. The only inclusion criterion was that the participant had to be a Plunket nurse currently practicing. No other exclusion criteria had been set. The clinical leader supported the study fully and helped to distribute the information sheet (Appendix A) and the return slip (Appendix C) to each Plunket nurse. PNs who were interested in participating were asked to complete the return slip and put it in the sealed box that was placed at the Waitemata area office. The return slip included questions about potential participants’ age range, ethnicity, nursing or other work experiences, and number of years working for Plunket. These basic details provided information to allow selection of a sample with maximum variation. Three Saturday mornings were offered and potential participants were asked to select the morning that they could come to join in the focus group.

The return slips were collected and seven nurses volunteered to participate in the study. Three nurses were able to come on one Saturday morning and the other four preferred another date. Thus, two focus groups consisting of three and four PNs (Group One and Group Two) respectively were arranged instead of having all the potential participants in one group as previously proposed. Unfortunately, only two PNs in Group Two attended the session; one reported sick on the date and the other gave no reason.

3.4 DATA COLLECTION

Two focus group sessions, one with three PNs and the other with two were conducted on two separate Saturday mornings in an agreed neutral setting. Although a bigger focus group of up to six PNs was planned initially, two focus groups with fewer PNs were conducted eventually due to difficulty in getting interested participants attending on the same date. In fact, four PNs had confirmed their enrolment for the second focus group date but unfortunately one of them had
severe flu on the date and another one did not come. This was beyond the researcher’s expectation. However, a good level of interaction happened among the participants in both groups and adequate time was allowed for each of them to express their opinions thoroughly within a smaller group. The first focus group discussion took 108 minutes and the second one 61 minutes including the introduction in the beginning and a brief summary at the end. All prepared guided questions were used and similar content covered. With the experience of conducting the first group, the researcher felt more confident with the second group and the process was even smoother with the questions asked in sequences logically. In-depth and detailed data were gained and as the data from the second focus group was largely in line with that of the first group, the researcher was satisfied with the depth of the data, and a further focus group was not planned. In hindsight, conducting a couple more individual in-depth interviews would have been ideal to include those interested participants who were not able to come on the set date. This was further discussed in Chapter 6 Section 6.6 as a potential limitation of the study.

The question of potential bias of those attended the project in relation to positive attitude or experience toward CAM had also been considered and it appeared difficult to avoid as participation was voluntary. In fact, the participants’ experience or knowledge with CAM varied greatly in the study with one participant actually having no experience with CAM and preferring mainstream services over CAM.

Prior to the focus group discussion, a consent form (Appendix B) was given to each participant and time was allowed to read it to ensure understanding before signing it. In the focus group, semi-structured questions were prepared (Appendix F) and used to facilitate the discussion. A fixed definition of CAM was avoided to allow free interpretation by the participants. Both sessions took around 90 minutes and they were audio-recorded. Observation notes from the discussion were recorded by the researcher immediately after the sessions. The atmosphere of the discussion, interactions among the participants and nonverbal clues of the participants were described to add detailed context for data analysis (Lindolf & Taylor, 2010).

Possible limitations were anticipated in data collection within the focus group session that included the fact that as the participants in the focus group were colleagues working in the same organisation, they could have already known each other and thus not feel free to articulate what
they really think in the group. This would be especially true if what they perceive conflicts with the policy or the interest of the Royal New Zealand Plunket Society (RNZPS). In addition, the presence of the facilitator who was a student of osteopathy might possibly affect their responses. Moreover, participants might not be equally articulate and perceptive (Creswell, 2009). Therefore, at the beginning of the focus group session, the participants were encouraged to express their views, feelings and concerns related to the topic freely. Mutual respect was emphasized when different or opposite opinions presented. Moreover, the participants were asked to keep what they heard or discussed in the group confidential and not to talk about them after the session. They were assured that their real names would not appear in the report of the study and their comments made in the focus group would be kept confidential to the researcher and the supervisors of the study.

3.4.1 PROCESS OF THE FOCUS GROUP DISCUSSION

The researcher arrived early to prepare the venue and refreshments, set up the audio-recording equipment and welcomed the participants when they arrived. Prior to the discussion, the researcher introduced herself and greeted every participant, ensured that they were comfortably seated and familiar with the environment. An overview of the study was introduced. The main purpose of the focus group meeting to collect their views toward the use of CAM in children was restated with the information sheet given again. The process of the discussion was introduced and the participants were encouraged in the session to share their points of view freely even if it differed from what the others had said. The participants agreed with the audio recording and the approximate finishing time planned for the discussion. Consent forms (Appendix B) were given and explained, and participants were invited to sign them if they understood and accepted the conditions stated in the consent form. Then, the participants were asked to introduce themselves briefly.

The discussion was formally begun with the researcher giving a short official definition of CAM from the NCCAM (2008) which was also adopted by the MACCAH (2004) of New Zealand. The participants were asked for their own understandings of the term CAM. Other questions were used as in Appendix F to guide the discussion. The five second “pause and probe” technique was used to draw additional information from the participants (Krueger & Casey,
After a participant had contributed to the discussion, a pause of five seconds was given to encourage her to elaborate her ideas further. In addition, probing questions such as: “Could you tell me more about that?”; “What experiences have you had that made you feel that way?”; “What aspect of this is challenging for you?” or “What do you think was in the mother’s mind when she asked that?” were used to facilitate the participants to describe their viewpoints and experiences in detail. To invite different points of view from participants, questions such as: “Has anyone had a different experience?” or “Does anyone see it differently?” were asked.

When all prepared questions had been asked and there were no more new ideas emerged, a brief summary of the main points from the discussion was given and the participants were invited to give additional comments, amendments or corrections. The audio-recording equipment was then turned off to signal the end of the discussion. A final question was asked - whether they thought anything had been missed in the discussion. Lastly, each participant was thanked for her participation.

Analysis began during the focus group discussion through observation and clarification of ideas with the participants. The transcript and observation note of the first focus group were reviewed to make improvement for the preparation of the second focus group.

### 3.5 DATA ANALYSIS

Audio-recordings of the two focus group discussions were saved in computer files and submitted to scribie.com[^3] for transcribing verbatim. As soon as the transcripts became available, they were reviewed by matching them with the original audio-recordings for accuracy and where words were missing, they were replaced. A deliberate decision was made that participants would not be

[^3]: Scribie.com is a website where people upload their audio files of phone calls, interviews, podcasts, videos, webinars, etc., to be transcribed by the company’s global team of freelance transcriptionists.
given the chance to review the transcripts or request changes so as to preserve the integrity of the discussion. This condition had been clearly stated in the participant consent form (Appendix B) which was signed by all participants and also reiterated prior to the commencement of the focus group. Participants were offered the opportunity to exit the focus group if they were uncomfortable with the discussion.

During the process of analyzing the collected data, the principles of interpretative description (ID) were applied. ID goes beyond merely description through inductive reasoning. It seeks to discover associations, relationships and patterns within the data and extends into the domain of interpretive explanation of the studied topic (Thorne, 2008). Thus, instead of asking such questions as “What is it?”, “What is happening here?” or “What variations exist?”, the researcher should look for elements in the data that answer questions like “What might that mean?”, “How do they relate to one another?”, “How are phenomenon similar or different from one another?”, “What pattern exists?” and “How do they operate?”. Moreover, interpretive description emphasizes understanding the bigger picture of the proposed inquiry rather than coding the data and drawing conclusions prematurely. In so doing, Thorne (2008) suggests to use broad-based code or group signifiers such as “Category A Data” to avoid inscribing meanings onto the groupings too early. In addition, sufficient time should be allowed for the researcher to immerse and interpret the data before making classification and linkages among findings. ID is appropriate to be used as a framework in analysing the data, as the aim of the study was not only to describe the perceptions and attitudes of PNs toward CAM use in children but also to know the factors that influence their perceptions and attitudes and eliciting implications for their professional practice.

The transcripts were read and re-read. In order to gain an overall impression and achieve an accurate description and interpretation of the collected data, special attention was paid to keep open-minded and avoid jumping into any conclusions before the reading was finished. Notes were made with regard to any significant ideas that came out after each reading of the transcripts. Constantly asked was the question of whether or not the ideas identified were actually from what the participants said or if they were reflective of the researcher’s own thoughts. Notes that identified similar ideas frequently were checked against the data to ensure they were supported with enough evidence. In addition, observation notes were incorporated in to the analysis.
According to Rothwell and Clark (2010), data derived from group discussions cannot be lifted unless the social and emotional context and the group setting where the discussions occur are attended to. Hence, observation notes describing the interactions among the participants and the atmosphere of the group discussions are indispensable in providing an in-depth and accurate understanding of the data. They were also used to verify the emergent ideas and ensure that they had not been changed unintentionally.

Ideas that frequently emerged from the data were gathered and then verified either against the transcripts or by listening to the audio-recordings. Following Thorne’s (2008) suggestion of using broad-based code or group signifiers, these ideas were categorized broadly using alphabets A, B, C etc... Crosschecking was carefully done between the categories and the transcripts to ensure the former was coherent with the latter. Relevant quotes from participants were put under each category as supportive evidence. The alphabetical categories were finally replaced with phrases or codes that reflected the identified ideas and that attributed to the establishment of the preliminary themes along with the subthemes of the findings.

Regular appointments were made to meet the supervisors to discuss any concerns that arose and to report on the up-to-date progress on the data analysis. In addition, the preliminary themes and the subthemes were presented anonymously to the researcher’s family members to seek for questions and clarity in understanding. Comments made by both supervisors and the family members helped identify areas with ambiguity, which necessitated further readings of the transcripts to ensure any clarification, verification or amendment reflected the data as truthfully as possible. Quotes were moved around to ensure that they were logically placed. Eventually, four main themes were finalized with two to three subthemes under each.

3.6 ETHICAL CONSIDERATIONS

3.6.1 CONFIDENTIALITY

To the largest extent possible, the participating PNs’ identities were kept confidential. The real names and work places of the participating PNs were not recorded in any notes or reports of the
study. In the beginning of the focus group session, the ground rule of confidentiality was emphasized and the participants were asked to ensure that what they heard in the group stayed in the group. All the data collected were used for the study only. The collected data were securely stored in a computer file that could only be accessed by the researcher with a password. The returned slips, the consent forms and the hard copy transcripts were kept in a locked filing cabinet. They could only be accessed by the researcher. The author believed that it would be very difficult to identify the individual participant as clinical leader and area manager were not included in the focus groups and they had no direct contact with interested participants during the process. Moreover, the study had been approved by the Royal New Zealand Plunket Ethics Committee (Appendix E) and the author had faith in the organization in observing the rules for research and the rights of the participants.

3.6.2 AUTONOMY

Participation in the study was voluntary. Only those who were interested in the study and willingly completed the return slips with their contact details and put them into the prepared sealed box were contacted. The information sheet was distributed to all PNs in the Waitemata district to read before they made their own decision to participate in the study or not. The information sheet clearly stated the purpose of the research, the arrangement of a focus group session as a method to collect data, the audio recording, the time required, the consent procedure and the use of the data. The consent form was distributed, explained and signed by the participants before the start of the focus group interview. They had the right to withdraw any time before and during the focus session. Also, they could ask for their part/parts of discussion in the focus group to be removed before the analysis process started.

3.6.3 RESPECT FOR PLUNKET SOCIETY AND THE PARTICIPATING PLUNKET NURSES

The approved research proposal together with the ethical application form was submitted to the Royal New Zealand Plunket Ethics Committee for their approval to undertake the research (Appendix E). Advice and recommendation from the ethics committee were followed accordingly. An interim report has been provided to the committee to inform them of the
progress of the research. A copy of the thesis will be sent to the Plunket Society after successful examination and the participants will be offered an electronic/hard copy of the research thesis once examination is completed.

The clinical leader of the Plunket Waitemata branch of Auckland region was consulted for the proper procedures in contacting their staff. Contact details were provided in the information sheet and the potential participants were encouraged to make contact for any queries or concerns. The study was supervised by experienced researchers and advice was sought regularly from them to ensure the process was carried out properly.

The focus group sessions were arranged on two Saturday mornings which was beyond the participated PNs’ working hours to avoid disruption of their routine work. The time required for the whole focus group meeting was clearly stated in the information sheet and kept accordingly.

3.7 MAINTAINING RIGOUR AND CREDIBILITY OF THE STUDY

In keeping the rigour and credibility of the study, strategies were taken to ensure that the data truly and fully reflected the participants’ points of view.

The questions asked in the focus group session were open-ended to allow the participants to elaborate their views and feelings; efforts had been made to ensure questions were not biased or misleading.

Notes were made immediately after the focus group session to record observation on the overall impression of the discussion, interaction among the participants, significant non-verbal cues of individual participants. The observation notes were cross-checked with the transcripts to enhance the trustworthiness of the findings.

Strategies were carried out to acquire an accurate description and interpretation of the data. As described in the data analysis section 3.5, the researcher had allowed enough time to become immersed in the data. Notes were made after each reading of the transcribed text guided by the questions suggested by Thorne (2008) and continuous comparison was made to ensure the ideas
were actually coming from the data. Broad categorization was used to prevent reaching a conclusion prematurely by ascribing meaning to the emergent ideas too early. Moreover, after the initial theme generation, the original transcripts were read again to ensure the data matched with the themes (Schneider, Elliott, LoBiondo-Wood, & Haber, 2003).

Throughout the process of the study, regular meetings with the supervisors took place to ensure the study was properly conducted. A reflective journal was kept to review researcher’s own values, beliefs and experiences. They were discussed with the supervisors to minimize any bias or preconception in data analysis. Themes derived from the transcribed text were verified by cross talking with supervisors and presentations to family members until an agreement of the themes was reached.
4.0 FINDINGS

4.1 INTRODUCTION

This chapter presents the findings from the interpretative analysis of the focus group data. Five Plunket nurses, all of whom were female, participated in the study. The focus group included participants whose experience and knowledge with CAM varied greatly from one nurse with no experience to one who used at least five types of CAM regularly for herself and her children. All participants received their nursing education in New Zealand. All had work experience in hospital and community settings and one also had midwifery experience. Three of them were European New Zealanders and two were Chinese who had been living in NZ for more than ten years. Their cultural background did not seem to affect their level of CAM acceptance. Although traditional Chinese remedies have been used in one Chinese PN’s family by the grandparent, she did not use them for herself or for her children. Another Chinese nurse preferred Western conventional medicine over Traditional Chinese Medicine (TCM). Their ages ranged from mid 20 to mid 40 years old. Their years of service with RNZPS varied from less than one year to 10 years.

Four key themes were identified from the data. They included “organisational policy constraints”, “ambivalence about being an organisation employee and independent health professional”, “fear of liability” and “desire for knowledge and resources”. The Plunket policy related to CAM was the prevailing topic in the discussions which was brought up repeatedly by all participants. When the PNs were asked about how they dealt with CAM issues in their practice, their first response was not about their own perceptions but the policy of the organisation they were working for. The Plunket Society had a clear policy that it did not recommend or endorse any CAM and it required its employees to follow this policy.
4.2 THEME 1: ORGANISATIONAL POLICY CONSTRAINTS

4.2.1 POLICY DIRECTED PRACTICE

In responding to parents’ questions about CAM, all participants said that they were not allowed to share any information about any CAM irrespective of their own personal perceptions, attitudes or knowledge about CAM. As employees of the Plunket Society, the PNs were instructed to follow the Plunket guidelines of not recommending or endorsing any CAM to families or children. Their reply to any inquiry related to CAM was generic. They would state the stance of Plunket instead of giving information based on their own understanding and knowledge of CAM.

*I feel I have to be very careful, because working for Plunket, you are not allowed to... not even allowed to say [CAM]... when someone says should I go to the osteopath or cranial therapy, we are not allowed to recommend that.*

Other PNs also said:

*I think Plunket is such a powerful organisation that sometimes, from my experience, is that we need to be... especially as I'm working for Plunket; I need to be really careful for what I'm saying [including CAM issues].

*Everyone’s [PN] got their own pool of knowledge [with CAM], but definitely restricted by the Plunket policy of what's acceptable to tell people.*

*It doesn't actually matter what they're using, because chances are that it’s not recommended by Plunket.*

All PNs admitted that they were required to observe the policy in their practice carefully irrespective of how much they knew about CAM and what CAM modalities parents considered to use in their children.

4.2.1.1 THOSE NOT FOLLOWING POLICY WERE REBUKED

Some nurses had been rebuked by their clinical leaders for sharing information with parents related to some form of CAM which they believed to be useful. They were told that it was not
their role as PNs to discuss about CAM. Because of the unpleasant experiences, they learnt to be very careful in dealing with parents’ inquiries. They changed their response to the way directed by Plunket.

As a young nurse, I was out with the clinical leader and a mum was asking me about lavender oil and I made a comment on lavender oil that I thought it was really good and I got taken away [by the clinical leader] and smack, smack, smack [she slapped the back of her hand], because that is not part of our role and we are not allowed to recommend it. I felt quite restricted.

Another nurse who was working in an environment where the clinical leaders were around had a similar experience. She was forbidden to speak about what she knew or believed but was instructed to be in line with Plunket stance which followed the Ministry of Health (MOH) guidelines.

... When I am talking to my clients and they [clinical leaders] can jump out and tell me, oh that's something I should not say. We follow the Ministry of Health guidance.

To avoid managerial disapproval, the nurses would not tell what they knew or thought about CAM but respond to parents’ questions tactfully with what the organisation wanted them to say. They would not share their experience or recommend them to parents.

So what I do as a Plunket nurse and what I do personally are very, very separate. So for her [her five-year-old daughter], I know when she gets sick, my first step is aromatherapy. And I will make up like a Vicks mix or rub or something and I will rub into her face and do a bit of reflexology and get her better. Like today I was coughing a little bit, so was (her daughter’s name), I have garlic and Echinacea like that and make it go away, but I wouldn't recommend it to a client because that would get me into trouble.
Other PNs also said:

So we’re really careful about it…So knowing what I should say and what I think I need to say [to clients] is something … quite, quite diplomatic…you don't want to be told off.

But now [after rebuked by the clinical leader] I am very careful, and we have to say, Plunket does not recommend alternative medication. Just go see your GP.

PNs felt restricted and frustrated, as they were unable to discuss CAM therapies/products which they had experience and knowledge of with the parents. Frustration and dissatisfaction were apparent from their tone.

4.2.1.2 DISCUSSION OF CAM WAS DISCOURAGED

CAM was not a topic which the PNs would discuss openly among themselves at the workplace. They avoided bringing up the topic for fear of offending the higher authority and being accused of not conforming to the organisation’s policy. The PNs perceived that Plunket was trying to discourage any discussion about CAM.

Because it's something [CAM] that does not really get talked about, we're not supposed to [recommend any CAM]...So it's not like a topic that comes up during work.

Other PNs agreed with her:

Yes. I mean, it was Plunket…and that sort of the knowledge [about CAM] was beneficial for us as well. And at this point Plunket is actually trying to discourage it [discussion of CAM].

It’s [CAM is] not part of policy. We don't emphasize that we know anything about it [CAM] or that we use it because we're not allowed to recommend it.

One nurse even said that she would not participate in the study if any clinical leader or manager was around in the focus group discussion. She felt that she was unable to speak freely about her
own perceptions and attitudes about CAM as she was concerned that her professional ability would be judged and her compliance with Plunket policy would be doubted:

I do know because you [the researcher] said that we could decide not to be part of this [study] before it started. I knew that if one clinical leader was here, I wouldn’t have come.

She also said:

...while I’m really confident anything that we’ve said [in the focus group] is not going to be an issue, but I would not trust, that would not change their opinion of my practice. I would not speak freely with somebody around who is of a higher authority.

Even though I have... I feel confident in the amount of knowledge I’ve got in the way I deal with people, I would not want them [clinical leaders and other PNs] to have known. So that’s why we don’t know what each other think [about CAM].

It appeared to be a taboo to talk about CAM issues within the Plunket environment and there was no sharing of information or discussion about CAM among the staff and with the clinical leaders.

4.2.2 OUTCOMES OF THE POLICY

4.2.2.1 OFF-THE-RECORD SUGGESTION

For some nurses who had enough knowledge and confidence with certain types of CAM, they might make a suggestion to the parents if asked for advice. In these circumstances, it was limited to verbal suggestion; they would not record any of their suggestion on the baby’s record or make any formal written referral to any CAM practitioners to avoid getting themselves into trouble for non-compliance with the guideline.

There are two things [CAM care] that are probably not in the official guidelines of what we should be endorsing, but it seemed to be effective enough for me to say, ‘Look, go. This is my suggestion, it’s not a recommendation, and it’s what
people found to be really helpful." I haven't had [recommended]. Yeah, so it is walking a line between whether you're supposed to do and not.

They tried to talk to the parents tactfully in an indirect way to avoid being held responsibility of breaking the rule.

It's mostly about the cranial osteopathy, the main one... they are doing with the head movement, I've sort of said [to parents] ‘I have heard that from other parents and they find that it works well. So, it could be something that you could choose to look at.’ So it's not a recommendation.

I talk about how other parents have tried it and that it can be something they can look into... because we aren't allowed to recommend anyway. So it's kind of... I don't want to jeopardize anybody's.

They would ask the parents to look up the information themselves and make their own decisions. By doing so, the parents were responsible for what they decided to use for their children.

But yeah, I will often suggest that they look at the information out there. But it's very much I leave them going away... And I suppose it's a way of not being responsible for what they're doing. 'You've got to go and investigate this... So it's not a referral and it's not... It's just... This is information for you that may be [helpful].

They were aware that Plunket would not approve of them making any CAM suggestions to parents. Therefore they did it in a subtle way to avoid being held responsible for the suggestions and being caught by omitting the recording of verbal suggestions in the child’s file.

4.2.2.2 PARENTS WERE DISCOURAGED FROM ASKING CAM-RELATED QUESTIONS

Some nurses believed that parents might want to ask advice from PNs related to CAM. The Plunket policy might have discouraged them in doing so because they knew that Plunket did not approve it.
They [parent] don’t always bring it [CAM issues] up themselves and I think sometimes that’s because they know Plunket won’t endorse it.

Restricted by the policy, the nurses felt that they could hardly offer any information to parents even if they did ask.

I guess they [parents] do want to ask for advice from us. Most of the families value us quite a bit, but anyways what we say is... it’s limited advice (on CAM) we can give them.

Sometimes they go, if it's your baby, what would you do? And then, I just say that’s put me in a really awkward position...Yeah. Sorry, I still can't recommend.

The communication between PNs and parents related to CAM could be halted when the PNs stated the stance of the Plunket policy. The existing policy and the generic response of the PNs discouraged parents from asking CAM questions.

4.2.2.3 NEUTRAL STANCE

With regards to CAM use in children, the nurses adopted a ‘neutral stance’. ‘Neutral stance’ was here defined as not initiating any recommendations or suggestions on CAM as required by the organizational policy. The PNs would neither proactively suggest the use of CAM nor discourage parents from using CAM for their children. But if the parents initiated a discussion on CAM, within the neutral stance, the PNs would not refrain from offering their opinions if they were comfortable in doing so. They considered that this was the most appropriate approach in the present situation because they would not act in opposition to the policy. On the other hand, they believed that they need to respect the practice of the families and support their decisions.

...we are in the neutral position. If parents want to do it, that's fine.

I just respect the fact that if that's what parents go for, I will support them.

As Plunket has a clear policy, PNs could only take a neutral stance in relation to CAM and leave parents to do what they choose to do.
At the meantime, I’m sort of support parent's own choice. I’m sort of say ‘Plunket does not support this, but if you choose it, this is what you're going for, we’re not going to stop you.

Just that Plunket would not recommend that, but you know it is your choice... I am here to support you in your choice.

When parents used some kind of traditional medicine or cultural remedies in their babies, the PNs could only take this neutral stance because they did not actually understand what they were and how they worked. They considered that it was very important to be non-judgemental but to respect the family’s cultural beliefs and practices.

Some of them [parents] actually do use different oils [for baby massage] from within their own culture, like homemade themselves, I guess you can just say Plunket doesn’t really have specific guidelines to do with the oil ... But that's your family's choice and you used it for generations and you're quite confident then we're not here to say to stop using it, do what you think is the right thing for your children.

So you do come across some very strange things. But again that is their choice. You can’t stop parents from doing, giving them [their babies] something that they use in their cultures.

Because that’s their choice and they've looked into it and they think that it's working well for their baby. And sometimes its cultural practices as well, so it's where the [nurses] being non-judgmental.

I have no idea what it was. From what he was telling me I was thinking that is a good idea, but again that's their choice. And if that's gone through his family's generations, "Oh we give it all the time in our country. It's normal"... who am I to tell them that that’s wrong.
4.3 THEME 2: AMBIVALENCE ABOUT BEING AN ORGANISATION EMPLOYEE AND INDEPENDENT HEALTH PROFESSIONAL

Ambivalence was expressed by the PNs toward Plunket policy. The term ‘ambivalence’ used in this thesis was defined as having mixed feelings and holding conflicting attitudes. Despite feeling restricted by the policy, some PNs considered that it might need to exist. On the other hand, they were dissatisfied with the present policy and the stance of the organisation for it hindered their role being a competent health professional in meeting the need of families and children.

4.3.1 STANDARDISED SERVICE

Some PNs believed that the policy could work as a measure to standardise Plunket service to the families. It was useful to maintain consistency of information given to parents. As each PN had her own experience and level of knowledge with CAM; the advice given to parents by PNs could be diverse or even contradictory to each other leading to confusion.

*I think that it [the policy] can be a two edged sword, because if a parent asked you about certain things, some nurses may know about it, some nurses may not. So the one thing about Plunket does not recommend [CAM] is that we can all say it. It's uniform.*

Moreover, some nurses thought that the policy was needed because it could prevent incorrect information being given to parents by those nurses who had insufficient knowledge about CAM. Incorrect information might cause harm to the children. Safety was a clear priority in health practice and service delivery which every health care provider should observe.

*If the nurse doesn't know enough about a certain product or therapy, the nurse may give misinformation if they're allowed to talk about it. And I guess there are too many therapies for us to know about everything. We can't do that. I don't know if I'd change it [the policy] if I could because it's a safety need.*
There was also concern that PNs could not respond to CAM inquires if the present policy did not exist.

*It's sort of once you open the door, we either have all the knowledge and information about every single thing so we're well equipped for any questions or problems we may come across. But then that's not possible.*

Furthermore, as employees of Plunket, the nurses are thought to be representatives of the organisation and what PNs told the parents was on behalf of Plunket. A standardized policy could save the organisation from getting into any trouble related to CAM, especially with those undesirable reactions if they occurred. As a result, the organisation’s reputation could be protected.

*I think it's because if we were just to do something [including CAM recommendation] and it was coming from a Plunket speaker and it didn't turn out to be very successful then that could come back to Plunket. So I guess that definitely tarnishes things.*

4.3.2 DUTY OF CARE

Although PNs thought that there were reasons for the policy to exist, they believed that it was their duty of care to respond to parents’ needs for CAM advice as health professionals. All PNs were aware that CAM is everywhere and they knew many parents used certain types of CAM in their children. Often, they hear of parents sharing CAM information with each other. Moreover, many PNs had experience with being asked by parents for their suggestions and opinions about CAM. They considered that they could not ignore parents’ inquires by just saying that Plunket did not recommend or endorse CAM. They thought that it was their responsibility to assist parents to make an informed decision by offering them information. They also considered that the organisation should equip them with the knowledge and provide them with the resources to enable them to fulfil their duty of care as a health professional.
I know that a lot of parents and children use cranial osteopathy as well as naturopathy and others … as opposed to going to the doctors.

Well actually there is so much out there. You look into any chemist and there are rows and rows of herbs. Lots of alternative stuff that can be helpful and even the chemists, those straightforward Western chemists, they have it sitting on their shelves… So I think that because there is so much out there… People deserve to have the correct information. We have an obligation to be part of the conversations about that.

The PNs thought that they should be able to provide options for the parents according to their individual need. Parents had different reasons in seeking CAM help. If a parent had a sick child and mainstream care could not provide an answer for them, it was more likely that they would seek help from alternative medicine. PNs need to address the need of the parent and the child in such a situation.

If you're perfectly healthy and you don't need anything, then maybe you wouldn't look for alternative answers. Whereas if you've gone to the doctor that says, "This is the tablet, this is the only thing I can do for you. Maybe you're not going to get better ever. So you go looking for other answers, something else that could give really some hope, something else.

For babies who are comparatively healthy but with some minor ailments, parents might also ask for CAM options which might help to relieve the discomfort of the babies. Again, the nurses considered that it was their responsibility to be able to offer options and resources for them.

But if you have the money and your child is not well, whether it's mild eczema, mild asthma, reflux you will do whatever to give relief to your child.

I tend to feel that we are in the position where we, if people are talking about things or thinking about options as informed consent we should be saying these are things that people are looking at.
One of the nurses raised ethical concerns about the policy. She thought that it was unethical and unlawful if the PNs failed to offer information which had already been known to be effective in treating their children’s problem.

I’m wondering where we fit ethically if we know something which can be helpful and we don’t tell people about it. You know the organisation can say we don’t endorse this, but if it is something that’s known, if you can take a scenario that somebody could be ending up in court about something and say I have found out that this would be helpful, but I wasn’t told about it.

They believed that many parents do have a level of health literacy that enabled them to make informed decisions.

The vast majority of people that we get coming in can go and make their own informed decisions about things. So if we say, ‘This may be helpful.’ They’d look at it, and then they’re going away making their own decision.

It was frustrating that they could not engage in the discussion of CAM issues with parents and assist them with their decisions. Some PNs blamed the organisation and its present policy which failed to support its staff in fulfilling their duty of care by providing them with adequate CAM information and resources.

I think that parents out there are going to be asking and it's a little bit like we're working in a situation where we're bit of an ostrich where we're just not going to talk about it... I think as an organisation, the obligation is that we do have the information to a level, that means that we can answer some question or know exactly who they refer to, because it is out there so much.

We probably need to have the information about these things so that we're actually responding, so that we're giving informed information to people for them to make their own decisions.

So by making it grey, by saying we don't recommend or endorse, we have been taking away that big body of information that maybe we should know about.
4.3.3 PERSONAL PERCEPTIONS VERSUS ORGANISATIONAL STANCE

Most nurses had been using some types of CAM regularly for themselves and some of them had also used them comfortably in their children. Some had taken courses about them for their own uses and they perceived that certain CAM practices are useful and safe from their own personal experience. They were also confident through their clinical experience, that certain CAM practices are useful in helping some babies. They believed that some types of CAM are useful with anecdotal evidence. Hence, there was a discrepancy between their perceptions about the efficacy and safety of certain types of CAM and that adopted by the organisation.

*I wouldn't use it [on herself and her daughter] if I didn't think it was beneficial.*

*I think most of it comes from that we're trying to work from evidence-based platform. And like, I said if the studies haven't been done and there's no evidence, that doesn't mean it's not going to be helpful.*

While the organisation emphasized evidence-based practice with a documented research foundation, some PNs were actually quite receptive to anecdotal evidence. From clinical experience, one PN talked about anecdotal ‘evidence’:

*So Plunket says that they only recommend things that are proven by research... But if you would ask me anecdotal evidence about people, mothers and things that I've talked to, about reflux babies who have had a difficult birth that have gone to an osteopath, had some cranial manipulation and then their sleeping and behaviour improves afterwards, I would say, that sounds really good. Things have worked.*

Another PN who had an extended knowledge about CAM and with a midwifery background had a similar point of view:

*So I came in Plunket with a reasonable background in alternatives, knowing from my experience that they have worked... As PNs we can't say they don't work because there’s enough anecdotal evidence that they do work.*
And they felt uncomfortable that they were required to respond in a particular way by Plunket:

*It always makes me feel uncomfortable because you kind of say "Oh, I can't say. I'm not allowed to recommend that (CAM) and Plunket doesn’t recommend it.*

In conclusion, there was a feeling of ambivalence between being a Plunket employee and an independent health professional. On one hand, they considered that the policy would be useful to prevent confusion among Plunket staff and parents, to avoid incorrect information given by PNs that might bring harm to children and to safeguard Plunket organisation’s reputation from being blamed for offering misinformation to parents. On the other hand, the nurses considered that it was their duty of care as health professionals to offer information to parents, also to provide options for parents and children according to their individual circumstances. Frustration could be felt among PNs toward the organisation. They expected that Plunket should face the increasing demand of parents for CAM and support its staff to perform their role appropriately. Conflict appeared between their personal perceptions and the organisational stance which explained why some nurses would work against the policy and offer verbal suggestions to the parents on certain types of CAM according to what they believed as discussed in section 4.2.2.1.

4.4 THEME 3: FEAR OF LIABILITY

There were other concerns which stopped PNs from discussing or suggesting CAM with parents even without the constraints of the existing organisational policy. They included: feeling a lack of CAM knowledge, fear of bearing responsibility for undesirable effects and the financial cost of many CAM for families.

4.4.1 LACK OF KNOWLEDGE

Most of the nurses perceived that they were not competent to suggest CAM due to lack of knowledge. Very often, the nurses did not actually know what the therapies or products were or if they were beneficial or might do some harm to the child. It was even harder to determine if that type of CAM was actually a traditional practice in the family’s own culture. They considered
that they had to respect the cultural beliefs of the families and they had no right to comment on them as they did not have enough knowledge of them.

I don't feel like I can say go on, get this and this and this because I don't know enough about it... If I had more knowledge then I'll feel more comfortable using it... It's just maybe we need more knowledge about it so that I can make that decision.

They recognized that with more knowledge and understanding, they could offer more options for the parents.

If I knew all the information and I felt more confident, I would quite happily go and say ‘Look, try this and try that.’ But I don't have enough knowledge, so I don't want to suggest something like that.

They thought that they had not received adequate education through Plunket education to be able to offer CAM advice competently.

But I guess the way that we train in the way the PNs are, I'm not ready to share knowledge and things, I'm afraid to say that I don't know.

And we may believe that information so that we can legitimately put it across, or ask people questions. [But] it doesn't tell us when’re in training. It's not like if the babies got a rash and we would normally say go the GP, we're going to say go to someone else instead. But I think very definitely we need the information.

Again it comes down to knowledge and I think unfortunately, we won't be giving... I'll be surprised if we ever get any of that within Plunket because it, I mean, it comes under the Ministry of Health to get that information, I think it's something that you just have to go out and do studies yourself and look.

4.4.2 SAFETY CONCERN

Safety was a strong consideration as well. Even PNs with considerable background on CAM were cautious in suggesting CAM for fear of bearing the responsibility if undesirable effects
occurred with what they had suggested. Special concern was that children were a vulnerable population and needed extra attention.

If I had given advice for something and then they end up having a side effect or negative experience towards it then it’s sort of hard to say whose responsibility it comes down to.

But they are children... babies and they’re other peoples' babies.

And they hesitated because of the fact that there was not enough scientific evidence to prove their safety.

Yeah that's theory, a lot of like theory [behind CAM]. As you say it's not, they don't really have much research on that and that's putting people off that. We need to be careful about it.

4.4.3 FINANCIAL COST

The financial cost of using CAM was another reason why PNs were hesitant to suggest CAM to parents even if there was no restriction by organisation policy. Many CAM practitioners worked in the private sector and the users had to pay the full cost of visiting them. They could be quite expensive and many families were just unable to afford it. In New Zealand, although osteopathy, chiropractic and acupuncture were covered by ACC, they were limited to those conditions related to injuries and accidents. They are not funded by government for treating babies or children’s conditions such as difficulty in sucking, reflux, unsettledness and misshapen heads. Moreover, the babies might need to visit CAM practitioners a few times before a desirable outcome could be obtained. Many PNs hesitated to recommend CAM to parents as many families were unlikely to be able to afford it especially for those with a lower income.

... Lots of them (CAM) can be quite costly, not all families can get access to them and we’re not created equal as well.
If you think you've got a baby that's in an unusual position in the uterus that has developed a stiff neck or a way of reacting to things, just a couple of treatments in the beginning may not be enough, but people can't afford it.

It could be embarrassing for the PN if the result of the recommended CAM was not as satisfactory as expected and the parents had already paid a lot of money.

I think the line that comes from that is that if it's horrendously expensive, you're actually saying this might work and then there's a financial cost to the parents that if it doesn't actually work, it's big money or something.

In conclusion, even without the organisation policy restraints, PNs might not be willing to talk about CAM for fear of being liable. The reasons were a perceived lack of knowledge and inadequate professional training, fear of bearing responsibility if undesirable reactions occurred and the financial cost of CAM to parents.

4.5 THEME 4: DESIRE FOR KNOWLEDGE AND RESOURCES

4.5.1 EDUCATION FOR CAM

Most of the participants did not feel competent to talk about CAM issues with parents. As mentioned in section 4.4.1, they perceived that they did not have enough knowledge about CAM. They would like to have more knowledge about CAM so that they can communicate comfortably with parents or make suggestions and recommendations for them appropriately.

I think that's what it sort of boils down to and unless you have the knowledge, you can't really properly come forth.

Let's hope we know all the therapies and how they work and what else could be working, what else is there that may help.

And they considered the current stance of the organisation did not support its staff well in this area. They hoped that Plunket would take the lead in providing them with adequate information.
And I think that it is a fault of the organisation that we don't have that knowledge.

But I think as an organisation, the obligation is that we do have the information to a level, that means that we can answer some question or know exactly who they refer to, because it is out there so much.

It would have to come from Plunket to provide information, because unless it comes from high up in Plunket then we can't change our practice.

4.5.2. UP-TO-DATE CAM INFORMATION

PNs thought that some CAM products and therapists have become more acceptable to the public and mainstream health professionals and thus they should have updated information and resources about them and their services.

I think one of the things that would be helpful is that we had more up-to-date research stuff coming through.

Another PN stated:

You know the information is out there and the research is out there, and the Ministry hasn't done it yet because they are like, everyone thinks it's a big organisation of new babies. So if you've got a guideline, like the one at National Women [Hospital], if you've got a guideline that's normal and you start doing it, and then information comes that it is not normal or it's causing a problem then how long does it take the Ministry of Health to adjust it. And you are responsible to the information that you are giving in the interim period [before the Ministry of Health updated its information and guidelines].

They considered that the government was too slow to react and update information and guidelines while evidence had already become available. They requested a more efficient system which could help the frontline health care providers to fulfil their roles properly.
Not many people could access CAM services due to the high cost and availability of the services. Hence, PNs would like to see an improvement in both of them so people could choose those CAM they wanted.

So that's not equitable. But it's restricting people's choices as well.

So I think that's one of the disadvantages of... With general medicine, there is always a chemist or an emergency department with something open somewhere, whereas when you go into those alternatives, you either have a therapist that you know and you feel comfortable about ringing out of hours or you should have a reasonable amount of money because they're not covered [government funded] so they've got to make a living and will charge a reasonable amount.

Other PNs thought the accessibility could be improved with government funding.

I mean I don't know what's restricted out there. I don't know what is necessary to get the subsidy.

I hear this awful crying, unhappy babies, and then, they go to osteopath and then they become right. The parents are happy at the end of the day. But again, not accessible to everyone, it’s not fair.

They [CAM] can be quite costly, not all families can get access to what they want... So in the ideal world, I hope that maybe, they can all be really accessible.

I think one of the other disadvantages of alternative therapy is just that they are usually not on call. So at the time you've got a sick child that you need something, you haven't got a resource to go to get the information for what you need.

Well, I think that if you actually... I mean in Britain like in homeopathic hospitals, I think when you've got those facilities there all the time, A: they will become more evident and B: they will become more mainstream. It's just that they have to
be alternative because... In some ways, some of them may have to be alternative because of the money side of it.

In addition, they would like to have more interdisciplinary connection with CAM practitioners so they know the progress of the children after receiving treatments. Integration of CAM services with mainstream health services would be another thing they would like to see happen to the health system as this could provide more options for the parents. Moreover, the effectiveness of some CAM could be measured more easily in such arrangements.

...but I think in a lot of ways it's not multidisciplinary enough to be able to see what's happening. And so for the chiropractors, the baby lies there and settles down and the mum says "Yes, he's much more settled than he was the last time. It looks like it’s working". So I think more interdisciplinary connections with things, with that sort of stuff, will be helpful.

To conclude, PNs would like Plunket to provide more in-service education and updated CAM information for them. In addition, they wished CAM services could be made more accessible to the families by a government subsidy and integration of it into mainstream health services.

4.6 SUMMARY OF THE FINDINGS

There were four main themes identified from the two focus group discussions. They were: ‘organisational policy constraints’, ‘ambivalence about being an organisation employee and independent health professional’, ‘fear of liability’ and ‘desire for knowledge and resources’. The overarching theme was the ‘organisational policy constraints’. All PNs brought it up and all indicated that they were required to follow it and discussion of CAM was discouraged at the workplace. PNs believed that the existing policy might discourage parents from asking about CAM. Some PNs felt restricted by the policy and might cross the line in making off-the-record CAM suggestions to parents. PNs’ feeling toward the policy was ambivalent. On one hand, they thought the policy might help to maintain the quality of service and protect the reputation of Plunket by standardizing information given by PNs. On the other hand, they were frustrated
about the policy and organisation for failing to support them to fulfil their duty of care as a competent health care professional. However, some PNs were concerned about bearing responsibility in discussing CAM if the policy was not in place. Finally, PNs were keen to have more CAM knowledge and updated information and they considered Plunket was responsible for providing this for them. In addition, they hoped that CAM services could become more accessible to families and children.
5.0 DISCUSSION

5.1 INTRODUCTION

This chapter discusses the key findings from the focus group data. Comparison is made with the existing literature to discuss similarities and differences. While some of the findings are consistent with the existing knowledge, new information is found which is unique to the study.

5.2 ORGANISATIONAL POLICY IN RELATION TO CAM

The overarching theme from the findings of the study is that PNs’ response to CAM enquiries from parents is directed by the Plunket Society’s policy which does not endorse any CAM therapy or product. PNs were mandatorily required to follow the organisation’s stance. In their practice, they were not allowed to advise or recommend any type of CAM to parents irrespective of the nurses’ own personal experiences, knowledge and attitudes, or individual family’s needs, beliefs and values. The concern was that the organisation’s stance toward CAM may bring some undesirable outcomes.

5.2.1 DISCOURAGES PARENTS FROM DISCLOSING CAM USE

Parents might be discouraged from disclosing their CAM use in their children to their PNs because of the policy. As stated in the literature review chapter, there is a substantial number of people including children who use CAM, internationally (Barnes, et al., 2008; Davis & Darden, 2003; Ernst, 1999; Ernst, 2000; Harris & Rees, 2000; Hunt, et al., 2006; Kemper, et al., 2008; MacLennan, et al., 2006; Sawni-Sikand, et al., 2002; Smith & Eckert, 2006; South & Lim, 2003) and in New Zealand (Armishaw & Grant, 1999; Ministry of Health [MOH], 2008; Wilson, et al., 2007). However, despite the high prevalence of CAM use, studies also found that few patients or parents disclosed their CAM use to their health care providers (Robinson & McGrail, 2004; Sibinga, et al., 2004; Sidora-Arcoleo, et al., 2008). Some of the reasons found to be associated with the low disclosure rate were fear of being judged by their doctors or simply just because the health care providers were not asking. To address the non-disclosure issue, many studies
highlighted the need for health care providers to initiate open discussion with patients of CAM use in a non-judgmental way to safeguard the patients’ health (Cuzzolin, et al., 2003; Ozturk & Karayagiz, 2008; Robinson & McGrail, 2004; Sewitch, et al., 2008; Sibinga, et al., 2004; Sidora-Arcoleo, et al., 2008). Moreover, health care providers have been urged to improve communication with clients by routinely asking questions about CAM use to facilitate monitoring and observing for any contraindications (Brolinson, Price, Ditmyer, & Reis, 2001; Brown et al., 2007; Harrington, et al., 2006; Kreitzer, et al., 2002; Sewitch, et al., 2008).

As a leading organisation providing well child health services in New Zealand, RNZPS emphasizes the use of standard guidelines based on evidence-based best practice to guide its service (RNZPS, 2012, p. 5). While scientific evidence to support the use of CAM is growing, many questions about its efficacy in treating ailments and diseases remain unsatisfactorily answered to mainstream health care professionals (Cuzzolin, et al., 2003). Some conventional health care practitioners also view CAM as potentially dangerous. With this strong guiding principle toward what is acceptable, it appears that RNZPS has adopted a risk-averse approach to prevent any practices that might cause potential harm to children. From the discussion with the PNs, it also seems that RNZPS want to avoid being held accountable for any negative effect that might happen to children from using CAM, to protect the organisation’s reputation.

It is questionable as to whether existing Plunket policy on CAM is aligned with the recommendations of many studies in providing a useful guideline to its staff to achieve the goal of protecting child health and safety. The existing policy appeared to be a hindrance in parent-Plunket nurse communication related to CAM which is counter-productive in encouraging disclosure of CAM use. From the findings of the study, the stance of the organisation of not recommending or endorsing any CAM potentially discourages parents from asking questions about CAM as parents perceive that Plunket is not going to approve of their choice. Moreover, even when parents do ask their PNs’ advice on their potential use, the generic response of the PNs may immediately stop them from enquiring further about them. Furthermore, the nurses are actually forbidden by the policy to share any information about CAM, thus limited advice would be given despite any wish to assist the parents in their decisions.
5.2.2 Off-the-Record Recommendations

Quality of service to families and children may be affected because of the policy. An unpublished study done by Peachey (2011) found that 1% of patients coming to visit osteopathic clinics in the Auckland region are actually ‘referred’ by PNs. In this study, some PNs also revealed that they did sometimes cross the line in suggesting parents to try certain types of CAM with which they were confident and believed to be beneficial in helping a number of ailments in babies. These nurses appeared to be more familiar and experienced with CAM. This is in line with previous studies showing that health care providers who have previous education or personal use of particular types of CAM themselves are more likely to recommend them to their patients (Holroyd, et al., 2009; Shorofi & Arbon, 2010; Thiago Sde & Tesser, 2011). However, in the study, the suggestions made by the PNs were exclusively verbal and they would not document their suggestions in the child’s record. Moreover, no actual written referral to CAM therapy was ever made. They intentionally skipped the information for fear that their clinical leader would rebuke them and accuse them of non-compliance with the organisation policy. In fact, accurate documentation is essential in health care services to record patients’ progress, maintain continuity of care and facilitate communication among the health care team (Owen, 2005). Without proper and accurate documentation, there is no sharing of information regarding CAM use in children among Plunket care team members and other health care providers. One may be concerned that this might affect the continuity of care to the children among the Plunket team, as there is no mechanism in place for monitoring the effect of CAM which the child has been using. As a result, the safety of children could be jeopardized if an adverse reaction occurred.

Moreover, the Health and Disability Code of Rights states that “every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups” (Health and Disability Commissioner [HDC], 2012). The Code requires the health care provider to respect the rights of their clients. Different parents and families have different values, beliefs and preferences in relation to their own health. Their choices should be respected and attended to. It is the duty of the health care providers to assist the parents/patients in making an informed choice in line with the Code’s rules. The PNs need the support from the organization in fulfilling their duty of care.
The policy may potentially hinder the delivery of best care for families and children. The mission of Plunket is “Together, the best start for every child” (RNZPS, 2012, p. 3). To pursue accomplishment of its mission, Plunket recognizes the importance of working together with other health and community services in order to optimize the health outcomes of children. Hence, one of the important roles of PNs is to identify and coordinate services available in the health care system and communities for the families and children accordingly. However, CAM services seem to be excluded in the list despite their popularity. There is a lack of formal communication and coordination between the PNs and CAM practitioners and sharing of medical information does not seem to exist between Plunket Society and CAM providers.

Whilst there are some CAM therapists who may be minimally trained, there are many highly qualified and regulated CAM practitioners who are formally educated, and may be able to provide suitable solutions to the child. However, by simply focusing on harm prevention as expressed in the policy, PNs would be unable to provide the best care to the child as the potential benefits of CAM are unexplored. It is in the best interests of the children for PNs to assist the parents in making an informed choice on all types of care, both conventional and CAM.

It is unknown to the author whether there are any other guidelines for the PNs in communicating with parents who consider the use of CAM in their children. Given that CAM therapies are often used by patients, the Statement on CAM from the Medical Council of New Zealand (MCNZ) has been released to inform its members of the standards of practice that are expected of them if they have patients who use CAM. It states that medical practitioners should acknowledge and be aware of CAM therapies; even if they do not intend to recommend them. Also, the medical practitioners should record what therapies their patients have been using as some therapies can adversely impact on conventional medical care. The medical practitioners should respect the culture, beliefs and values of their patients. If a patient expressed an interest in CAM, the medical practitioner should indicate the limit of their knowledge. The medical practitioners could suggest the patients obtain information from reliable sources such as the Cochrane Collaboration, BMJ Best Treatments, a relevant CAM practitioner, or a New Zealand-based professional body. Medical practitioners are also advised to assist patients in making an informed choice between
conventional medicine and CAM by presenting information to the patients such as the expected risks, side effects, benefits and cost of each option (Medical Council of New Zealand [MCNZ], 2011).

The New Zealand College of Midwives is similar in that there are guidelines in place with regards to CAM. It states that it recognizes the potential benefits of complementary therapies such as homoeopathy, rongoa⁴, herbal therapy, aromatherapy, naturopathy and acupuncture on the progress of pregnancy, labour and birth, and the postnatal period for both the woman and her baby. Guidelines have been provided and midwives incorporating CAM therapies into their practice should either have undertaken a recognized education programme or they should refer clients to an appropriately qualified CAM practitioner (New Zealand College of Midwives [NZCOM], 2000).

Furthermore, New Zealand Nurses Organisation (NZNO) considers that it is the role and responsibility of nurses to ask their patients about the use of CAMs. It is an important part of nursing assessment due to the potential interplay of some CAM care with conventional treatments. In addition, NZNO believes that nurses should have adequate knowledge of the range of CAM which people may utilize in order to be able to provide appropriate advice and nursing care in their respective clinical settings. Their advice may include material resources, education, and/or referrals to qualified practitioners. NZNO emphasizes that the fundamental principles of autonomy (self-determination), beneficence (doing good), non-maleficence (doing no harm), justice (fairness), confidentiality (privacy), veracity (truthfulness), fidelity (faithfulness) and guardianship of the environment and its resources as stated in the Code of Ethics for nurses are applicable when providing advice, support or education to patients who choose to use CAM as

⁴ Rongoā is the traditional Māori healing in New Zealand. It operates within a wider philosophical context in which people, places and events are to be respected and breaches of any of these invite mental and physical consequences, such as disease. Healers of rongoā address both the physical symptoms and the metaphysical causes of any diminution of health or well-being (New Zealand Waitangi Tribunal, 2011).
part of their health care. Some useful resources have been listed in the NZNO practice position statement for nurses’ reference (Appendix H) (New Zealand Nurses Organization [NZNO], 2011). Given that many PNs are members of NZNO, it appears that the PNs are working under conflicting advice as instructed by the Plunket Society their employer and NZNO their professional body. This further explains the ambivalence feeling of PNs about being an organization employee and independent health professional as discussed under Section 4.3.

5.2.4 DISSATISFACTION AMONG PLUNKET NURSES

Frustration had been expressed toward Plunket’s approach to CAM. One nurse described the organisation as “ostrich” which ignores the fact that CAM products and therapies are everywhere. Although at the time of writing this report, there was no consensus on the prevalence of children using CAM in New Zealand, international studies (Barnes, et al., 2008; Ernst, 1999; Kukuruzovic, 2005; Robinson, et al., 2008; Simpson & Roman, 2001) and some local regional studies (Armishaw & Grant, 1999; Wilson, et al., 2007) show a high prevalence and it is reasonable to believe CAM use in children is high in New Zealand and that CAM may become an important issue the organisation and the nurses encounter in their service to families and children. Simply stating ‘not recommending or endorsing CAM use’ did not help the nurses in facing the challenges of the continuously increasing demand from their target population. The majority of the participating nurses believed that Plunket Society, as a leading provider in child health, needed to take up the responsibility to provide their staff with knowledge and resources about CAM to enable their nurses to fulfil their duty of care to families and children.

From the findings, frustration was higher in those nurses who have been using CAM themselves and in their own children. This is also true for those who had extended nursing experience and appeared to be more familiar with CAM (observed as those who use CAM regularly and have researched into CAM therapies). This is consistent with previous studies which found a positive correlation between experience and attitudes (Holroyd, et al., 2009; Shorofi & Arbon, 2010; Thiago Sde & Tesser, 2011). From their personal and working experience, they had recognized the potential benefits of some CAM modalities for children and they thought that it was their duty of care to be able to discuss and provide the options for the parents. Bounded by the policy,
their decision making is inconsistent with fundamental nursing values which recognize the unique needs of individuals.

5.3 FEAR OF LIABILITY

The participating nurses expressed their fear of liability in suggesting CAM despite a positive attitude toward CAM. This finding is in line with the existing studies which showed referral to CAM from health care providers had been low despite their positive attitudes toward CAM and concern about CAM efficacy was one of the main reasons (Sewitch, et al., 2008). Although PNs perceived some CAM were safe through observation in practice and anecdotal evidence, safety was still their major concern for children using CAM. Adverse reactions had been reported in children using CAM products or therapies (Lim, et al., 2011; Michail, Sylvester, Fuchs, & Issenman, 2006; Myers & Cheras, 2004; Woolf, 2003). Moreover, interactions between CAM remedies and conventional medication had also been reported (Cuzzolin, et al., 2003). Based on the possibility of interactions and adverse reactions of CAM, understanding of the research behind CAM (where available) is essential for protection of children. As discussed in the literature review chapter, studies urged health care providers to understand the evidence of efficacy / lack thereof and potential side effects of CAM.

5.4 DESIRE FOR KNOWLEDGE AND EDUCATION

The findings indicated a feeling of lack of knowledge and education related to CAM among the participating nurses and they considered themselves not competent and uncomfortable in discussing CAM with parents. All participants expressed a desire to learn more about CAM therapies especially those most likely to be used in children. They believed that they would feel more comfortable communicating with parents and offering their opinions related to CAM issues if they had more knowledge about them. This finding is consistent with many other studies which show that most mainstream health care professionals perceived their professional preparation of CAM knowledge to be fairly limited and would like to acquire more knowledge of
CAMs to enable effective communication with and accurate guidance of patients in their practices (Brolinson, et al., 2001; Brown, et al., 2007).

In a comprehensive literature review on the perceptions of paediatricians toward CAM, Cuzzolin et al. (2003) also found that it is challenging when the providers have limited knowledge about CAM and the practitioners may choose to neglect the request of the parents. He suggested that the paediatricians should equip themselves with enough knowledge in order to disagree or support the patients’ decision in CAM care. They also have a duty of care to explore the best care for the patients no matter whether it was a conventional approach or CAM. Kemper (2008) agreed that when the risk of harm was low and the efficacy had been established by scientific evidence, mainstream health professionals should refer the patient accordingly.

The participants also looked for updated information on CAM. Health practices do change over time as new evidence evolves and it is likely that people would change their attitude toward the practices as well. As an example, the use of raw cabbage leaves for breast engorgement has been anecdotally reported. With support from studies it has now one of the standard recommendations in reducing breast swelling and improving milk flow in nursing mothers with breast engorgement (Arora, Vatsa, & Dadhwal, 2008; Nikodem, Danziger, Gebka, Gulmezoglu, & Hofmeyr, 1993; Roberts, 1995).

Some PNs in the study reported that they had learned certain types of CAM such as reflexology, acupuncture, tuina for personal and family members use. From their observations, there was neither formal training nor course related to CAM use in children from Plunket. Moreover, the participants reported that the source of their knowledge relating to CAM came from the internet and their clients who used CAM. Similar findings have been found in previous studies showing that much of the CAM knowledge held by nurses appears to be derived from personal experience, the internet, friends or family rather than from professional education (Brown, et al., 2007; Sohn & Loveland Cook, 2002).

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5 Tuina is a hand- on body treatment for both acute and chronic musculoskeletal conditions, as well as many non-musculoskeletal conditions. It is often used in conjunction with acupuncture and Chinese herbalism.
In order to increase their competence in communicating with parents about CAM in their practice, PNS would like to have some specific in-service education provided from the workplace in relation to CAM. Similar demands from health professionals have been found in other studies supporting the need to increase CAM content in formal academic programmes, professional conferences and in-service education opportunities (Kreitzer, et al., 2002; Sohn & Loveland Cook, 2002). In fact, as the prevalence of CAM use by the public has been increasing, the majority of medical schools in the United States now offer courses in alternative medicine (Eisenberg, et al., 1998). Moreover, many academic institutions in the United States have incorporated CAM content into their conventional health professional training programs in response to the public’s expectation that health professionals be knowledgeable about CAM (Kreitzer, Mann, & Lumpkin, 2008). These initiatives aim to enhance communication not only between conventional health care providers and patients using CAM, but also between conventional health care and CAM providers. Through better health care coordination, the ultimate aim is to ensure the safety of CAM use and prevention of CAM interactions with conventional health care. Gaylord and Mann (2007) had concluded after a review of CAM use in the United States that overall quality of care to the public could be improved through better informed CAM use.

Details of some CAM can be obtained from various websites, societies, organisations and comprehensive publications with well-balanced information. The Natural Medicines Comprehensive Database offers reviews of daily supplements and nutrition and they are evaluated with respect to their levels of scientific evidence (Natural Medicines Comprehensive Database, 2013). Reliable resources should be explored and made available to support their PNs with detailed information of the theoretical foundation and scientific data related to different types of CAM. It could also be useful to offer the PNs information or instructions on how to evaluate health information or health claims on the internet, given the confusing excess of information on the internet (Gaylord & Mann, 2007).
5.5 INTEGRATIVE HEALTH SERVICE

Besides safety considerations, the financial cost of CAM is another barrier for PNs suggesting CAM to clients even if there were no constraints by the Plunket policy. In New Zealand, ACC subsidizes chiropractic, osteopathic and acupuncture treatments for people sustaining injury. However, childhood conditions seeking CAM treatment are not covered under ACC criteria and thus CAM therapies and products for this situation are fully consumer paid without any subsidy from the government. It is expensive especially when repeated visits are needed to obtain a desirable outcome. This restricts people’s choice as many people cannot afford it.

Some PNs would like to see an integration of safe and effective CAM into mainstream public services. This finding is consistent with the results of the surveys which also indicated favourable attitudes of health professionals toward the integration of CAM into mainstream education curriculum and clinical care in responding to patient’s expectations and needs (Frenkel & Borkan, 2003; Kreitzer, et al., 2002).

While integrative medicine has been utilized in some countries such as Germany, Switzerland, France and Austria to complement mainstream medicine in helping adult and paediatric patients, the availability of CAM therapies is still lacking in general in many other countries including New Zealand.
6.0 CONCLUSIONS

6.1 INTRODUCTION

This chapter provides a summary of the key findings and discussions. The implications and recommendations for mainstream health care providers in particular Plunket nurses, CAM practitioners and the relationships between mainstream health care providers and CAM practitioners are presented. Recommendations for future research and finally a review of the limitations, strengths and trustworthiness of the study are made.

6.2 SUMMARY OF KEY FINDINGS AND DISCUSSION

This is an interpretative descriptive qualitative study using focus group method capturing five Plunket nurses’ perceptions and attitudes towards CAM use in children. Four key themes emerged from the analysis. They included ‘organisational policy constraints’, ‘ambivalence between being an organisation employee and independent health professional’, and ‘fear of liability ’ and ‘desire for knowledge and education’. The organisational policy stood out as the main theme mentioned regularly by all participants during the discussion.

The organisation policy of not endorsing and recommending any CAM directed the nurses’ response to parents’ enquiries related to CAM care. Being an employee of the organisation, the nurses were expected to follow the policy. Some nurses learnt to respond carefully after the unpleasant experience of being rebuked by their clinical leaders for not being in line with the stance of the organisation. In the workplace, CAM was not a topic that could be discussed openly and freely. The nurses were concerned that their personal attitudes or perceptions would be judged, their nursing competence and professionalism would be doubted and their compliance with the policy would be challenged.

The nurses considered that parents might be discouraged from disclosing their use of CAM in their children because of the stance of the Plunket policy. This raised the concern of the non-disclosure problem which was revealed and discussed by many studies. Without communication
related to CAM use, the health professionals were unable to monitor any adverse effects, the possible interaction between CAM (especially CAM products) and conventional medicine and thus could not safeguard the health of their patients. Moreover, under the constraints of the policy, some nurses actually crossed the line in suggesting CAM care which they perceived to be safe and effective to parents to try in their children. No proper referral was made and the suggestions were not documented in the child’s record. This potentially affected the continuity of care within the health care team, and made the monitoring of the efficacy or adverse effects of CAM even more difficult.

Most studies agreed that open, non-judgmental communication with patients was best to deal with the concern. In New Zealand, the Medical Council, the College of Midwives and Nurses’ Organisation have established guidelines for their members in handling patients’ use of CAM and the advice in the statements were in line with the recommendations from recent trends and studies. The feeling of the participating nurses toward Plunket’s policy was ambivalent. Although feeling restricted and frustrated by the constraints of the policy, the nurses considered the existence of the policy could standardize the service delivered by the Plunket Society without causing confusion for parents by being given different or contradictory information by different PNs according to the personal perceptions and knowledge toward CAM. Moreover, the policy was established in consistency with Plunket Society’s guiding principle in service delivery which is based on scientific evidence driven by a strong medical model. Keeping all its staff in the same stance or position, the Plunket Society could be in a safer situation if negative effects of CAM occurred and the organisation’s reputation could be protected.

On the other hand, the nurses believed that they had a duty of care as independent health care professionals to offer the best care options, both conventional or CAM to the parents according to the need of the families and children. They considered that they had a responsibility to provide information to assist parents to make informed decisions. They also felt that it was their ethical obligation to offer CAM options that had been proved to be effective.

Although the nurses felt a responsibility to offer CAM advice to parents as a competent health professional, they were afraid to be liable for the advice especially if negative effects occurred.
The reasons underneath were perceived lack of knowledge, concern about the efficacy and safety of CAM practices and the high financial cost to parents.

The nurses were eager to have more knowledge about CAM to enable them to effectively communicate with parents or caregivers in relation to CAM care. All called for some in-service training or education to improve their knowledge of CAM and training in techniques for effective communication with parents in relation to CAM. Also, the nurses would like a more open atmosphere in the workplace so CAM can be discussed and information shared with colleagues and clinical leaders. Moreover, they would like to have access to updated information and resources about CAM products and therapies to support their practice. They considered that the changes had to be initiated by the organisation itself and from the higher authority that designed the policy and established the guidelines.

6.3 IMPLICATIONS AND RECOMMENDATIONS

6.3.1 MAINSTREAM HEALTH CARE PROVIDERS

The prevalence of CAM use in children indicates that CAM is an aspect of child health care that the health professionals can no longer ignore. RNZPS is the leading primary health care provider in child services in New Zealand. More than 90% of babies and children from newborn to five years of age are registered for Plunket service. The organisation holds a significant gatekeeper position to assess and monitor the effects and side effects of CAM care in this vulnerable population group. Almost all recent studies recommend mainstream health care providers establish open and non-judgemental communication with families to encourage disclosure of CAM use.

From the findings of the study, the existing Plunket policy appears to be going in the opposite direction. Therefore, guidelines need to be developed by the policy makers of the organisation to match up with the recommendations of current studies in optimizing patient care and minimizing potential liability in offering CAM advice. Instead of pressuring the staff not to share any
information on CAM, steps should be taken to educate staff on how to communicate with parents on CAM use.

PNs are the frontline workers in regular contact with parents and young children. Families value their advice on child health, on the safety and efficacy of a particular CAM, and on identifying CAM practitioners. It is important for the PNs to observe some important principles in addressing parents’ choice of CAM for their children. To enable them to fulfil their professional responsibilities in practice, the organisation should provide them with in-service training and education on CAM in particular of those frequently chosen by parents for their children, also on techniques in asking questions appropriately and the ways of communicating effectively with families in relation to CAM use. The nurses have the responsibility to explore the best options of care to children regardless of whether they are conventional medicine or CAM. The organisation should provide resources such as updated CAM information and a list of registered CAM therapists for its staff when requested by the parents. For CAM information which is beyond the knowledge of the nurses, they could refer them to reliable sources of information and the appropriate CAM practitioner’s professional bodies. Detailed documentation is encouraged for any suggestions and referrals made and the nurses should not be judged or punished if they have given advice to the parents accordingly and their professional assessment and judgment on the individual need of the families should be trusted and respected. Communication between team members should be encouraged instead of suppressed. If the nurse is in doubt about a certain CAM practice, she should be encouraged to discuss this with the clinical leaders so further information can be sought.

6.3.2 CAM PRACTITIONERS

Safety and efficacy of CAM are the major concerns among mainstream health care providers in accepting CAM. Therefore, to gain recognition from the mainstream health care providers to allow options in the best interest of the patients, CAM practitioners are requested to conduct vigorous research to establish evidence of safety and efficacy. While the use of research is still a controversial topic between CAM and mainstream health care providers, CAM professionals should still undertake studies to demonstrate the use and underlying mechanism of the treatment they recommend.
In New Zealand, the Ministerial Advisory Committee of Complementary and Alternative Health (MACCAH) recommended that if specific CAM modalities can contribute to New Zealand’s health strategies, are cost effective and have proof of efficacy, further integration should be encouraged. Assistance from the government and private sector subsidies for the development and research into CAM should be sought.

This study concentrated on CAM use in children. As children are not small adults and the treatment methodologies could be quite different to those for adults, specific education or qualification should be required for CAM practitioners who wish to treat children. This would need to be enforced by their professional and regulatory bodies to ensure safe practice and that the best care is provided for children.

At the regional conference of the Osteopathic Council of New Zealand 2012, paediatric osteopathic practice was one of the main themes. The Council recognized that children are potentially the most vulnerable group of patients seen by osteopaths. The Council plans to do further work in setting up clinical standards for its members. By doing so, it can be sure that children receive standard care by people who have proper training and are accredited in treating children. To provide safe treatments to children and to protect the profession as a whole, it is an important step to build up the trust among the public and other health professionals.

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6.3.3 COORDINATION BETWEEN MAINSTREAM HEALTH CARE PROVIDERS AND CAM PRACTITIONERS

From the data as discussed under section 4.5.3, the PNs indicated that they would like to have more interdisciplinary connection with CAM practitioners so they could monitor the progress of the children in using CAM in regard to its effectiveness or adverse effects. However, at time of writing this thesis, it appeared that there is no formal communication and no coordination between the Plunket staff and CAM practitioners. A survey done by Ben-Arye (2011) finds that parents actually highly support (95.2–97.4%) doctor-CAM practitioner communication concerning their child. The parents believe that the doctor-CAM practitioner communication can influence the diagnosis and treatment of the child’s disease, and also prevent conventional-CAM treatment interaction. The parents also state that their doctor should be the one to initiate communication with the CAM practitioners. The communication between doctors and CAM
practitioners regarding mutual patients is considered to be important as well from the doctor’s perspective according to study done by Schiff et al (Schiff et al., 2011). Furthermore, if the child is seeing a CAM practitioner, the doctors should include the CAM practitioners in the over-all care coordination (Kemper, et al., 2008).

In fact, the current public health model favours a multidisciplinary health care approach. Studies demonstrate that the public has urged the integration of certain CAM modalities into the mainstream health system. Thus, the cooperation and coordination of mainstream health care providers and CAM practitioners are encouraged to optimize patient care and communication between them is essential. The mainstream health care providers should collaborate or consult the professional CAM therapists objectively in circumstances beyond their own knowledge, skill and judgement when dealing with patients with CAM issues. Inter-professional communication should not be restricted just inside the mainstream circle, for example there could be inter-professional clinical sessions. Therefore, for the best interest of the children, better communication and coordination between CAM and Plunket staff are recommended.

To increase mutual understanding, CAM therapists could also seek opportunities to make contact with the mainstream health care providers. The author would like to suggest that representatives from the osteopathic community or Unitec’s Department of Osteopathy could take the initiative to introduce osteopathy to various mainstream health organisations, such as the Plunket Society. The representatives could provide information on osteopathy education and how osteopathy could complement various health practices.

6.4 FUTURE RESEARCH

At the time of writing up this study, there is no national data on the prevalence of children using CAM in New Zealand though regional data demonstrated a high prevalence. The common modalities of CAM given by parents to their children need to be explored too. These studies could offer valuable information to policy makers and health agencies in targeting health services to children. The Plunket Society holds a good position to initiate these studies as the majority of children from newborn to five years of age are under their care. The studies can
inform Plunket Society further if there is a need to amend its existing policy and to establish strategies to better serve the children and families in New Zealand.

This study involved a small group of PNs with a qualitative approach to explore the perceptions and attitudes of PNs toward the use of CAM in children. Owing to its qualitative and exploratory nature; the result does not claim to generalize to that of the whole PN population. Yet, the themes and subthemes of the findings of the study could be used to organize a questionnaire to conduct a survey for a larger sample size. The participation of a larger group of PNs would involve participants with a wider range of opinions about CAM, thus better representing the perceptions and attitudes of PNs as a population.

6.5 STRENGTHS OF THE STUDY

The vast majority of existing literature discusses the challenges posed to nurses regarding the increasing use of CAM in clients, also nurses’ potential response and responsibility to patients; few studies have been conducted that explore the opinions and clinical behaviours of nurses related to the topic. This study adds knowledge into this arena.

Limited studies have been done related to the topic on health professionals in the New Zealand context, thus the study is unique in reflecting a local issue.

As stated in the introductory chapter, I suggested that my personal cultural and career background adds strengths to the study. My personal experience and knowledge meant I had a relatively broad understanding of both oriental and western health systems, and of different opinions related to conventional medicine and CAM. My career background as a PN helped my understanding of the participating nurses’ clinical situation dealing with the CAM issues.
6.6 LIMITATIONS OF THE STUDY

The majority of the PNs who agreed to participate in this study have positive experiences with CAM. Those with limited or no experience with CAM were neutral and open. No PN expressed negative feelings toward CAM. Thus, the findings could potentially reflect just one view.

As I am an osteopathic student, it is possible that the participants would try to keep any negative feeling toward osteopathy or CAM aside to avoid offending the researcher. However, I was aware of this potential bias and was careful to remain neutral during the conversation. It did not seem to be a strong factor in this study as all the PNs appeared to give their own points of view freely during the process without signs of holding back.

One participating PN who had an extended knowledge and experience with CAM had a tendency to become a dominant speaker in the group. Trying to avoid the potential bias of having one strong voice in the group, the researcher was careful to allow equal chance and enough time for other participants to express their view points. Although this participant spoke a bit more than others, she did not intrude other participants’ conversation. Moreover, from the researcher’s observation, other participants in the group agreed to her opinions by nodding their heads, and also adding in what they thought to support the ideas of what the strong voice had presented. No one appeared to sit back or hesitate to speak.

The study included a small number of Plunket nurses. In hindsight, some in-depth interviews could have been conducted to increase the number of the participants and to enrich the data. It provided alternative to those interested participants who were not able to come on the set date of the focus group meetings. Moreover, individual private interviews could increase the validity of the study by further minimizing the potential weaknesses of focus group as discussed in the above paragraph where some participants might feel more comfortable to express their views privately.

Moreover, though I considered my career and cultural background might add strengths to the study, some readers might think otherwise. As a potential limitation, they might think that I might be influenced in my interpretation of the data due to my previous knowledge, experience and beliefs. I was aware of these and constant self reflection was done to ensure that the findings
came from the data instead of my own assumptions or preconceptions. Meetings with experienced supervisors also helped to avoid them.

6.7 CONCLUDING THOUGHTS

The overarching theme of the organisational policy constraint was an unexpected finding in the study. While the participants expressed their feelings of restriction and frustration toward the organisation related to its present policy toward CAM, it is significant that the Plunket Ethics Committee had approved the project to be carried out and great support had been given by the regional manager and clinical leaders. It is unknown to the author whether there is any discrepancy between the policy makers in the Wellington headquarters of Plunket and the frontline workers in the district region in the interpretation and implementation of the policy.

Armishaw, J., & Grant, C. C. (1999). Use of complementary treatment by those hospitalised with acute illness. *Archives of Disease in Childhood, 81*(2), 133-137. doi: 10.1136/adc.81.2.133


Natural Medicines Comprehensive Database. (2013), from http://naturaldatabase.therapeuticresearch.com


Hello Plunket Nurses of the Waitemata Branch! My name is Stephanie Lo (an ex-Plunket nurse) and I am currently studying toward a Master of Osteopathy at Unitec New Zealand. My course involves a research project and my topic is “Perceptions and Attitudes of New Zealand Plunket nurses toward the use of Complementary and Alternative Medicine (CAM) in children”. This research has been approved by both Plunket and Unitec’s Ethics Committee and I would like to invite you to participate in a focus group for the project.

To acknowledge your participation a petrol voucher of NZD $30.00 and a thank you letter from Unitec’s Head of Nursing will be given to participating nurses.

THE AIM OF MY PROJECT

Whilst empirical evidence on the safety and efficacy of Complementary and Alternate Medicine (CAM) is still limited, statistics has shown that CAM use in children has been increasing in New Zealand and around the globe. As a major children’s healthcare provider, Plunket nurses play an important role in assisting parents in making informed decisions regarding children healthcare which also includes the use of CAM. The project aims to understand the perceptions and attitudes of Plunket nurses toward the use of CAM in children.

HOW YOU CAN PARTICIPATE

I would like to invite you to participate in a focus group with other Plunket nurses where we can talk about:

- The meaning of CAM to you
- Your personal experience/practice experience with CAM
- Your perceptions toward the use of CAM on adults/children
- Your attitudes towards parents taking their children to visit CAM therapists
- Your response to parents or care givers about their use of CAM with their children

The focus group is going to be held at Plunket Family Centre, Woodford Ave, Henderson in a Saturday morning, on a date that has the maximum number of available participants. The session will take around 90 minutes and will be audio-taped.
WHAT WILL I DO WITH THE INFORMATION

I will transcribe the focus group discussion and read it. I will then send my initial interpretation of the discussion to you for your validation. The main themes identified from the discussion will be used to develop a preliminary questionnaire which will then be piloted among a small group of Plunket nurses. A report of the results will be written as my Master's thesis. It is possible that the report may be sent to an appropriate journal for publication or be presented in conferences. The thesis will be held by Unitec and the Plunket Society, and will also be available electronically via the Unitec library database.

CONFIDENTIALITY AND YOUR RIGHTS

I will ask all participants of the focus group to keep the discussion confidential. All participants will be assigned a pseudonym in the transcript and no true name will be mentioned anywhere in the report. All information collected from you and during the group session will be stored on a password protected file and only myself and my supervisors will have access to this information. Participation is voluntary and you are free to withdraw from this study before the start of the focus group session. Please note that in order to maintain the integrity of the discussion you cannot withdraw your information once the focus group is underway.

IF YOU ARE INTERESTED IN PARTICIPATING

Please write down your contact details on the attached return slip and I will contact you. Alternatively, if you want further information about the research please feel free to contact me at:

Stephanie Lai Ha Lo

- Tel: (09) 416 9825
- Mobile: 021 1120 953
- Email: laihalowong@gmail.com

If you have any concerns about the research project you can also contact my supervisor Dr. Elizabeth Niven, Senior Lecturer at Unitec New Zealand, at (09) 815 4321 ext. 8320 or email her at eniven@unitec.ac.nz

I am looking forward to meeting you and I believe you will find your involvement interesting.

UREC REGISTRATION NUMBER: 2011-1167

This study has been approved by the UNITEC Research Ethics Committee from 27th April, 2011 to 26th April, 2012. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 6162). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
APPENDIX B: PARTICIPANT CONSENT FORM

Participant consent form

| MASTERS RESEARCH PROJECT: Perceptions and attitudes of New Zealand Plunket nurses toward the use of Complementary and Alternative Medicine (CAM) in children |

I have had the research project explained to me and I have read and understand the information sheet given to me.

I understand that I will participate in a focus group with other Plunket nurses sharing views and opinions on the use of Complementary and Alternative Medicine (CAM) in children.

I know the time taken for the focus group session will be around 90 minutes.

I understand that our discussion in the focus group will be audio-taped and transcribed into a verbatim record.

I understand that everything I say in the group is confidential and none of the information I give will identify me in the report. Only the researcher and her supervisors will have access to the information. I also understand that all the information that I give will be stored securely in a password locked computer file which only the researcher can access.

I understand that I can withdraw from the study anytime before the focus group session. However, I cannot withdraw my information in the focus group once the focus group is underway to maintain the integrity of the discussion.

I understand that I will have an opportunity to give feedback to the concepts derived from the analysis of information in the focus group; also, I understand that I can see the finished research document.

I have had time to consider everything and I give my consent to be a participant of this project.

Printed name of Participant: ......................................

Signature of Participant: …………………………..            Date: ……………………………

Project Researcher: …………………………….               Date: ……………………………

UREC REGISTRATION NUMBER: 2011-1167

This study has been approved by the UNITEC Research Ethics Committee from 27th April, 2011 to 26th April, 2012. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 6162). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
APPENDIX C: PARTICIPANT RETURN SLIP

RETURN SLIP

Title: Perceptions and Attitudes of New Zealand Plunket Nurses toward the use of Complementary and Alternative Medicine (CAM) in children

If you are interested in participating in the focus group and agree for me to contact you, please complete this form and then place it into the return box (white box with label located in your area office) after sealing the form in the envelope provided before 30th June, 2011. This is not a consent form for the study’s participation. A consent form will be signed when your participation has been confirmed prior to the actual focus group meeting.

Printed Full Name: ___________________        ____________________        ______________________

Name

First Name                               Middle Name (if any)                                    Last Name

Mobile ph number :                      Best time to call at this number :                      ______
Work ph number :                         Best time to call at this number :                      ______
Home ph number :                         Best time to call at this number :                      ______

Primary Email address :                  _____________________________________________________________
Secondary Email address :                _____________________________________________________________
Physical address:                        _____________________________________________________________

Your Age: □ 20+   □ 30+   □ 40+

Please tick √ the suitable boxes (you may tick more than one):

Nursing experience:  □ Hospital               □ Community               □ Midwifery
Other work experience: □ Health               □ Social                  □ Commercial

□ Others, please state: _____________________________________________________________

Years working for Plunket: □ <1 year   □ 1-5 years   □ 5-10 years   □ >10 years

Working area: □ Urban                  □ Suburban       □ Rural

Ethnicity: □ European     □ Maori         □ Pacific      □ Other, please state: _______________________

On which Saturday mornings (10-12 pm) can you come (you can tick more than one or all of them):
□ 9th July           □ 16th July         □ 23rd July

Signature: ___________________________________

Remarks: You may not be selected to participate if the required number of participants has been met, I will let you know as soon as possible.
APPENDIX D: APPROVAL LETTER FROM UREC

Stephanie Lai Ha Lo
40 Wiseley Rd
Hobsonville
Auckland

28th April 2011

Dear Stephanie,

Your file number for this application: 2011-1167
Title: Perceptions and attitudes of New Zealand Plunket nurses toward the use of complementary and alternative medicine (CAM) in children

Your application for ethics approval has been reviewed by the Unitec Research Ethics Committee (UREC) and has been approved for the following period:

Start date: 27th April 2011
Finish date: 26th April 2012

Please note that:
1. The above dates must be referred to on the information AND consent forms given to all participants
2. You must inform UREC, in advance, of any ethically-relevant deviation in the project. This may require additional approval.

You may now commence your research according to the protocols approved by UREC. We wish you every success with your project.

Yours sincerely,

Scott Wilson
Deputy Chair, UREC

Cc: Elizabeth Niven
Cynthia Almeida
Ms Stephanie Lai Ha Lo  
40 Wisely Road  
Hobsonville  

17 May 2011  

Dear Ms Lo  

Perceptions and attitudes of New Zealand Plunket nurses toward the use of Complementary and Alternative Medicine (CAM) in children  

The Plunket Ethics Committee has considered your application and has approved it. Just note the following concerning the information sheet:  

1. It should provide information about the use to which the data will be put.  
2. With focus groups it is not possible to withdraw once the groups are underway; it is also impossible to have parts removed.  
3. The possibility of being identified is always present.  
4. Elizabeth Niven’s title and role should be included  

Yours sincerely  

D Gareth Jones  
Chair, Plunket Ethics Committee
Guided Questions in Focus Group Discussion:

- What does CAM mean to you?
- Do you have experience with any type of CAM personally? How do you feel about it?
- Do you ask parents or caregivers any question related to CAM use?
- Have you ever be asked for advice on CAM by parents or caregivers at work?
- Have you encountered parents using CAM for their children?
- What do you feel about CAM use in children? Do you use any type of CAM on your own children? Do you think they are useful?
- How do you respond to parents or caregivers about using CAM for their children?
- How do you feel about talking about CAM with parents regarding CAM?
- Is there any difficulty or barrier for you in discussing CAM with parents? What are they? Is there anything you want to change if you can?
### APPENDIX G: CAM MODALITIES AVAILABLE IN NEW ZEALAND

<table>
<thead>
<tr>
<th>CAM Modalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action potential stimulation therapy</td>
</tr>
<tr>
<td>Acupuncture</td>
</tr>
<tr>
<td>Alexander technique</td>
</tr>
<tr>
<td>Anthroposophical medicine</td>
</tr>
<tr>
<td>Applied Feng Shui</td>
</tr>
<tr>
<td>Applied iridology</td>
</tr>
<tr>
<td>Aromatherapy</td>
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<tr>
<td>Aura-soma colour therapy</td>
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<tr>
<td>Ayurveda</td>
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<tr>
<td>Bach flower remedies</td>
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<tr>
<td>Bio-energy therapy</td>
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<tr>
<td>Biological medicine</td>
</tr>
<tr>
<td>Body electronics</td>
</tr>
<tr>
<td>Bowen therapy</td>
</tr>
<tr>
<td>Caeteris body/mind energy balancing</td>
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<tr>
<td>Chi Kung</td>
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<tr>
<td>Chinese herbal medicine</td>
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<tr>
<td>Chiropractic</td>
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<tr>
<td>Colon hydrotherapy</td>
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<tr>
<td>Colour therapy</td>
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<tr>
<td>Cranio-sacral therapy</td>
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<tr>
<td>Crystal therapy</td>
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<tr>
<td>Dynamic phytotherapy</td>
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<tr>
<td>Educational kinesiology</td>
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<tr>
<td>Feldenkrais</td>
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<tr>
<td>Flower essence therapy</td>
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<tr>
<td>Gentle therapeutic manipulation</td>
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<tr>
<td>Hellerwork</td>
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<tr>
<td>Herbal medicine</td>
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<tr>
<td>Holistic animal therapy</td>
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<tr>
<td>Holistic pulsing</td>
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<tr>
<td>Homoeobotanical therapy</td>
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<tr>
<td>Homoeopathy</td>
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<tr>
<td>Human potential</td>
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<tr>
<td>Hypnotherapy</td>
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<td>Ifas</td>
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<tr>
<td>Intuitive healing</td>
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<tr>
<td>Iridology</td>
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<tr>
<td>Isopathy</td>
</tr>
<tr>
<td>Jin Shin Jyutsu</td>
</tr>
<tr>
<td>Kinesiology</td>
</tr>
<tr>
<td>Maharishi’s Vedic approach to health</td>
</tr>
<tr>
<td>(Maharishi Ayur-Veda)</td>
</tr>
<tr>
<td>Massage (therapeutic and remedial)</td>
</tr>
<tr>
<td>Medical herbalism</td>
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<tr>
<td>Medium channelling/intuitive healing</td>
</tr>
<tr>
<td>Natural healing sciences</td>
</tr>
<tr>
<td>Naturopathy</td>
</tr>
<tr>
<td>Neurofeedback (EEG biofeedback)</td>
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<tr>
<td>Neuro-linguistic kinesiology</td>
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<tr>
<td>Neuro-linguistic programming (NLP)</td>
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<tr>
<td>Oriental massage</td>
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<tr>
<td>Ortho-bionomy</td>
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<tr>
<td>Osteopathy</td>
</tr>
<tr>
<td>Paramedical aesthetics and aesthetic medicine</td>
</tr>
<tr>
<td>Pacific traditional healing modalities</td>
</tr>
<tr>
<td>Pilates based body conditioning</td>
</tr>
<tr>
<td>Primal healing</td>
</tr>
<tr>
<td>Psychotherapy</td>
</tr>
<tr>
<td>Rebirthing</td>
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<tr>
<td>Reflexology</td>
</tr>
<tr>
<td>Reiki</td>
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<tr>
<td>Rife therapy</td>
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<tr>
<td>Rolfing (structural integration)</td>
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<tr>
<td>Sclerology</td>
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<tr>
<td>Shiatsu</td>
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<tr>
<td>Spiritual healing</td>
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<tr>
<td>Sports therapy</td>
</tr>
<tr>
<td>Touch for health</td>
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<tr>
<td>Traditional Chinese medicine</td>
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<tr>
<td>Vegatest method</td>
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</tbody>
</table>

Source of information: Ministerial Advisory Committee on Complementary and Alternative Health (2003, p. 43).
# APPENDIX H: CAM RESOURCES

Useful resources:

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>The Cochrane Library</td>
<td><a href="http://www.moh.govt.nz/cochranelibrary">http://www.moh.govt.nz/cochranelibrary</a></td>
</tr>
<tr>
<td>BMJ Best Treatments</td>
<td><a href="http://besthealth.bmj.com/x/index.html">http://besthealth.bmj.com/x/index.html</a></td>
</tr>
<tr>
<td>Ministerial Advisory Committee on Complementary and Alternative Health</td>
<td><a href="http://www.newhealth.govt.nz/maccah.htm">http://www.newhealth.govt.nz/maccah.htm</a></td>
</tr>
<tr>
<td>New Zealand Register of Acupuncturists</td>
<td><a href="http://www.acupuncture.org.nz/">http://www.acupuncture.org.nz/</a></td>
</tr>
<tr>
<td>New Zealand Council of Homeopaths</td>
<td><a href="http://www.homeopathy.co.nz/">http://www.homeopathy.co.nz/</a></td>
</tr>
<tr>
<td>New Zealand Register of Holistic Aromatherapists</td>
<td><a href="http://www.aromatherapy.org.nz/">http://www.aromatherapy.org.nz/</a></td>
</tr>
<tr>
<td>New Zealand Society of Naturopaths Incorporated</td>
<td><a href="http://www.naturopath.org.nz/">http://www.naturopath.org.nz/</a></td>
</tr>
<tr>
<td>The Osteopathic Society of New Zealand</td>
<td><a href="http://www.osnz.org/go/">http://www.osnz.org/go/</a></td>
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</table>