

Considerations for Implementing a Pediatric Integrative Medical Service

by

Izabela Bienko

Bachelor of Child and Youth Care, University of Victoria, 2014

A Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of
Masters of Arts
in the Department of Child and Youth Care

© Izabela Bienko, 2014

University of Victoria

All rights reserved. This thesis may not be reproduced in whole or in part, by photocopy or other means, without the permission of the author.

Supervisory Committee

Considerations and Implications for Implementing a Pediatric Integrative Medical Service

by

Izabela Bienko

Bachelor of Child and Youth Care, University of Victoria, 2014

Supervisory Committee

Dr. Daniel Scott, Faculty of Human and Social Development

Supervisor

Dr. Maria Mayan, University of Alberta

Additional Member

Supervisory Committee

Dr. Daniel Scott, Faculty of Human and Social development

Supervisor

Dr. Maria Mayan, University of Alberta

Additional Member**Abstract**

Complementary and alternative medicine (CAM) is increasingly in demand and utilized by the public, specifically by families and their children who are being cared for by current mainstream in-hospital services. Integrative medicine (IM) is a strategy by which conventional health care is attempting to address the use of CAM and explore considerations to implement a pediatric integrative medical (PIM) service. This study will add the otherwise unexplored perspectives of CAM practitioners and hospital administrators to current literature. Semi-structured interviews with 10 CAM practitioners and 4 administrators were conducted. A qualitative comparative content analysis explored considerations for CAM integration in a pediatric hospital, including varied attitudes; levels of understanding and experiences with CAM; communication between professionals; expectations; skepticism and resistance to change; gaining knowledge about CAM; opposing health care ideologies; adapting to different health care environments; funding; safety; redistribution of care; therapeutic milieu; and patient centered care. There is a reservation toward IM in pediatric hospitals, despite generally positive personal and professional experiences and attitudes towards CAM. The realities and challenges of IM are identified. Implications for inclusion of key stakeholder perspectives are discussed in the context of IM for pediatric patients.

Table of Contents

Supervisory Committee	ii
Abstract	iii
Table of Contents	iv
Acknowledgments	vii
Dedication	viii
Chapter 1 Introduction	1
Overview	2
Reflexivity: Creating My Own Balance	3
Chapter 2 Literature Review	8
Parameters and Key Words	8
Definitions of Complementary, Alternative, and Integrative Medicine	8
Physicians and Health Care Professionals' Perspectives and Attitudes	10
CAM Practitioners' and Administrators' Attitudes and Perspectives	14
Family, Parent, and Patient Perspectives and Attitudes	16
Chapter 3 Methodology	21
Objective	21
Research Question	21
Research Orientation	21
Social constructionism	21
Critical constructionist	22
Method: Critical Focused Ethnography	24
Recruitment	29
Sampling: Convenience Sampling	30

Participants.....	31
Data Collection	32
Data Analysis	32
Chapter 4 Results	33
CAM Practitioner’s and Administrator’s Attitudes, Experiences and Expectations of CAM.....	33
Varied attitudes and levels of experience, interactions and communication	33
Different expectations for different CAM modalities.....	40
Considerations for a PIM Service, According to CAM Practitioners and Administrators	42
Skepticism and resistance to change.....	42
Gaining knowledge and experience with CAM.....	43
Opposing health care ideologies	49
Adapting to different professionals and health care environments.....	56
Funding and the political nature of the conventional health care system	62
Safety, Risk Management, and Responsibility	65
Redistribution of care.....	70
Therapeutic milieu and patient-centered care	74
Chapter 5 Discussion and Conclusion	78
Considerations for Implementing PIM	78
Reservations About PIM.....	78
Risks of PIM	81
Assimilation versus integration.....	83
Opposing health care ideologies	84
Integration Through Patient-Centered Care.....	87

Limitations	89
Implications for Future Research	90
Conclusion	90
References.....	95
Appendix A: Invitation Letter [e-mail].....	101
Appendix B: Information/Consent Letter	102
Appendix C: Consent Form	107
Appendix D: Administrator’s Semi-Structured Interview Questions.....	108
Appendix E: CAM Practitioner’s Semi-Structured Interview Questions.....	110

Acknowledgments

I would like to acknowledge and thank Dr. Sunita Vohra of the CARE program at the University of Alberta for your support in the beginning stages of this project.

To all the participants who shared their perspectives and experiences about a subject that is very important to me: I appreciate your honesty, the time you took to provide your views, your obvious dedication to your respective fields, and your hard work with children and families.

Dedication

I dedicate this study to all those who have directly and indirectly influenced my learning and progression through this journey.

Those to whom I need to express my gratitude, first and foremost, are Dr. Daniel Scott and Dr. Maria Mayan. The balance of professionalism and approachability certainly came with a combination of years of experience with students, a passion for research and higher education, and an enviable amount of patience, insight, and talent. Thank you for your guidance, respect, and confidence in this project, and in me.

To my supportive family and friends: My learning extended far beyond that of the scope of this research project due to your unwavering conviction that I would always persevere and succeed.

Chapter 1

Introduction

Integrative medicine (IM) is increasingly discussed in the health care literature and subsequently is becoming more common in the conventional health care system. Complementary therapies are now being offered in conventional medical settings throughout North America. Dedicated funding for Complementary and Alternative Medicine (CAM) research has been created within the National Institute of Health (NIH), primarily at the National Center for Complementary and Alternative Medicine (NCCAM). Funding is also available at other centers and institutes such as the Office of Cancer and Complementary and Alternative Medicine at the National Cancer Institute (Vohra & Cohen, 2007).

CAM is more in demand and utilized by the public, including families and their children who are being cared for by current mainstream in-hospital services (Kemper & Wornham, 2001; Vohra & Cohen, 2007). However, CAM has been researched much more extensively in adult populations than in pediatric populations for the treatment of various health conditions and their symptoms. Kemper and Wornham (2001) stress that while research is ongoing, demand for explicitly integrating CAM services into mainstream settings as an adjunct service will continue to grow, particularly for those institutions providing care to the sickest and most vulnerable children. As demand grows, more institutions should develop and implement responsible strategies for meeting the demand (Kemper & Wornham, 2001). These strategies will require ongoing professional education; outreach to respected CAM therapy providers; innovative institutional policy making; and a return to basic concepts of individualized, patient-focused caring and communication between physicians, families, and other health care providers (Kemper & Wornham, 2001).

Since the use of CAM is relatively new, especially in its use with children, it is still a controversial modality in conventional medical settings because there are few clinical trials of safety or efficacy. There have been quantitative data such as surveys and questionnaires that point to potential factors that may contribute to our understanding about why people use CAM. However, there has been little qualitative research done to more deeply explore these factors and how these may affect quality of care. Little information is available to guide clinical practice and training. Furthermore, licensure standards are not consistent (Cuzzolin et al., 2003; Kelly, 2007; Post-White, 2006; Scrace, 2003).

In order for IM to be successful for the pediatric population, the perspectives of all key stakeholders need to be considered. Currently, perspectives, opinions, and experiences of physicians, nurses, allied health care providers, and patients and their families have been accounted for in the literature. However, there is much less literature available from the perspectives of CAM practitioners or children's hospital administrators regarding the use of CAM in children's hospitals, or the process of implementing integrative services for pediatric patients.

Overview

This study invited participants to provide their perspective regarding CAM use and CAM integration into the conventional health care system. The research objective is to add this perspective of CAM practitioners and hospital administrators to the current health care literature regarding implementation of integrative medical services for pediatric hospital patients. In light of the fact that CAM services are becoming more in demand and utilized by the public, I hope that supplementing the current literature with CAM practitioner and administrative perspectives, the conventional health care system can begin be more aware of what might be required to create

an environment that better supports children and families on their individual health journeys. Administrators at the Stollery Children's Hospital and CAM practitioners, who provide acupuncture/acupressure, massage therapy, music therapy and/or reiki, or a combination of these therapies in the community, were recruited for this study. Qualitative semi-structured interviews were conducted that explored participants' attitudes, opinions, and experiences of CAM, interdisciplinary communication, and CAM integration.

I begin by discussing reflexivity and reveal my motivations behind this research, including my personal experiences and biases about CAM and integrative medicine. After a brief outline of relevant background information and key definitions, a literature review follows, summarizing current literature regarding the perspectives of conventional health care and CAM practitioners, families, and patients.

I use a qualitative comparative analysis to analyze the data, superimposing the themes from the CAM practitioners with those of the administrators, making visible the complexities and opposing paradigms held between the two groups who claim to have a shared goal of safely and effectively integrating CAM into a pediatric hospital. Main themes are presented in the results and then subsequently discussed. I conclude with study limitations, implications, and future research directions.

Reflexivity: Creating My Own Balance

As with the beginning of any project, there is a motivator, something that drives an individual's need to pursue a subject matter, and grow through and because of it. This research study is driven by my own professional and personal journey through the conventional health care system and the alternative health care system. I am familiar with complementary and alternative modalities. I have explored many of them in my own professional career as a mental

health therapist in a pediatric hospital, as well as personally in my own health journey to help deal with health issues. I have a great deal of energy and time invested in maintaining good health both professionally and personally. Because of this personal involvement with CAM, as a researcher, it is important to reflect on what some of my biases are and how they might change, obstruct or focus my perspectives regarding different perspectives about integration into mainstream healthcare.

Reflexivity is an important dimension of ethnography and qualitative research (Denzin & Lincoln, 1998; Hammersley & Atkinson, 2007). According to Denzin and Lincoln (1998), reflexivity refers to a process by which researchers are obliged to delineate clearly the interactions that have occurred among themselves, their methodologies, and the settings and actors studied. Murphy et al. (1998) stated that qualitative research calls for a level of self-conscious reflection upon the ways in which the findings of research are inevitably shaped by the research process itself and analysis that takes such factors into account. Reflexivity is focused on making explicit and transparent the effect of the researcher, methodology, and tools of data collection on the process of the research and the research findings. We are imbued with ideologies, values, and belief systems (Schwandt, 2007). The aim of reflexivity is to acknowledge the influence of our values and belief systems in a transparent fashion. Reflexivity allows the researcher to establish the validity of the phenomena being studied and that it is not just an expression of his or her ideology (Schwandt, 2007).

The CAM practitioners and administrators may have viewed me as not an unbiased researcher, but as an ally, considering my interest in this topic and in their perspective on it. This could have been both beneficial and problematic because on the one hand, it may help the participants feel like they could be more open in discussing their opinions and experiences with

me. As the researcher I may therefore be able to gather richer data. Taking on this project, already seeing myself as an advocate for CAM integration, on the other hand, could be problematic because this may skew how I interpret and present the data. However, I can appreciate that even with my preferences to advocate for and use CAM, there will always be a wide range of perspectives and opinions about this topic.

My purpose in being reflexive is to remain aware of these biases, and work towards providing good information through which we can continue improving care for the most vulnerable children and families in the health care system. Even though CAM gave me the opportunity to feel more empowered in my own health journey, I recognize that every journey is unique. It may be beneficial for further research, policy development, and health education to understand and value a wider range of perspectives.

My journey started 13 years ago, when I began experiencing health issues at the age of 17. I attributed much of this to the stress of being a full-time student. I went to my family physician who also attributed much of this to stress. I was told my health was good overall but was put on medication anyway. I had visited a naturopathic doctor out of curiosity a few years later to get a different perspective and insight into how I can better manage the stress and other symptoms I was experiencing. I did what was recommended and it helped, in the short term. I hadn't realized at this point that I needed to integrate this new approach into my lifestyle over the long term in order to maintain better health. In retrospect, it stemmed from a belief and attitude I held at that time, that after a treatment or pill, everything should get back to normal.

After suffering my most severe migraine two years ago, my family physician and I decided on a different approach. In light of a recent finding, the approach did not include medications. I did what he recommended, and what I experienced since was the onslaught of my

symptoms when I first went to see my physician all those years ago as a teenager. The addition of several more symptoms quickly got my attention. Based on my past experiences with CAM in trying to deal with stress, this is where I turned next.

I had made another appointment with my physician to bring up why this diagnosis had not been previously discussed. I was told at this appointment that all the symptoms that I had been experiencing were mild and nothing to worry about. I was motivated to get better, but there was nothing more my physician would do for me at this point, as my condition was not something that was considered treatable, but could only be managed. I felt dismissed and defeated. I wanted to be more preventative and proactive with my health and not resort to stressful, expensive, and lengthy treatments in the future when it got serious enough.

This is when I found true value in CAM. It was through this health route that I am beginning to find my way back to balanced health again. Through nutrition, supplementation, naturopathic medicine, and acupuncture, in conjunction with regular visits to my physician, I feel I have found my own unique integrated approach. I am creating this balance for myself. I respect that both approaches have been crucial to my understanding of how this balance could be maintained within the current health care systems. Advocating for a balanced perspective is how I understand the effects of my own experiences, attitudes, and biases about IM and CAM use within the conventional health care system.

As a mental health professional, working with children in a psychiatric facility, I am embedded within a multidisciplinary team. On a weekly basis, the team meets to discuss cases. The program is designed so that the child's family and their goals are priority items. I have prior exposure to the more acute levels of care within the Stollery Children's Hospital, specifically at the Oncology unit. Locating myself in my research as a professional familiar with the hospital

environment, with different professionals, working from a patient-centered perspective, I was able to place myself within the conventional health care system. This is another bias to consider throughout this study as I do have experience and an understanding of both systems. This allowed me to gain rapport with participants as a result, perhaps more quickly than I would have if I did not have this level of insight. Also, discussions during the interviews may have taken on a deeper level of inquiry, using similar language, examples, and context to gain a common ground with participants as a basis for the interviews. Participants were also given general background information about who I am as a researcher, why I was doing the study, and why I wanted to speak with them specifically.

Personally and professionally, I began this study having awareness and experience from both perspectives. Although this does create a bias and a specific lens of which I have to continually be conscious, I was also able to identify with my participants, take on the point of view, and have sometimes difficult discussions regarding their current professional identity and circumstances. I do not believe these issues are easily talked about. Having a level of insider experience, being someone who could relate to the participants, perhaps has allowed me to gain deeper and more saturated data. With the theoretical perspective and methodology I take on for this study, discussed in the sections to follow, this type of data was crucial.

Chapter 2

Literature Review

Parameters and Key Words

I conducted a search for qualitative and quantitative studies, with most sources published in North America. The databases I used to conduct my literature search are as follows: Elton B. Stephens Company (EBSCO); Academic Search Complete; The Cumulative Index to Nursing and Allied Health Literature (CINAHL); Google Scholar; Summon; and Alt. Health Watch, from the University of Victoria Library search engine. The disciplines I focused my search in are integrative medicine; complementary and alternative medicine; pediatrics; public health; and nursing. The following key words were used: *child**; *pediatric*; *complementary and alternative*; *integrative*; *medicine*; *therapy**; *service(s)*; *cancer*; *oncology*; *hospital*; *parent**; *profession**; *practitioner*; *physician*; *nurse*; *parent*; *perception(s)*; *attitude(s)*; *opinion(s)*. (*Includes variations of key term).

Definitions of Complementary, Alternative, and Integrative Medicine (CAM)

CAM encompasses a variety of therapeutic methods and techniques rooted in traditional, philosophical, and empirical systems of medicine that view health and disease in the context of the human totality of body, mind, and spirit. The establishment of the National Center of Complementary and Alternative Medicine (NCCAM) by the U.S. National Institutes of Health in 1997 marked a shift in the relationship between mainstream conventional medicine and CAM (Ben-Arye, Frenkel, Kleinc, & Scharf, 2008). The National Center for Complementary and Alternative Medicine (NCCAM, 2011) defines CAM as follows: A group of diverse medical and health care systems, practices, and products that are not presently considered part of

conventional medicine. CAM has caught the attention of conventional medicine including academic hospitals (NCCAM, 2011).

“Complementary” typically refers to those methods that augment conventional therapies, and “Alternative” refers to methods used instead of or in addition to mainstream treatments (NCCAM, 2011); that is, any diagnosis, treatment, and/or prevention which complements mainstream medicine by contributing to a common whole, by satisfying a demand not met by orthodoxy, or by diversifying the conceptual frameworks of medicine (Cuzzolin et al., 2003). Bold and Leis (as cited in Myers, 2005) define unconventional therapies as those therapies other than standard medical treatments that pediatric cancer patients received specifically for their cancer and/or associated symptoms of conditions, regardless of the type of provider (e.g., alternative health practitioner). In other words, unconventional therapies are health-related practices that are outside the domain of mainstream Western medicine, that are neither widely available nor taught in conventional medical schools, for which interest is becoming widespread (Cuzzolin et al., 2003; Kelly et al., 2004).

“CAM” is being replaced with terms such as “holistic” or “integrative” medicine. Holistic medicine refers to patient-centered care that includes consideration of biological, psychological, spiritual, social, and environmental aspects of health. Integrative medicine is relationship-based care that combines mainstream and complementary therapies for which there is some high-quality scientific evidence of safety and effectiveness to promote health for the whole person in the context of his/her family and community. Integrative medicine also reaffirms the importance of the relationship between the practitioner and the patient, emphasizes wellness and the inherent drive toward healing, and focuses on the whole person, using all appropriate therapies to achieve the patient’s goals for health and healing (Kemper, Vohra, & Walls, 2008).

Additionally, the list of what is considered to be complementary and alternative changes continually, as those therapies that are proven to be safe and effective become adopted into conventional health care and as new approaches to health care emerge, such as cognitive behavioral therapy or massage therapy (Gottschling, Langer, Tautz, & Graf, 2006; Kelly, 2007; Scrace, 2003; Tacon, 2003).

Attitudes of health care professionals toward complementary and alternative medicine are important, in part, because CAM use among the general population in North America is widespread (Sewitch, Cepoiu, Rigillo, & Sproule, 2008). Recognizing its potential impact on patient care, health care professionals' attitudes toward patients' use of CAM have been evaluated. However, the reviews conducted show variability in results (Sewitch et al., 2008). As definitions change, so do opinions and perceptions about CAM therapies and, therefore, their applications.

Physicians' and Health Care Professionals' Perspectives and Attitudes about CAM

The American Academy of Pediatrics stated, "Pediatricians and other clinicians who care for children have the responsibility to advise and counsel patients and families about relevant, safe, effective, and age-appropriate health services and therapies regardless of whether they are considered mainstream or CAM" (Kundu et al., 2011, p. 154). However, conventional healthcare providers historically have received limited or no formal education in complementary and alternative medicine and have been perceived by patients as being biased against CAM (Kreitzer, Mitten, Harris, & Shandeling, 2002).

Pediatric oncologists, along with most practitioners trained in the Western medical tradition over the past decade, however, have struggled with the fact that patients are using CAM at increasing rates (Kelly, 2007; Sencer & Kelly, 2006). Therefore, according to Cuzzolin et al.

(2003), many physicians tend to refuse these often scientifically not-proven methods, even if they are unobjectionable. Physicians frequently face questions about CAM, but, because of a lack of education and experience, are likely to respond to patients' inquiries neutrally or negatively and feel uncomfortable discussing these treatments with their patients, or try to avoid any discussions about CAM altogether (Cuzzolin et al., 2003). Pediatric oncologists need to be open-minded and willing to discuss possible benefits, risks, and costs of CAM with patients and their parents (Gottschling et al., 2006). There is a clear need for physician education on this topic (Gordon, 2008; Kemper & Wornham, 2001; Scrace, 2003), because whether or not evidence exists, clinicians are expected by their patients to advise them about CAM and include them in decision-making and treatment choices (Post-White, 2006).

It has been suggested that a lack of time for discussion with pediatricians drives people to different types of practitioners without information about the efficacy and safety of CAM (Cuzzolin et al., 2003). A health care professional and a patient or parent may have differing opinions, and parents appreciate the greater attention and time often given by alternative practitioners. Only when parents feel comfortable about entering into dialogue with practitioners on the use of complementary and alternative treatments will it be possible to identify those treatments that may be harmful or potentially beneficial (Cuzzolin et al., 2003). The International Society of Pediatric Oncology (2010) calls for the health care team to be attentive to complementary therapies that may be physically or psychologically harmful to children and their parents and for the health care team to not automatically and dismissively discourage the use of non-harmful complementary therapies (Cuzzolin et al., 2003; Kelly, 2007). Scrace (2003) claims multidisciplinary collaboration and communication are essential if CAM is to play a more significant role in symptom control or pain management.

Physicians are more negative than nurses and other health care professionals about CAM (Sewitch et al., 2008). Older, more experienced, male physicians are less likely to recommend CAM therapies to their patients compared to younger, less experienced, female physicians. Older physicians are also less likely to use CAM for themselves and their families compared to younger physicians. More positive attitudes among female health professionals, therefore, may be explained by their lower average age or by the higher probability that they use CAM themselves (Kurtz et al., 2003, as cited in Sewitch et al., 2008). Even when physicians hold positive attitudes, it is not reflected in CAM referral or prescription patterns.

Even though physicians' attitudes are more negative compared to other health professionals, interest in CAM among health care professionals in general is high (Sewitch et al., 2008). Up to 81% of primary care physicians wish to increase their knowledge about CAM modalities. Moreover, medical and surgical physicians, dietitians, pediatricians, and primary care medical schools report they need more information about CAM modalities. Views on CAM therapies among oncology health care professionals (e.g., physicians, nurses, and social workers), reveal that approximately two-thirds of those surveyed felt comfortable discussing CAM with their patients, although only 21% initiated the discussion, even though patient nondisclosure of CAM use is common (Sewitch et al., 2008). Attribution of the responsibility for nondisclosure is inconsistent: Physicians attribute nondisclosure to patient fear of being discouraged, while patients attribute nondisclosure to their own uncertainty of benefits and to the observation that their physicians rarely ask them about CAM use (Sewitch et al., 2008).

Primary care and subspecialty pediatricians in a major children's hospital in the United States, as one example, have positive attitudes toward CAM therapies (Kundu et al., 2011). Not only are the majority of these providers aware of CAM used by their patients, but they also

recommend CAM therapies to their patients and personally use CAM. The results of the Kundu et al. (2011) study further suggest that there is a positive relationship between personal CAM use by conventional medical providers and the likelihood that CAM therapies will be recommended for patient care. Nevertheless, communication between conventional medical and CAM providers was often suboptimal despite awareness of simultaneous use of CAM and conventional therapy by patients. These data suggest that CAM therapies may have gained more acceptance in mainstream conventional medicine, but they have yet to penetrate the professional culture in the hospital setting (Kundu et al., 2011).

In a study of pediatric patients by Fearon (2003), over 56% of the study participants (physicians) have discussed CAM use with families. This is a higher figure than in adult populations where well over one-half do not inform their doctors of CAM use. It may be that in pediatrics the nature of the relationship between health professionals and their patients/families encourages open discussion. However, it was usually the family that initiated discussions. In Fearon's study (2003), doctors and nurses in a children's hospital who completed a questionnaire and an interview, demonstrated that even though attitudes were generally positive towards CAM use in children, doctors and nurses did not routinely introduce the topic. This could suggest that CAM use in children may be higher than in the general population, assuming that all those families who discuss CAM actually use CAM for their children (Fearon, 2003). Both physicians and nurses demonstrated that knowledge of CAM was very limited but did not prevent staff from discussing CAM with patients or endorsing its use providing it did no harm (Fearon, 2003). Some pediatricians refer patients to CAM providers or provide complementary therapies themselves, integrating them into conventional medical practice (Kemper et al., 2008). Concerns were expressed, however, relating to parental wishes overriding the child's choice (Fearon,

2003). Even though the pediatric health professionals were aware that a child may be less able than an adult to articulate concerns about care, most staff felt that children should be able to use CAM (Fearon, 2003). There was a feeling that it offered more benefit to those children with chronic illnesses and that its most important role was probably in the psychological support it could provide (Fearon, 2003).

Safety was clearly an important issue that was not highlighted in the literature review where concerns center more on the other issues such as lack of research to demonstrate effectiveness (Fearon, 2003). However, as CAM is becoming more in demand, and accepted throughout the medical community, issues around safety and efficacy are becoming less problematic. Many academic institutions, for instance, now have departments of integrative medicine, which respond to these demands of service users (Sencer & Kelly, 2006). Large hospitals, which once shunned complementary and alternative medicine, are now touting its benefits in cancer support (Russell, 2004). Given that the ultimate goal of health care is to improve patient health, increasing health care professionals' knowledge of CAM therapies and their availability in the community may help to integrate CAM into mainstream medical care (Sewitch et al., 2008).

CAM Practitioners' and Administrators' Attitudes and Perspectives about CAM

A study by Ben-Arye et al. (2008) which examined the perspectives and attitudes of CAM practitioners towards integration of CAM in primary care that focused on adult populations was done in Israel. The study referred to the importance of integrating the physician, CAM practitioner, and patient perspectives, and found that even though:

Patients, primary-care physicians (PCPs), and CAM practitioners suggested that family physicians play a central role in CAM referral and, to a lesser extent, that they actually

provide CAM treatment...more CAM practitioners and patients, as opposed to PCPs supported the family physicians' role in referral to CAM. (Ben-Arye et al., 2008, p. 400)

Furthermore, patients and CAM practitioners supported a referral by a family physician significantly more than PCPs themselves did (Ben-Arye et al., 2008); these results may be further interpreted as a positive attitude towards integration by CAM providers. However, Ben-Arye et al. (2008) found that patients, PCPs, and CAM practitioners view differently the issue of who should provide CAM in an integrative primary care setting. They conclude that future studies will need to clarify the possible role of dual-trained CAM practitioners as therapists in primary care clinics and examine the triangular patient-PCP-CAM practitioner perspective. It appears that even though CAM practitioners may have positive attitudes about PCPs referring out to CAM services, perspectives and attitudes regarding interdisciplinary roles and communication on the other hand is a separate, albeit related, discussion altogether.

I refer to this study because it demonstrates the lack of research on CAM practitioner and administrative perspectives and attitudes regarding CAM and integrative medicine services. It does, however, point to an important consideration that understanding all three sides of the patient-PCP-CAM practitioner triangle creates a more comprehensive and realistic view of current health care practices (Ben-Arye et al., 2008). The sections to follow outline in more detail the objective of this study. A more balanced perspective is created in which different views are considered by the health care team. The outlook from the study by Ben-Arye et al. (2008) demonstrates a fundamental requirement in establishing patient-centered integrative care and integrating CAM into primary care (Hollenberg, 2006).

Family, Parent, and Patient Perspectives and Attitudes

Research regarding attitudes toward CAM has been explored in medical providers (i.e., doctors, nurses, medical students) but largely neglected in healthcare recipients (McFadden, Hernández & Ito, 2010). There are various reasons for the growing use of CAM; many users of CAM reported use “Not so much as a result of being dissatisfied with conventional medicine, but largely because they found these health care alternatives to be more congruent with their own values, beliefs, and philosophical orientations toward health and life” (Kemper et al., 2008, p. 1375). Parents’ reasons for seeking care for their children from CAM providers included, in decreasing order of frequency: anecdotes and word of mouth that a particular CAM treatment was considered effective, a fear of drug adverse effects, dissatisfaction with conventional medicine, and the need for more personal attention. In addition, many groups may use CAM because of their values and beliefs (Kemper et al., 2008). Complementary and alternative approaches offer an opportunity for patients to participate actively in their own care.

Studies have found that feelings of loss of control in response to cancer were significant predictors of recurrence and death; that is, an attitude of helplessness toward cancer is related to poor prognosis and recovery (Scrace, 2003; Tacon, 2003). Gordon (2008) states that these complementary approaches have the promise to significantly reduce stress and enhance immunity, enhance the quality of the lives of people who have cancer while in hospital, and, perhaps increase the length of their survival.

With this promise, families and parents of ill children take on a more open-minded and curious attitude towards using CAM. Subsequently, having greater control over personal health, or the health of a child, is a commonly reported reason for seeking CAM treatment (McFadden et al., 2010). Dissatisfaction with conventional medicine is frequently mentioned anecdotally as a

reason for using CAM, and this may account for relatively little variance in why people actually seek CAM (McFadden et al., 2010). The various assumptions, beliefs, and attitudes held by the parents of pediatric cancer patients and the health care professionals regarding CAM can vary significantly (McFadden et al., 2010). The current data suggest that CAM is sought primarily because of an approach toward mind-body practices rather than out of a desire to avoid conventional medicine (McFadden et al., 2010). Having a positive attitude toward CAM was correlated with having an internal health locus of control (HLC). Consequently, health is believed to be the result of personal behavior and holistic balance, which may include CAM treatments. An internal HLC was also associated with current CAM use and greater likelihood of using CAM in the future, such that those who believe personal actions to impact health are more likely to use CAM (McFadden et al., 2010).

In general, adolescents seem to be more open than adults are to using CAM therapies, and adolescents are more inclined to use CAM if their parents also use these therapies. As they begin to take responsibility for their own health needs, adolescents also may use CAM therapies as self-treatment (Kemper et al., 2008). Furthermore, children with chronic illness, disability, or special health care needs are frequent users of CAM. According to Kemper et al. (2008), the rate of CAM use for this population is estimated to be 30% to 70%. In their survey of families of children with developmental disabilities, families wanted their clinicians to be able to counsel them about CAM options (Kemper et al., 2008).

Most parents surveyed chose to use CAM for their children to combat side effects of the cancer or the cancer therapy; CAM is rarely used as the primary means to treat the cancer (Sencer & Kelly, 2006). Meanwhile, Myers and colleagues (2005) found parental reasons for use of non-Western therapies included, in order of frequency, reducing pain, shortening the

therapeutic cycle, limiting side effects, increasing the child's internal strength, improving the child's ability to cope with unpleasant medical events, and curing the disease. According to the study by Martel et al. (2005), which looked at the prevalence of CAM use in children with cancer, none of the CAM users who reported the use of CAM for their children said they refused a conventional treatment.

Surveys (Kemper & Wornham, 2001; Myers et al., 2005; Post-White, 2006; Scrace, 2003; Sencer & Kelly, 2006) consistently show that the majority of CAM users choose CAM therapies as a complement to conventional therapy, not as an alternative. People value conventional medicine despite their growing interest and use of CAM. More specifically, CAM therapies are primarily perceived and used as supportive therapies to alleviate pain and symptoms of cancer and especially to ameliorate actual or perceived toxicities of conventional cancer treatment (Kemper & Wornham, 2001; Myers et al., 2005; Post-White, 2006; Scrace, 2003; Sencer & Kelly, 2006). Myers et al. (2005) reviewed 14 studies of survey and interview data collected from parents on children's use of complementary and alternative therapies. More than 50% were rated as *very effective*, and an additional 34% were rated *somewhat effective*. Only 3% of unconventional therapies were judged *non-effective* (Kelly et al., 2007).

Parents' desire to try to do everything possible to improve their child's health likely plays a major role in their decision to use CAM therapies for their child (Kelly, 2007). A Canadian pediatrician survey by Vohra and Cohen (2007) acknowledges the relevance of these initiatives. The proportions of children with cancer, specifically, who use CAM at some time during their treatment range from 31% to 84% (Gottschling et al., 2006; Myers et al., 2005; Post-White, Sencer, & Fitzgerald, 2002, as cited in Ott, 2006; Post-White, 2006). According to Cuzzolin et al. (2003), the parent should be treated as a partner in interactions. Parents uniformly expressed

gratitude at being empowered to do something to help their child, even in the face of an incurable disease (Kemper & Wornham, 2001).

Families having children with chronic illness seek CAM more frequently than families with well or acutely ill children. While the reasons for use and types of CAM used vary, parents who wish to use CAM for their children want information, resources, and financial assistance in offering CAM interventions that may help their children. Parents also want information to help them evaluate safety and efficacy. (Post-White & Hawks, 2005, p. 109)

The prevalent attitudes among families and parents of children undergoing cancer treatment seems to be one of encouragement, curiosity, and open-mindedness since most people consider CAM therapies to be natural and thus safe (Cuzzolin et al., 2003). However, they can at times become the treatment of last resort in which they place a lot of confidence, faith, and hope. CAM is rarely used as the primary means to treat cancer. Most parents surveyed chose to use CAM for their children to combat side effects of the cancer or the cancer therapy (Sencer & Kelly, 2006). As the rapidly growing body of research tells us, these approaches have the promise to significantly reduce stress and enhance immunity, to enhance the quality of the lives of people who have cancer while in the hospital, and, perhaps, to increase the length of their survival (Gordon, 2008).

With this promise, families and parents, take on a more open-minded attitude towards CAM. Having greater control over personal health, particularly the health of a child, is a commonly reported reason for seeking CAM treatment (McFadden et al., 2010). Parents uniformly expressed gratitude at being empowered to do something to help their child, even in the face of an incurable disease (Kemper & Wornham, 2001). This is consistent with the

literature regarding the parents' desire to try to do everything possible to improve their child's health and likely plays a major role in their decision to use CAM therapies for their child (Kelly, 2007).

Identifying the attitudes and perspectives underlying CAM use could help explain the increasing popularity of CAM, as well as what aspects of healthcare are valued. This knowledge could be used to modify conventional medicine by incorporating certain aspects of CAM into traditional medical treatments (McFadden et al., 2010). Possible ways to approach this could be to encourage health providers to support and emphasize personal responsibility, particularly for their health. In addition, information could be provided to patients about a range of CAM treatments (McFadden et al., 2010).

There are gaps in the CAM and IM literature, as this section has illustrated. Some perspectives have been looked at extensively, such as those of physicians. In the section to follow, the voices of CAM practitioners and administrators are added regarding attitudes and experiences of CAM, and considerations for IM and CAM integration into pediatric hospitals, as these perspectives have not been looked at to the same extent as others.

Chapter 3

Methodology

Objective

The research objective is to add the perspectives of CAM practitioners and hospital administrators to the current health care literature regarding implementation of integrative medical services for pediatric hospital patients. In presenting the often opposing and conflicting approaches to health care between the conventional and alternative systems, I hope to identify some of the realities and challenges of IM.

Research Question

From the perspectives of CAM practitioners and administrators, what are the considerations for implementing a pediatric integrative medical (PIM) service?

Research Orientation

Social constructionism. Social constructionism is based on an understanding of knowledge as the product of particular people within particular communities, guided by particular assumptions, beliefs, and values (Gergen & Gergen, 2004). Truth is not a search for knowledge, but rather, truth is constructed within language, communities, and relationships (Gergen & Gergen, 2004). Each group's knowledge functions in a different way for different purposes. In other words, each group develops paradigms within which they function. A paradigm is constituted by the shared set of assumptions, methods, ways of writing, rewards, and so on that hold the community together and influence how meaning is made (Gergen & Gergen, 2004).

Western/conventional medicine, for example, is a paradigm, as is alternative/holistic health care. However, those inside a particular paradigm can find it difficult to see beyond its

assumptions. The constructionist challenge, then, is to blur the disciplinary boundaries and show how truth and reality are brought into form through specific social practices and relational meaning-making processes. In the study by Ben-Arye et al. (2008), primary care physicians and CAM practitioners expressed an interest in clinical practice collaboration, they preferred using a medical letter to communicate with each other and expected to consult with each other about mutual patients to formulate treatment plans. According to Gergen & Gergen (2004), our ultimate welfare lies in cross-talk, the kind of dialogue that allows multiple realities and values to intersect. Through this kind of encounter, all parties are enriched, but more importantly, scientific work is more likely to speak of issues of general significance to society, such as the increasing demand for and use of CAM.

Social constructionist ideas have encouraged a variety of practices for enhancing coordination among people, for bringing diverse people into a common cause, and for reducing differences (Gergen & Gergen, 2004). I take on the epistemological stance that knowledge resides between us, not within a specific person, but within the constructs of relationships, whether personal or professional. From this understanding, different disciplines can begin to create and bring a truth, a reality, through relating. How to create collaborative teamwork between physicians and CAM practitioners is one of the puzzling areas in integrative medicine research. Through perspective building and a thorough compilation of all disciplines, their truths, realities, and perspectives, we can begin to construct a system of health care that supports interdisciplinary communication and collaboration (Ben-Arye et al., 2008).

Critical constructionist. The constructionist orientation assumes that knowledge and realities are created collaboratively through language and other social and professional practices. “While ‘constructions’ are not more or less ‘true’, in any absolute sense, they are simply more or

less informed and/or sophisticated” (Guba & Lincoln, 1994, p. 110) This theoretical perspective favors an ever-open dialogue in which there is always room for another voice, another vision and revision, and further expansion in the field of relationships. The critical constructionist approach I use to orient myself throughout this study is concerned with how the various individuals or “actors” in a given environment are involved in the construction and meaning of “phenomena” (Latimer, 2008, p. 154). Contextual features, such as the place where this occurs (children’s hospitals) and organizational cultures and policies (conventional health care system), also play a role in shaping these constructions. Typically, realities are co-constructed with others through interaction: Some constructions are thus held by many individuals and even across cultures (Koehn, Kozak, & Drance, 2011). In this sense, constructions are not benign. This is a key premise of critical theory, namely that “All thought is fundamentally mediated by power relations that are socially and historically constituted” (Kincheloe & McLaren, 1994, p. 139).

Critical theorists such as Bourdieu and Foucault have argued that individuals with the greatest social capital tend to reproduce social realities that favor their own interests and silence the most vulnerable (Faubion & Marcus, 2008; Lechte, 1994; Miller, 2008). Here, social capital refers to the economic, social, and symbolic power held by individuals and reproduced by institutions and practices such as biomedicine (Lock & Scheper-Hughes, 1990). Power is linked to knowledge, which may be very context specific. Thus, in the conventional health care environment, physicians and nurses have specialized largely biomedical knowledge on which patients and their family members depend. The conventional health care system can also become a tool of knowledge, and hence power, in the sense that a small number of clinical staff are responsible for the surveillance of a relatively large number of patients (Lechte, 1994). They are

themselves constrained by the relative power of the biomedical hierarchy, administrative, and organizational structures (Koehn et al., 2011).

In my personal health journey, I began to grow gradually more curious as to why my own power as the patient and my own voice are not equally positioned within the conventional health care system. This is a pivotal revelation that sparked my interest in this research project. I am passionate about expanding my relationships with my various health care providers, both conventional and CAM, and co-creating a different reality of health for myself. I am still balancing and integrating divergent approaches in my health. As my knowledge and understanding of my own health and the health care system continues to grow, so does my sense of empowerment and sense of control. Through active participation and a critical approach throughout my own journey, I am now better positioned to explore these sometimes hidden, taken-for-granted assumptions, attitudes, beliefs, values, and perceptions regarding CAM and IM.

Method: Critical Focused Ethnography

We understand that cultures and subcultures are everywhere and are found among people in a specific place (e.g., a hospital or organization) or among people who share a similar experience but might not know each other (e.g., CAM practitioners considering IM) (Mayan, 2009). Therefore, I draw from traditional ethnographic methods of inquiry that work within the culture of a group of people, where the focus can be on language, values, behaviors, and so on, of the group of people and how these develop and give clues about what is going on in the culture (Mayan, 2009). The end result of ethnography is an attempt to describe the culture of a given group as the individuals in the group see it. This is the emic view: How individuals within a culture (as opposed to outside of it) describe and construct meaning about cultural norms and behavior (Mayan, 2009). “An ethnography might appear as a thick description of a group’s social

or cultural setting. The goal in traditional ethnography is to make the culture intelligible and comprehensible to others” (Mayan, 2009, p. 38). Critical ethnography is the theoretical position that I specifically combine with the method of focused ethnography as “it promotes and encourages questioning of taken-for-granted assumptions. Critical ethnography requires us to link participants’ experiences to broader structures of social power and control and explain how these structures reinforce existing social images of our participants” (Mayan, 2009, p. 39).

“Focused ethnography is a more targeted form of ethnography and is led by a specific research question, conducted within a particular context or organization among a small group of people to inform decision-making regarding a distinct problem. Compared to traditional ethnography, it is more time limited” (Mayan, 2009 p.39). In this section, I break down and outline my method, looking through the critical lens within the focused context of pediatric integrative medicine.

The usefulness of ethnography, either as the sole research approach or as an adjunct to others, is increasingly recognized within the field of healthcare research and applied to practical concerns that have been identified by policy-makers, managers, or practitioners (Dixon-Woods, 2003). Ethnography is especially suited to advancing the cause of qualitative inquiry within healthcare research. Its particular strengths, such as its attention to context while giving voice to individual experience, provide a counter for the totalizing tendencies of evidence-based practice customary with experimental research in the conventional health care system (Savage, 2006).

I draw on the theoretical position of critical ethnography because ethnographers are concerned with gaining the perspectives of numerous and differently positioned individuals, giving attention to questions of power, inequality, and how some voices are heard above others (Savage, 2006). Critical ethnography generally aims to speak on behalf of research participants, with a view to lending more authority to their voice (Thomas, 1993, as cited in Savage, 2006).

By adding the voices of CAM practitioners and administrators into the evolving health care system, different constructs of health can be taken into account; therefore, relationship dynamics can begin to accommodate different professional perspectives that could potentially better serve the health care system as a whole, rather than specific subgroups. To engage participants in the construction of meaning, a reflexive dialogue process will be employed (Jones, 2001). People can construct worlds together or against each other, and what are viewed as good or bad interactions can be seen as a function of how well different actors interpret and present phenomena through their constructions, which in turn need to be understood in terms of who (or what) benefits from them (Koehn et al., 2011). Since everyone agrees that there should be benefit to the patient, ultimately this becomes the common ground among these different actors in their attempt to create an integrated health care context.

Power, privilege, funding, space, and language all play subtle but powerful roles in determining CAM availability; affordability and access to CAM services; information and attitudes about CAM; and consequently, patient outcomes. We know that CAM is used by a large proportion of the population, including children and adolescents (Vohra & Cohen, 2007). We also know that integrating these services is becoming more and more commonplace within North American Hospitals (Vohra & Cohen, 2007). So why have the perspectives of CAM providers not been thoroughly addressed in the pediatric health care literature? It is, after all, their services that are being integrated. Additionally, considering that hospital administrators hold much of the power, space, and decision-making privileges within the conventional health care system, why have their perspectives not been explored?

Traditional ethnography speaks about the participants' environment and asks, 'What is,' whereas, critical ethnography speaks on the behalf of the participants by stating, 'Why this is and

what can be done about it' (Cook, 2005). As such, critical ethnography studies culture to change it. As Carspecken (1996) stated, "Criticalists find contemporary society to be unfair, unequal, and both subtly and overtly oppressive for many people. We do not like it and we want to change it" (p. 7). Critical ethnography challenges the status quo and the dominant powers in society...critical ethnographic research can provide an avenue for meaningful health promotion practice (Cook, 2005).

Considering the voices of physicians, conventional health care providers, patients and their families are crucial to building health care services that serve the public in an effective and meaningful way. However, by taking a closer critical look at the perspectives of other stakeholders, and allowing fair consideration, we can begin to adjust the status quo of the current health care culture and construct a system which benefits and serves the needs of its users in a more effective and meaningful way. Perhaps the increasing use of CAM by the public is pointing to an avenue of health care practice in which CAM practitioners have more say in our current health care system. The critical lens, therefore, lends itself to investigating the divergent ideologies behind conventional health care versus the complementary and alternative health care approaches. Challenging the current hierarchical system upon which health care is predicated could perhaps move us towards a more constructive, cooperative system.

Focused ethnography is an applied research methodology that has been widely used in the investigation of fields specific to contemporary society, which is socially and culturally highly differentiated and fragmented (Knoblauch, 2005). It is particularly useful in evaluating or eliciting information on a special topic or shared experience (Richards & Morse, 2007). Focused ethnography has emerged as a promising method for applying ethnography to focus on a distinct issue or shared experience in cultures or sub-cultures in specific settings, rather than throughout

entire communities (Knoblauch, 2005). The approach targets shared features of individuals in specific groups, so that the researcher can focus on common behaviors and experiences (Richards & Morse, 2007). Because of its nature, focused ethnography allows the researcher to better understand the complexities surrounding issues from the participants' perspectives (*emic view*) while bringing the outsider's framework to the study (*etic view*) (Roper & Shapira, 2000).

Focused ethnographies tend to have pre-selected topics of inquiry, use interview topics that are highly structured around the issues, and either limit or remove participant observation (Higginbottom, 2011). The data collection method focuses directly on the research questions; however, it does allow for some digressions and open discussion of related subject matter. In this study, participant observations within a pediatric setting are not included. One goal of focused ethnography is to acquire the background knowledge necessary to perform the activities in question. Thus, it still addresses the emic perspective of the insiders' point of view, yet in a very specific sense with respect to certain situations, activities, and actions. Knoblauch (2005) noted an increasing interest in the use of focused ethnographies among those whose focus of study is limited to small elements of society (Cruz & Higginbottom, 2013).

Pediatric integrative medicine and CAM use among pediatric patients remains a relatively small area within the health care system as well as an unexplored topic within health care research. The main features of focused ethnographies as described by Muecke (1994) are as follows: (a) Based on conceptual orientation of a single researcher; (b) Focus on a discrete community or organizational social phenomena; (c) Problem-focused and context-specific; (d) Involvement of a limited number of participants; (e) Episodic participation observation; (f) Participants usually hold specific knowledge; and (g) Used in academia as well as for development in healthcare services. The focused ethnography approach offers much in way of

the “how,” and critical ethnography offers a way to explore some of the “whys.” In combination, I take on a critical focused approach to deeply explore considerations for implementing a pediatric integrative service by focusing on a specific area of health care, pediatric integrative medicine.

Recruitment

This study informs another trial at the University of Alberta. The pediatric integrative medicine (PIM) trial involves offering CAM therapies (massage therapy, reiki, and acupuncture) to inpatients in pediatric oncology and general pediatrics through a consult service called the pediatric integrative medicine (PIM) service at the Stollery Children’s Hospital, Edmonton, Alberta. The purpose of the PIM study is to evaluate several complementary services to determine if a PIM service is effective in reducing pain, nausea/vomiting, and/or anxiety, in hospitalized children when compared to conventional care. The PIM study will also evaluate cost-effectiveness and safety, and include qualitative research to allow for in-depth exploration of parent satisfaction, decision-making, and health care provider satisfaction. This study will inform and supplement the information gathered in the larger PIM study by providing the otherwise unexplored opinions and perspectives of the various CAM practitioners and hospital administrators regarding integrative services at the Stollery. Note as part of the PIM study, the researcher conducted qualitative interviews of senior hospital staff to identify potential challenges that the PIM trial may face.

CAM providers and administrators involved in the PIM trial, who work in affiliation with the hospital, or who are affiliated with the University of Alberta’s Hospital and the Complementary and Alternative Research and Education (CARE) program, are included. A letter of invitation via email was used (Appendix A) to recruit CAM and administrative participants.

Study information, consent and contact information were given to the participants prior to the interviews (Appendices B and C).

Sampling

Convenience Sampling. Due to my previous involvement with the PIM trial at the University of Alberta, I gained access to the participants as a professional research assistant at the CARE program. My study was introduced to participants by the leading researcher/physician of the trial. After inviting all CAM practitioners who attended the PIM trial meeting to provide contact information to learn more about the study, most were willing to be contacted for an interview. Even though my selection was based on a convenience sample, that sample was highly representative of the specific population of interest for this study, CAM practitioners. Selection criteria for CAM practitioners included CAM professionals who work in the community and have experience treating children and families. Many CAM practitioners have dual- or multi-designations; however, they were considered for this study if they were registered in one of the following professions: acupuncture, massage, reiki, or music therapy.

Administrators were selected via a convenience sampling procedure for an independent research project done by the researcher prior to this study. Criteria included administrators who work for the Stollery Children's Hospital. These participants' contact information was available through Dr. Sunita Vohra, at the CARE program at the University of Alberta, of which the researcher was an employee and prospective student at the time.

Both samples were taken at a time when the researcher had the opportunity to interview specific sets of participants and subsequently address a specific research question and gaps in the health care literature specific to pediatric use of CAM and IM in children's hospitals.

Participants

Qualified survey participants included CAM practitioners who had provided services in the community or in a clinical setting to children and families in acupuncture, massage therapy, music therapy, or reiki. Also included were senior administrative participants who worked at the Stollery Children's Hospital and the University of Alberta. Some administrative participants also had professional backgrounds related to their work in the conventional health care system, such as physicians and nurses.

Most CAM participants have experience within conventional health care environments, such as hospitals. However, most of the health-care work has been with adults, such as in palliative care. Furthermore, CAM participants have very little to no experience with chronically ill children in the hospital environment. Most have experience with children in their private clinical practices in the community, treating their pediatric patients for various health conditions such as earaches, digestive issues, as well as chronic conditions including cancer, mental health issues, and so forth.

None of the administrators recruited for this study had any direct professional experience working with a CAM therapy. They were aware that currently some of their patients were using CAM, but they had not been involved in the CAM therapies as part of usual treatment in hospital. However, three out of the four administrators reported to have personal experiences with CAM therapies and disclosed stories about patients they know of or personal accounts with CAM.

CAM therapies include a broad range of modalities; therefore, CAM practitioners who practiced forms of CAM other than what is listed were not included in this study. As well, CAM and administrative professionals who did not work at the Stollery Children's Hospital or who

were not affiliated through the CARE program, or the with PIM trial, were not included. This selection process insured a timely and convenient recruitment and scheduling process.

Data Collection

Qualitative semi-structured interviews were conducted with 14 participants, either CAM practitioners or administrators. I used interview scripts (Appendices D and E) as is customary with the semi-structured interview method. I also used clarifying questions and probes during the interview to gain content saturation.

Data Analysis

A qualitative comparative content analysis of 14 interviews by CAM practitioners and children's hospital administrators was completed. I coded and organized the data for general categories. Specifically, "latent content analysis is the process of identifying, coding, and categorizing the primary patterns in the data. The researcher examines the meanings of specific passages within the data and determines appropriate categories within a specific context" (Mayan, 2009, p. 94). I explored the data for experiences, attitudes, ideas, insights, and essentially the considerations regarding the integration of CAM into pediatric hospitals. First, however, it was necessary to transcribe, read, re-read, highlight, code, organize, summarize, and categorize the data. Only then was it appropriate to theorize how the categories from the perspectives of CAM practitioners and administrators were related to the big picture of IM. "To form themes, the researcher returns to the 'big-picture' level and determines how the categories are related. Through the categories and then the themes, the researcher can make overall conclusions about the research" (Mayan, 2009, p. 97). Themes were discussed through a critical theoretical perspective employing the method of a focused ethnography to answer the research question, as well as discuss implications for future research.

Chapter 4

Results

CAM Practitioners' and Administrators' Attitudes, Experiences, and Expectations of CAM

Varied attitudes and levels of experience, interactions, and communication. CAM practitioners show a commitment to chronically ill children despite varied attitudes and levels of experience and communication with conventional health care providers. In general, CAM practitioners have more experience working within the conventional health care system than administrators do with CAM. As a result, CAM practitioners also have more experience working with children who use CAM. Both groups have direct or indirect personal experiences of CAM. Additionally, both CAM practitioners and administrators agree that there are differences between children and adult patients in their physical, emotional, psychological, and cognitive development. Despite differing levels of experience among the participants, there is an understanding and acceptance that pediatrics needs to be a separate and respected space, and not under the same system as adults, especially when it comes to CAM use.

There are mixed attitudes about CAM by conventional health care providers, according to the CAM practitioners. Many CAM participants described the attitudes of health care professionals as “curious,” “interested,” “accepting,” “really good,” “appreciative,” and “open and on board.” However, participants also have experiences with conventional health care professionals that they describe as very “skeptical,” “not ready for CAM,” “impatient,” “resistant,” or “completely closed off to CAM.” Administrators agree that “some staff are either very positive about the therapies or don’t believe in them...they might inadvertently undermine the study or oversell it. It could go both ways depending on the staff bias” (Administrative Participant 1, 2012). Most participants agree that there is a wide variety of attitudes and opinions

among conventional health care providers; some like to experience CAM for themselves and recommend it to their patients, while other providers have a cautious or negative opinion of CAM. “I mean we’ve got pockets of people who would be huge proponents, very receptive to it. But I know that we would have some physicians, staff...they don’t believe in it” (Administrative Participant 1, 2012). “I’m recognizing that some people may have their own prejudices against CAM. They may have experienced families that have lost their life-savings or used something that really was harmful and that will colour how they see us” (CAM Participant 1, 2013).

An interesting point that several CAM participants make is that attitudes are affected positively if the CAM provider has an affiliation or association with an already respected member of the conventional system, such a physician, researcher, or other highly regarded health care professional or stakeholder. The CAM service in this case is not the basis for having a positive attitude, but who the provider is. Therefore, if a CAM provider is associated with a highly esteemed conventional health care practitioner, then they themselves are more likely to be regarded with respect among other conventional health care providers.

Administrators recall many anecdotes of their experience with CAM throughout the interviews in the context of the PIM trial and integration in general. These anecdotal accounts are equally positive and negative experiences of CAM.

These practices have been around for hundreds of thousands of years so there must be a reason for that...we can’t always explain everything. I think that we need to study them to be clear and that’s the nice thing about being involved in something like this. We are able to look at it a little more objectively and form a base of evidence and either prove or disprove, or support or not support their use, in very particular conditions rather than going on anecdotes. (Administrative Participant 2, 2012)

Even though there are many stories of negative, controversial, and sometimes regrettable incidents of CAM use by the administrators, participants remain open to learning more about CAM, and generally hold positive attitudes and expectations regarding CAM use. “I think it’s positive for the reputation of the Stollery to have a sort of openness to trying things that maybe aren’t standard of care everywhere” (Administrative Participant 1, 2012).

Previous experiences of CAM shape attitudes about CAM use; some people will be open to trying new approaches to health, while others will be highly skeptical and consider CAM ineffective or unsafe. Because of this, there is some anxiety and hesitation the CAM participants express about being involved in a hospital trial. “The idea of the trial is absolutely thrilling...it’s something that you can’t pass up. No way. No way. Even if it is something that scares the pants off me, I’m going to do it” (CAM Participant 6, 2013).

While CAM practitioners have considerable experience in the conventional health care system or in their private practices with pediatric patients who are receiving adjunct treatments by the conventional health care system, administrators have little experience of CAM use among adult or pediatric patients within the conventional health care system. CAM practitioners also have more direct experience and involvement within the conventional system. This includes direct contact and interaction with health care professionals and patients. However, most CAM practitioners do not have experience specifically in children’s hospitals, with severely chronically ill children. Despite whether experiences and attitudes about CAM are direct or indirect, negative or positive, both CAM practitioners and administrators agree that the conventional health care system is changing. More specifically, it is adapting to the increasing demand for CAM. “The evolving nature of health care...the evolution of what we want to be well for longer, we’re living longer, and [want] to be treated more holistically...I don’t want just

a pill, I want something different” (CAM Participant 4, 2013). One thing that does not change, however, is that these health care professionals prioritize their patients’ wellbeing and are committed to improving the health care system in order to provide better care.

So across Canada, it’s my understanding that in the children’s hospitals this isn’t happening yet, but in the US there are services that they’ve developed. So it’s nice to be sort of leading the way in this as well, because I think there are so many things that we can be doing better and that we’re not able to manage well, especially for chronic patients. (Administrative Participant 2, 2012)

Participants discuss varied levels experiences with CAM within the conventional health care environment; as a result, interprofessional communication and interaction also varies. Depending on their level of experience within a hospital and relationships with conventional providers, CAM practitioners report a range of communication and interaction experiences with conventional health care providers. Communication can be indirect, direct, or none at all regarding patient care and treatment. Most CAM practitioners, however, state that communication and interactions when they do happen are “positive,” “very good,” “awesome,” “respectful and trusting,” and “comfortable” with the physicians and staff.

My connections [are] very good...I always see the patients by referral...I have communication with [conventional health care providers] and I can get all the charts and then talk about the information...[with] the family GP or the family...I think we should always communicate, whether we treat with the doctor who’s taking care [of the patient; even] if we don’t have a chance to communicate, then we should explain to them what we think is happening, and then...follow a plan together to see what is wrong with the patient...working together towards wellbeing. (CAM Participant 8, 2013)

Some CAM practitioners have gained experience and relationships through long years of working within a hospital or with conventional practitioners.

Having CAM providers ongoing in this work, it would really come back to again this skill of the clinician...The ability to really communicate, and negotiate, and navigate, and fit the modality into the flow of care in a way that's seen as helpful, that's seen as respectful. I think a lot of that would be relationships, professional relationships. I think if the care of the patient always has to be central...the vision for integrating the CAM modalities would be because it is beneficial to the child, and the family. (CAM Participant 9, 2013)

If CAM practitioners work in a hospital setting, or often come into the hospital to consult with patients, the staff becomes familiar with the CAM practitioner and they have more direct contact and more opportunity to build relationships. This is true, even if not all communications and interactions are always direct.

Word of mouth travels fast with nursing, especially if you're walking into an environment where everybody is already accepting and positive of it, so you sort of adopt that... So there is a level of understanding between us that we have developed... Interaction will depend on [the] relationship...that will be important in the longer term, with the integration of all of it...I'm very integrated with the team that way. (CAM Participant 5, 2013)

If the CAM provider is working out of a private clinic, and has had no direct or indirect contact with conventional health care professionals, the communication and interaction is described to be "none," or "very little," "brief," "shallow," or "nondescript." CAM practitioners mostly speak specifically to physician contact, such as in the case for

the following participant. “Zero and not for a lack of trying...I’ve tried lots. I’ve been practicing for 15 years now...nearly impossible. Letters, phone calls, whatever, nothing...I don’t know what I’m supposed to do” (CAM Participant 10, 2013).

CAM practitioners are also concerned that patients are not communicating with their conventional health care providers about CAM use, or that patients may have negative experiences in general when trying to talk to their health care providers. “They get a referral note and that’s the extent of the communication” (CAM Participant 4, 2013).

We have no communication because they are not interested...There should be a lot more. I would always have to initiate [communication], every time...which is unfortunate but it also has to do with the system, and the time...Patients have to be their own advocate...I’m a patient advocate. And I think in this environment, at the hospital environment, I’m going to be a patient advocate. Often times I don’t think patients understand or know about all the different options they have...there needs to be more accessibility...and communication...it’s very important, what I find here is that people are really beaten down, they don’t know where to go, even the cancer patients I treat, I treat a lot of cancer patients, they are so sick and tired of the doctor coming in for 5 minutes and not even saying anything and writing in a chart and leaving. All they [the patients] want to do is have a bloody conversation...they just want to be made to feel better. Even if it’s verbally...they are all deflated. Every patient I see is deflated. (CAM Participant 9, 2013)

Patient charts, letters of correspondence/reference, email, and phone calls are the most common indirect ways that the CAM practitioners communicated with the conventional health care providers. Seldom do CAM practitioners communicate more with conventional health care

providers in person. A few CAM practitioners, who already have regular contact with the conventional system, attend rounds, interdisciplinary meetings, or conferences about specific patients. “Client charts and charting can be a great tool for communication...also been part of interdisciplinary team meetings” (CAM Participant 1, 2013). “I always work together with the doctors...I find it very, very important from the beginning to work together with the doctor and so...I never do anything without the consent from the doctor” (CAM Participant 2, 2013).

There is some communication through the patient, as patients are asked by their CAM providers for referrals of copies of blood work, or to simply talk to their doctor about the CAM services they are receiving. Speaking directly to nursing staff or physicians...when I have very limited time...rather than checking anything, I’d just ask the nurses...they always know. (CAM Participant 3, 2013)

Furthermore, CAM practitioners need to be able to define and articulate what they do, what their modality entails, and what patients can expect as far as results. They need to do this with the medical team, the patients and families, and among other CAM practitioners. Adapting professional language can be a challenge, and this is what CAM professionals state is necessary in order to be successful in an integrated system.

Finding a way to communicate in a language that would be understood...you may be coming (from) very different philosophies...Finding a way to explain the potential in a way that you can be having the same conversation together...What is your role? What can you offer? What can you bring? You have to get in there and find out how to speak to them, what kind of language did they need to hear to understand what it is that [CAM] therapy is...I think communication would be a big challenge for the new CAM providers, if they haven’t worked in the setting. (CAM Participant 7, 2013)

Communication is really challenging because we'll have a lot of certain terminology that is different, so language is totally different...we diagnose the whole [person], whole diagnostic medicine...We'll come with our different languages and different understandings...certainly we know that Western Medicine is a technical language.

(CAM Participant 3, 2013)

In order to integrate CAM and a PIM service into the conventional health care system, CAM practitioners report that maintaining a consistently open mind and open dialogue will be key. "An open mind, and a willingness to communicate and maybe go outside of your comfort zone...to be open to having conversations... Because we are all there with the same intention" (CAM Participant 6, 2013).

Open mind, open mind, open mind. We [are] on the healing...end; it's up to the patient. Not to us. Doesn't matter what we do if the patient doesn't want to heal. So we have to work together to make it easy for the person if they want to heal...There should be a kind of conversation when we accept each other that both are grateful to learn from each other because then we can bring it to the benefit to the patient. It's all about the patients, not us, or how important we are...how powerful, or what position...So accept each other. (CAM Participant 2, 2013)

Different expectations for different CAM modalities. CAM practitioners hope and expect CAM therapies to be effective and well received, as well as improve quality of life for patients in the hospital. CAM practitioners identify expectations for specific modalities as being effective for specific conditions and symptoms. CAM practitioners express that their expectations are based on research or clinical experience. "My opinions [are] based on research"

(CAM Participant 7, 2013). So they expect that acupuncture and reiki will be more successful for specific symptoms while music therapy and massage may be effective for anxiety, for example.

Acupuncture is phenomenal for controlling nausea. Phenomenal...It's also excellent for pain...and anxiety as well...[because it] is just one of the quickest most effective ways to turn down the sympathetic nervous system. (CAM Participant 6, 2013)

Anxiety can really be linked in with the physical symptoms...different symptoms are connected, like pain, anxiety, if you can cut in and break through one, then you can maybe help affect the other. (CAM Participant 7, 2013)

CAM practitioners express that different CAM modalities can provide different levels of care. CAM modalities are very different from each other in what they can provide as far as results for patients. "I don't like that we are all clumped together" (CAM Participant 9, 2013). However, CAM practitioners admit that "There is a lot of overlap" (CAM Participants 5, 6, & 9, 2013) between modalities and among their effects.

CAM practitioners identify that unrealistic or misguided expectations can be a challenge for the patients and families. "Their expectations may be more than what a complementary therapist really can do...That's a challenge for the parents to understand the limitations and also a challenge for the CAM practitioner" (CAM Participant 5, 2013).

Hopefully, parents' biases don't get imposed on the children...I think that will happen depending on the age anyway...but their families are such a huge integral part of the children's experience and [they] colour their choices, what they're going to trust and that isn't just for CAM therapists, it's for anybody who walks into that room. (CAM Participant 10, 2013)

According to several CAM practitioners, the concept of CAM, or the idea of an unconventional treatment in the hospital may be a challenge. “Parents may not know about what we are doing” (CAM Participant 7, 2013). “Conceptually, they may or may not be open to thinking outside of what they’ve already experienced” (CAM Participant 6, 2013). CAM practitioners see “getting over those barriers to allow someone that practices medicine they don’t understand” (CAM Participant 6, 2013) as a challenge for patients and families. “I think accepting something that they don’t know or they aren’t familiar with: The unknown. I think it’s going to be a major challenge actually. So I think that the challenge for them is to be able to ask the questions of the right person to get answers that they want so they can make an informed decision” (CAM Participant 7, 2013).

Considerations for a PIM Service, According to CAM Practitioners and Administrators

Skepticism and resistance to change. Introducing change can present challenges, especially when introducing change to a well-established system or institution. CAM is something relatively new and therefore it will be in the spotlight initially as understanding and comfort with it grows. “If you introduce any new thing into the university level or teachings, every department is watching and seeing what you are doing...they will be watching and observing at how effective this PIM program is running” (CAM Participant 8, 2013).

One of the first major considerations is how to overcome the resistance to change, in order to integrate a different approach to health care. There are many considerations and stakeholders involved, and participants expect that there may be a lot of resistance to integrating CAM into a pediatric hospital. “You will run into people who are totally against it...it will not work on people who are closed up [to] it anyway...people are fearful of new things at first”

(CAM Participant 2, 2013). CAM practitioners see challenges in the initial stages of fitting in and among the already established professions.

I think what's going to be a big challenge for me is figuring out how to go in as a practitioner and make sure I'm getting all the information that I need to get without stepping on someone's toes in a sense...because I like to work a certain way, in a way that I think is most effective, and I know that I'm going to have to change that, or adapt to it to a certain degree out of respect for other peoples' knowledge and professions. (CAM Participant 9, 2013)

Administrators of children's hospitals are concerned that there will be resistance to change and that will make it more difficult to implement CAM and offer it as a consistent service in the hospital.

It would be something of a culture shift of the Stollery so you would have to do the work to demonstrate to the people who don't really embrace change in the same way, to say that there's potential for some new services, and to use them, to actually use them, and offer...them. (Administrative Participant 1, 2012)

CAM practitioners state that they feel anxious about entering a hospital environment. They experience a fear of "coming up against resistance from the staff, but also from the families...you just come up against a stone wall of opposition...This is a new environment and new world completely" (CAM Participant 6, 2013).

Gaining knowledge and experience with CAM. CAM practitioners recognize that their involvement in the PIM trial and in the hospital in general promotes further study in the field of integrative health and medicine, and this is one of the ultimate benefits and goals. Therefore, participants are willing to deal with some of the challenges they may face in order to move

towards a more holistic and integrated health care environment: “Further research or further exploration of bringing these kinds of modalities to people in active care” (CAM Participant 6, 2013), as well as bringing recognition for CAM modalities and “getting respect” (CAM Participant 10, 2013). “To make medicine integrated, to become more holistic, to become more preventative, a more natural approach and [a] benefit for [CAM] health care providers...to understand the Western health care system” (CAM Participant 8, 2013). It is considered a benefit for the CAM providers to gain the knowledge, experience, and exposure in a hospital environment according to CAM practitioners: to “familiarize myself with the hospital environment” (CAM Participant 5, 2013). “It creates avenues, opportunities for your professional expansion, opportunities for...professional growth and development, to learn stuff beyond what we expect...huge exposure” (CAM Participant 4, 2013) as well as “staying on current research” (CAM Participant 7, 2013). Learning was an important benefit of IM for CAM practitioners. “The benefit is that you have a steep learning curve...that you get paid for, to be humbled, and to have access to...many different expertise...you’re contributing to the science that will be the basis of other people’s experiments” (CAM Participant 8, 2013).

Gaining knowledge and an understanding of CAM promotes education, opportunities for working together, and integration of the team. As much as the level of knowledge, education, and buy-in were considered an initial challenge, CAM practitioners also see these as opportunities for professional development. In many cases, it’s a “double-edged sword for everything” (CAM Participant 4, 2013). What is considered a challenge at first is often discussed later as a potential benefit.

A different perspective, more knowledge in an area where they...get to see a different approach and the benefits of such an approach in term of integrating it into the

system...and a certain comfort level with allowing someone outside of Western medicine into the environment...to new concepts...fill a lot of gaps for these providers that they maybe didn't realize were there until they saw them get filled...that there is something more. (CAM Participant 6, 2013)

CAM practitioners anticipate that there may be some conventional health care staff that may not be open to gaining education or knowledge about CAM, or may not receive CAM practitioners well in the hospital environment. "Of course the staff have their own techniques and their own training in how to be compassionate, but they may like to have some other options" (CAM Participant 5, 2013), "[a]nd offering options to people [to] improve their quality of life, quality of care" (CAM Participant 10, 2013). However, "To understand what the different therapies, the modalities, treatments...what they can do or not do because sometimes even in the literature it's not always explained well" (CAM Participant 1, 2013). "I think educating ourselves...it's an important part, and not everyone sees it like that, maybe some doctors feel like: 'Ok, I know my medicine, that is all I need to know'" (CAM Participant 7, 2013). Therefore, participants express that it is important "for doctors to have their own stuff challenged, too" (CAM Participant 7, 2013). Participants express that there may be the initial lack of knowledge and education about CAM, and even perhaps a possible unwillingness to learn about CAM, "in the communication of it, the buy-in, at the very initial stages of it might be where the majority of the challenge sits" (CAM Participant 5, 2013). There may be a lack of "buy-in...having them understand...the scope of what CAM providers can offer, and then finding a way for it to fit in with the regular flow of the workday" (CAM Participant 5, 2013). "I think the challenge for Western medicine is going to be their lack of understanding or desire to

understand what it is that we do...for them to really understand what [CAM] is all about and what we do” (CAM Participant 9, 2013).

I think it’s going to be a challenge for allied health professionals and doctors to really look outside the box, and think about things in terms of “you know what, whether I believe it or not, if it works and it makes the patient feel better...great! Then go for it.” (CAM Participant 9, 2013)

CAM practitioners concur that as far as conventional practices are concerned and evidence-based medicine, it basically comes down to, “You don’t promote what you don’t understand” (CAM Participant 9, 2013). CAM providers expect it could be difficult for staff and physicians “to be able to step back and give space for the CAM provider to do their thing” (CAM Participant 6, 2013), and become comfortable with the CAM practitioner working alongside them, looking after their patients. Additionally, conventional practitioners may also be “shut down to the possibility that [CAM] may be effective” (CAM Participant 9, 2013). “The only challenge I see is that the staff knows what we are doing and accepts it; we have to tolerate and accept each other” (CAM Participant 2, 2013). “When you know that you’re well received, then you can come in with a certain confidence, but when you go in...you’re stepping into their world” (CAM Participant 3, 2013).

It is a challenge to move past the uncomfortable, the unfamiliar, and, in this case, get to know the practitioner instead of allowing past experiences influence what you see. I think they would have a hard time gaining a comfort level as to competencies for CAM providers...if I was a conventional medical provider...that would be my concern. (CAM Participant 10, 2013)

Some CAM practitioners suggest that one way for conventional health care professionals to build understanding and a comfort level about CAM is that “They should experience the techniques...that would be some way to build some understanding around it, and comfort around it” (CAM Participant 4, 2013). Another way one CAM practitioner suggested to increase comfort with CAM is to use CAM for self-care.

To learn self-care practices, not only to offer it to their clients but for themselves because if you're not about to take care of yourself, you're not able to handle those situations...Everyone who's less stressed out can cooperate and communicate with each other more effectively...Self-care for everybody would generally be beneficial. (CAM Participant 1, 2013)

Administrators admit that so far there is little understanding or appreciation about CAM and integration in general. From their perspective, they can appreciate that CAM can attend to a more holistic approach to health; yet, there currently exists a difference between the two systems and how they approach patient care. Administrators agree that a benefit for the CAM practitioners is to gain exposure and experience in the conventional environment, and “having the opportunity to sort of see a new aspect of health care. I mean it's just learning, ongoing professional development, really 'cause they're learning about something that's new” (Administrative Participant 2, 2012). “I think some of the exposure to the types of range of medical and nursing and allied health treatments and services may be education as well for CAM providers who don't have a health care background” (Administrative Participant 3, 2012).

In health care because most of us have a science background and there's maybe some healthy skepticism around the effectiveness and the treatments...mostly people are educated in the physical health or in the mental health and usually not strongly in both.

And the nice thing about complementary therapies is that in a sense is that they are addressing both. You get the physical effect, which we know is very linked, yet we don't treat them that way. (Administrative Participant 1, 2012)

CAM participants speak about the many learning opportunities for parents as well. Some CAM skills can be taught to the parents that they can use with their children. "I'll always involve the parents in education and I'll teach them a few things to do with their kids every night" (CAM Participant 7, 2013). "Teaching and letting them provide some of the care...parents do want to be involved" (CAM Participant 3, 2013). CAM practitioners express that they hope that children and families will see the benefits of CAM and continue with CAM post-discharge. "Especially with children, they'll walk into their futures and they'll already know...Passing it on to their families" (CAM Participant 8, 2013). "It exposes all these young children to another version of medicine" (CAM Participant 6, 2013).

Additionally, education, exposure, and having a choice of CAM therapies are ways for children and families to gain some of the power and control back over what happens to them in the hospital. "Just having a choice...that provides that sense of control...the benefit of just having the control...I think having a choice can reduce anxiety but not knowing what is going to happen can increase it" (CAM Participant 7, 2013).

Administrators agree that CAM provides patients and families with options that may help with symptoms and an overall better quality of life that conventional treatment may not.

A feeling of more control, that they're, instead of...I think, in general, a lot of people like the idea of CAM therapies; and, you know, that they'll have the idea that they're using more natural therapies to treat [the] child's illness rather than all the medicines that we traditionally give. (Administrative Participant 4, 2012)

That they'd actually be receiving good care again, less intrusive than our traditional medicine. It gives the parents some choice...One of the things that parents say is that they lack control with treatment, and it gives them a bit more control over the child's experiencing, so I think that's a good thing. (Administrative Participant 1, 2012)

Hospital administrators agree with the CAM practitioners that education and exposing patients and families to CAM as options is beneficial by providing them with tools that they can take home and use on their own.

Some of the [CAM] practitioners...said that...they can help parents learn some of the techniques. So that's the other thing that families can maybe observe and participate in, and that way can maybe add a few things that they can try at home that have been effective for their child in the hospital. (Administrative Participant 3, 2012)

Opposing health care ideologies. CAM practitioners state that if the person is supported in the right ways, physically, emotionally, mentally, and so forth, they will be more equipped to assist in their own healing process. This points to an opposing ideological stance to conventional medicine, and is seen as a potential challenge in how CAM is viewed, applied, and potentially integrated into a hospital environment.

We [are] working with the physical, emotional, mental, and spiritual level of the body and only when all four are balanced and in harmony, their own healing mechanism can kick in...It promotes process...It boosts the immune system and other body systems. (CAM Participant 2, 2013)

I have the ability to view things from both paradigms, Western and Eastern paradigms. I certainly have a lot more Western medicine, and Eastern medicine is a lifelong pursuit, but I think my knowledge of Western medicine, and how I can help a patient understand

what Eastern medicine is going to do from a Western medicine perspective. (CAM Participant 9, 2013)

The philosophy about most CAM therapies is that the body has an innate wisdom to heal. And so what we're doing through our therapies is creating an environment that the body will take and then run with it and do what it has to do. So we're less about fixing the problem than just supporting the person in creating their own healing process.

(CAM Participant 4, 2013)

The distinct differences in ideologies, priorities, and orientations with regards to health can be vast and they shape the way professionals, CAM or conventional, view their patients. We are striving towards an integrated medical system within an existing medical system. Therefore, we need to view patients in a way that reflects this goal, as integrated, whole beings. This is what the following CAM practitioner points to as a consideration in implementing a PIM service. "I think medicine should not have divisions" (CAM Participant 8, 2013).

The conventional health care ideology focuses on evidence-based practice, and a more physical, biological, and chemical approach to health. "The holistic piece is often missed when we start measuring each individual component" (CAM Participant 5, 2013). "I don't mind thinking in scientific terms, I don't mind overlapping ideas...with science or intersecting them" (CAM Participant 10, 2013). However, "The way that I practice is based on not symptoms, treating based on the whole body, which tends to be way more effective when you're treating anybody for anything" (CAM Participant 9, 2013).

I want their experience while they're here to be a little more whole. Because I think conventional medicine can be very fragmented...it's this body part, and this tissue, and that diagnostic test, and this blood result, so I think it disembodies them, almost. I'm

hoping the techniques we use bring them back to their wholeness. (CAM Participant 4, 2013)

CAM is process-oriented and self-guided; its ideology is holistic, sensitive, prioritizing the connection to patients, accepting that mind, body, and spirit work together for overall wellbeing and health.

[CAM] does not shy away from using esoteric terms to explain symptomology or conditions. CAM appreciates the body's own natural ability to heal and CAM aligns itself with, and supports patients to allow their own healing process to occur, more naturally. CAM also values prevention and health maintenance.

Most holistic modalities or complementary therapies work on the philosophy that we're imbalanced and not balanced when we're ill...So to help balance whatever it is that needs to be balanced...homoeostasis...a little bit of assistance to help that body...our mental and emotional and spiritual being altogether and we can bring some balance there and [help the body heal itself]. (CAM Participant 9, 2013)

Even though CAM practitioners agree that in general CAM is a more holistic, they do give credit that conventional providers also appreciate other aspects of health. So the ideologies may be different, and that may translate to different applications for health care treatment. However, CAM practitioners state that, in this respect, all professionals see health in an integrated way, because whole person, or patient-centered, care is becoming the norm in the conventional health care system.

I think the holistic perspective, like the fact that our training is in whole person care, and that we have awareness and assessment and skills in working in the emotional/physical/spiritual/social/mental realms...I do see it as very integrated...I'm not the only person

that cares about the emotional well-being of these kids, of course not. The [conventional health care providers] do too. (CAM Participant 5, 2013)

CAM practitioners admit that there is anxiety around integrating CAM into the hospital, since the process is likely to be complicated. CAM practitioners are worried about how “to stay semi-autonomous within this other world” (CAM Participant 6, 2013).

I think one of the challenges is just going to be setting up a really strong coherent program that involves equal say for [CAM]. That will never happen; there will never be equal say, I don't think. And I don't know if there has to be equal say. (CAM Participant 9, 2013)

Additionally, CAM practitioners question how not to lose sight of their holistic ideology and perspective, while attempting to work alongside conventional practitioners. Integration eliminates another set of treatment options for patients within the conventional system, that really did not change much at all in the end.

That's another fear of integration, is that it will turn more into assimilation where we lose that what is special about what we do because we're trying to jam into this model...that's probably the biggest fear, of total integration...It has to be done the right way...or it will be diluted and gone. It'll change into something...it'll just change, and it'll be something else. (CAM Participant 9, 2013)

Dilutes it down to cookbook [CAM]...and that takes all of the skill and the knowledge of years of practice out of it...and that's the expectation of Western medicine...to standardize everything... “We only care about the mechanics”...It takes away from the art of the medicine. (CAM Participant 10, 2013)

Another CAM practitioner asserts that integration is not an appropriate term to be using when considering using CAM in hospitals for patients. “I feel like the challenge is going to be that they are going to see these two things as being separate when they should be looking at them as working together” (CAM Participant 9, 2013). In other words, this anxiety about losing what makes a particular CAM modality special and unique is behind much of the reservation about implementing IM into children’s hospitals.

What we call integrated medicine and I think that everybody, both conventional doctors, researchers and CAM providers, all have to get their head around the idea that we’re going to integrate [CAM] through the process of evidence-based medicine, evidence-based practice. So only what’s been demonstrated through research is what we’ll do. That looks like a great policy...we’re only going to adopt CAM as we find out the mechanisms of action...as it conforms to the way that we do double blind placebo controlled RCTs...that we do science and medicine, as it fits into plugs, into that formula, then we can integrate it and as much as it doesn’t then we don’t, and I think that you’ll never...I just don’t think it’ll ever happen...I have a low-grade apprehension around the word integrative...I think they should be using the word assimilative. “We’re going to assimilate this medicine into us, on our teams, our scientific terms, evidence-based and mechanism of action”...I think that’s what they mean, we’re going to assimilate these things because now we accept it...You’re making it part of something else, you’re not just working alongside it. (CAM Participant 10, 2013)

I think collaborative [is a better word]...integrative...doesn’t respect the reality of what’s happening or what’s not going to happen...I have a scientific mind...I know about science and I can read research and I know what physiology is...I have those bodies of

knowledge that I use actively...I don't even pretend for a second that they marry, that they fit together hand and glove or that they go together...I know when to use this body of knowledge and I know when to use that body of knowledge and sometimes those two bodies of knowledge totally and completely collide. They don't fit together at all...and maybe that's a part of the struggle, like how do you let something co-exist, and I think that...it's not about making somebody believe something you do, it's about coexisting. That's a hard thing to do in our personal lives and now we're asking people to do it in our professional sphere and I think we're going to see as much pushback as we do with people personally.... You have more emotional investments personally to certain beliefs...You know people generally tend to believe and that's why they're drawn to the hospital environment and that's just who they fit with and then you're introducing this...you better get used to Zen paradoxes...things contradict each other that you're not ever going to solve. (CAM Participant 10, 2013)

Administrators see a PIM service as a benefit to work alongside CAM practitioners to gain a better understanding and respect for CAM, and build professional relationships that ultimately benefit the patients. If the CAM practitioners worked at the hospital, that would facilitate trust in relationships with conventional providers and working with each other would therefore become more efficient.

It's nice to work, I think, alongside of the providers so that we have a better understanding of what the other person is doing...it's nice to have a service where we can work together and sort of respect what the other person is doing and make sure, making sure that at the end of the day it's in the mutual benefit of the patient. See an opportunity to develop a network of colleagues sort of as a referral base that you know will work well

with the team. So you want to be working with people who will work effectively as a team, it's better that team cares for families, so that an opportunity to build network both in and outside of the hospital...where you're developing these relationships that can stretch out but can still be trusted and worked together on a regular basis just for purely the benefit of the patient. (Administrative Participant 2, 2012)

To have a system that is truly collaborative means to have one that works more efficiently, rather than a system that consults with or works with CAM practitioners in the community who come into the hospital but are not part of usual care. This can be done by "minimizing some of these challenges...a streamlined process for how we have access and how access can be more universal" (CAM Participant 5, 2013) within the hospital environment for the patients and families. As one CAM practitioner states, "One system is lost without the other" (CAM Participant 2, 2013). "It would also change our communities" (CAM Participant 7, 2013).

There's more value added...added support and more people trying to support us in multidimensional or multivariable manners...Expanded support team, expanded...community...So I think that's a huge benefit is thinking that you have a professional health community that is behind your kids; I think a lot of people would be pretty impressed with that...I would say that most of the public views conventional medicine and then alternative medicine...one is mainlanders and one is on the island...I would say the general public loves the idea of when two things meet...there's no divide between alternative medicine and conventional medicine anymore, they're all working on the same team and they're all coordinated...as a perception, as optics for the public, the public likes the idea. So they like the idea that East and West...are working together and

the old and the new, the traditional ancient knowledge and the new science are working together, they like that idea. (CAM Participant 10, 2013)

Adapting to different professionals and health care environments. Many CAM participants work in private practice, and CAM practitioners identify many differences from the hospital environment that they need to consider, such as being adaptable, flexible, and in the flow of the hospital environment. “Because the medical system is already in flow...I think that might be a challenge with people who haven’t been used to working in such a team environment. Another challenge may be making sure you’re not getting in the way, too. Everybody has got their flow or job and space is an issue” (CAM Participant 4 2013). “I think one of the challenges is timing...we need to be fluid, and we need to flow where the need is...it’s best if the provider can be fluid” (CAM Participant 5, 2013).

Just trying to adapt because we don’t work in hospitals...orienting yourself...just the kind of interaction and reporting...I think that’s going to be a big challenge...getting used to that and fitting into that and then also their patient interaction is going to be different...also adapting to that and being able to establish a good patient dialogue and patient rapport and delivering good service in that context, which is slightly less controlled for them. (CAM Participant 10, 2013)

Such adjustments may need to be made, and the process of integration “might be a bit of trial and error” (CAM Participant 3, 2013). “And just how to navigate logistics, paperwork, [charting]” (CAM Participant 6, 2013). “I find [CAM is] very adaptable and...it’s an opportunity to maybe go down a little more deeper into that tool box to see how adaptable it can be because you’re going into an environment that is quite restrictive” (CAM Participant 3, 2013).

Additionally, the constraints and distractions of the physical space are challenges for the CAM practitioners.

To work under noise and lights and people and...the whole set up with the bed, the equipment, we won't have access to get in to that back of the head...the bed will be wider, the rails...time management thing...extra documentation...overlap of co-treating...being in a kind of a fishbowl, and there will be a lot of people that will want to see what we are doing, and I'm not used to that either, because it's usually a one-on-one experience, so...I'm hoping it won't be overly distracting. (CAM Participant 4, 2013)

CAM participants understand that there are many practical considerations regarding CAM integration. Scheduling and maneuvering in a different environment than CAM practitioners are used to can make integration difficult.

The need for all of the conventional medical...for both groups to be a little flexible...in practical terms, scheduling...and the integration of two without scheduling because...you can't schedule someone being nauseated...you can't schedule someone having an emotional release, so rather than scheduling, it's flowing, being flexible. (CAM Participant 1, 2013)

Space is also limited in the hospital and this is a challenge to introducing CAM as an adjunct service within the hospital. "Physical space would be a problem...seems like space is at a ridiculous premium" (CAM Participant 6, 2013). "We can't keep any supplies or anything on the units, or charts or anything like that...we're integrating ourselves into their world in some ways" (CAM Participant 4, 2013).

It's a process, there's going to be these pragmatic things practically speaking; how this is going to look, and I think...we're probably going to have to just plan and change things

as we go...practitioners on the front line, they're used to...being able to be fluid, which is what you need [in that] environment. (CAM Participant 7, 2013)

There are many similar considerations to implementing a PIM service that can make it challenging from the perspective of hospital administrators. One of the first of these is practical considerations; specifically, the day-to-day routines and schedules of tests and lab appointments make the coordination and timing of the CAM services challenging. Administrators subsequently note and describe these daily routines and how difficult it can be to integrate new people and services into them. "The physical space, I mean that's sort of an issue" (Administrative Participant 2, 2012). The administrators express that the introduction of a new group into the established team can be problematic, specifically regarding orientation, communication, boundaries, space, scheduling, and coordination. "It's not the therapeutic environment that you would really want. If we could design it differently we would. The environment's quite different and it'll be interesting to see how the environment supports or doesn't support [CAM] work" (Administrative Participant 1, 2012).

Children associate the hospital bed, the environment, sometimes with painful procedures, so it's not like going into a different environment, so it could be, could create some anxiety in them. Having people touch them, strangers, at least initially, like the first introduction. So it would be they actually approach the children...it is a different environment that the kids experience in the beds. It's a safe environment but not necessarily a different environment, from the child's perspective. (Administrative Participant 1, 2012)

There's a whole new administrative structure that would have to be put in place...It's a whole thing about, we're bringing a brand new entity, into the system, and so all aspects

of service, where are they going to go...just everything. (Administrative Participant 3, 2012)

When considering the hospital environment, this also includes time, routines and schedules, shared work spaces, rules, regulations, legalities, and policy, all bringing into question the appropriateness of CAM in the hospital setting altogether.

It's a brand new people, brand new service, who's going to fund them? Where would they [go]? Who would they report to? Who assesses their professional practice? As there's turnover, who hires? Fires? Who evaluates? Who provides whatever kinds of upgrading and you know professional education that is relevant to their specialties or their practice areas? Where are offices going to be for them? Who's going to schedule? Are they seeing outpatients and inpatients? Who schedules that? How do they do a rotation? Are they on call? (Administrative Participant 3, 2012)

Days can be quite busy with treatments, tests, having to go to different labs or diagnostic areas, and so depending on what's going on, on a given day, it might be difficult to say to a massage therapist, for instance, here's your window of time, and even if we have a window of time, that can change, because departments are late doing other tests, that kind of thing, some of the scheduling and coordination will be challenging. (Administrative Participant 3, 2012)

Most CAM practitioners acknowledge that the parents and families usually take an active part in their child's care while in the hospital. CAM participants rarely separate the child from the family, or at least parental influence. Families are usually comprised of more than just the parents, and there can be multiple members, all involved and invested in the child's care. "From my own experience with families, usually have more than one member and more than one

perception...so with parents, with families in general, there can be differences in beliefs and that can cause some issues” (CAM Participant 5, 2013).

There are many factors that come into play when considering the preferences of the family unit. “It depends on the age...it depends on what their background is and what their belief is” (CAM Participant 10, 2013). “Some of the challenge is going to be perception...family pressure, staff pressure...making the choice because you think you should? Or is it culturally influenced? Is it religion? Are you getting social pressure?” (CAM Participant 7, 2013). “Cultural, spiritual sort of aspects, that they may not agree with certain things...with touch, with massage, there could be issues culturally about areas that we touch and the areas that are exposed” (CAM Participant 4, 2013). It could be an issue that people are unfamiliar with CAM and “Overcoming their own kind of, either preconceptions or misgiving about different therapies, and just potentially confronting their own, whether ignorance, or...closed mindedness” (CAM Participant 3, 2013). “The way that I address it is that I’m treating both of them...it’s like I have two patients” (CAM Participant 9, 2013).

CAM practitioners consider the patient as part of a family unit and, in this way, treating pediatric patients may be different from private community treatment. From their professional perspective, the priority is the patient. However, from the holistic perspective by which many CAM practitioners practice, the child cannot be separated from their context. “I think it is definitely going to be a challenge to really get the parents to be comfortable because the kids are going to take their cues from the parents” (CAM Participant 9, 2013). CAM practitioners acknowledge that families and parents will also need to adjust to new CAM services and providers.

One of the other considerations that both CAM practitioners and administrators identify for patients and families is dealing with new practitioners in general, “just another person doing another thing to [the patient]” (CAM Participant 1, 2013). “Yet another person involved in their care” (Administrative Participants 1, 2, and 4, 2012). Participants agree that children and families are already bombarded with new people during their admission, and this can be challenging to deal with. “It’s more people on them, it’s additional providers that are poking them and prodding them, more people coming in and out and asking them questions” (CAM Participant 10, 2013). So there could be a barrier that “They may be skeptical, and just the whole idea of another person, another thing happening to [the] child” (CAM Participant 2, 2013). Participants report that due to the nature of the hospital and how many professionals a child may see in a day, it “might be a challenge, to overcome their initial fear about it...so building trust will be really important” (CAM Participant 4, 2013). “So it’s getting over that first experience to let them familiarize” (CAM Participant 5, 2013). Additionally, as the parents and families are the primary caregivers, it may be a challenge for the child and the families to see practitioners providing care that they may not be fully equipped to provide at the time, in the hospital; in particular, care and nurturing that they would usually provide for the child themselves.

So it might be a challenge for them to watch us comfort the child in a way that they can’t yet, or maybe don’t know how to yet...So I’m hoping that they will accept us to be, not taking over their role, but it’s supporting them in their own. (CAM Participant 4, 2013)

Being prepared to see suffering and chronically ill children is another factor that a few CAM practitioners discuss, especially if CAM practitioners do not have much prior experience with chronically ill children. “To see these kids as sick as they are...It’s going to be one of the

biggest challenges for me is not to be walking around the halls of the Stollery bawling my eyes out” (CAM Participant 6, 2013).

I’m not good with seeing children that are dire ill, [be]cause I haven’t been exposed to that enough to know how to personally manage what comes up from that. And I’ve never worked in a hospital environment, so I don’t know how to navigate that structure of a ward. (CAM Participant 6, 2013)

Lastly, many CAM practitioners recognize that children may be sensitive to the use of needles with the acupuncture modality, perhaps because “It’s the same word and they associate it with the same pain and experience” (CAM Participant 7, 2013). Considering how many actual needles pediatric cancer patients need to endure during their hospital stay, this may be a barrier for some patients and families in accepting a potentially beneficial treatment. It is a fact, as some CAM practitioners admit, “Sometimes healing can make people worse before they get better” (CAM Participant 4, 2013). This may be difficult for families to accept and adapt to in the conventional health care environment, that healing takes time and can be a process, at least from the CAM practitioner perspective.

Funding and the political nature of the conventional health care system. Funding is a major consideration that CAM participants identify for successful CAM integration. They admit that “If you don’t affect the bottom line and money, you’re not going to get back in there...in the end, it comes down to money” (CAM Participant 7, 2013). Participants state that for CAM to be successful in the hospital, it has to show that it is worth having it there. “[CAM] is a lot cheaper than drugs” (CAM Participant 10, 2013), but can it demonstrate cost-effectiveness?

I think cost-effectiveness would be one of the driving factors to change anything in Alberta Health Services...For people that are making policy and crunching numbers, it's going to be cost-effectiveness. (CAM Participant 6, 2013)

So long as we can, we'll make expensive choices as long as we can financially service our ideological biases we will and when we go broke then we'll look at other options...that's not a five-year thing or a ten-year, it could be a 25, it could be a 40-year, I don't know when it's going to be, but when we can no longer finance this super, super expensive system with patented medications for everything; when our frontline defense is expensive patented medications and imaging, then we might start looking at lower tech, simpler options, and frontline options...in the long term. (CAM Participant 10, 2013)

Funding is a major consideration and possible barrier to the implementation of a PIM service. The administrative participants identify that funding CAM is the main challenge in our attempts to integrate a PIM service at the Stollery. "CAM continues to be a service that is not funded by Alberta Health and Wellness and there is no other direct source of funding for these therapies" (Administrative Participant 1, 2012).

The major challenge would be funding a service, so to introduce a new program and service into the hospital, because the practitioners, because they are all non-physicians there would have to be a different stream of funding than the department of pediatrics...So funding is the driver, always for programs; and because several of these groups of providers are non-regulated at this point, that could be challenging as well. (Administrative Participant 3, 2012)

So if they can show that it's cost-effective then they're more likely to invest in it. 'Cause quite often if it's effective, if it makes patients feel better, they'll say that's nice but it's

too expensive. ‘Cause usually if it’s cost-effective, it’s also helpful. (Administrative Participant 2, 2012)

Administrators state that in order for CAM modalities to be considered appropriate treatment for pediatric cancer patients, funding and cost-effectiveness need to be demonstrated. Administrators will not fund something that physicians are not comfortable with or do not know about, or that may potentially harm patients.

Getting hospital approval I would think for administering, and also having physician comfort in being somewhat responsible for alternative therapies that aren’t necessarily proven to work. I think medically, legally you’re going to have people who are nervous about being involved in the care of somebody who’s using alternative therapies openly in a hospital setting unless of course it’s gone through multiple levels of policy.

(Administrative Participant 4, 2012)

CAM practitioners consider various challenges in dealing with the political nature of the conventional hospital environment. “I think one of the challenges for staff like administrative staff...is just...playing the political game, and in other ways, acknowledging the political game...and it’s a real thing” (CAM Participant 7, 2013).

Our stakes are again that patients are healthy and we can do whatever it takes to make that go, that’s it...I don’t deal with the politics. I would do this for free, you know what I’m saying? So if the stakes are money and politics, then that’s unfortunate; but I guess that is the way it goes in that environment...cost-effectiveness would be last on the list because...I would do it for free just to save the hospital money in order to provide the patient something. That’s not the way I make my living, that’s just the way I make money. (CAM Participant 9, 2013)

CAM practitioners state that recognizing who are key decision makers and developing rapport with them is a consideration and challenge that needs to be faced in efforts towards integrating CAM.

The opinions of the policy makers, and it's the opinions of the physicians, and even though there is a lot of good quality research showing the benefits of all these modalities...is there enough compelling evidence to change the minds of these wonderfully scientific straight-and-narrow minds? (CAM Participant 6, 2013)

Name your gatekeepers...it would be helpful going in knowing who's got buy-in, who's that person with that sympathetic ear that's got a way with their colleagues or with their environment...Who are those key stakeholders that I need to [know], so that we can all be effective? (CAM Participant 7, 2013)

Safety, Risk Management and Responsibility. CAM practitioners report that there are safety considerations when integrating with the conventional system. "The medical profession is very cautious and rightly so, worried about their patients or families being taken advantage of. Because there are people out there that have [been] disingenuous" (CAM Participant 5, 2013). However, CAM practitioners recognize that there are many potential risks and dangers of conventional treatment.

There's a lot of safety issues right now, purely with adverse stuff...they're doing chemotherapies, they're doing polypharmacy as it is; but polypharmacy on top of polypharmacy...now you're giving a sleeping pill, and you're giving an anti-anxiety pill, and you're giving something for nausea, and you're giving a stool softener...you can cross check generally drug interactions [but] polypharmacy isn't evidence-based; drugs are tested in isolation. (CAM Participant 10, 2013)

Many CAM practitioners have experience with the conventional system and treatments. And, they agree that risks exist between the two systems if there is lack of communication or misuse leading to adverse effects. However, risks also exist within the conventional system; and CAM providers present these as well as acknowledging that, in order to minimize potential risks of CAM use in a hospital setting, there needs to be a measure of standardization.

I think there should be standards between all of us practitioners but that's also very difficult to do. And the fact of the matter is, is that there are some practitioners that are part of the program that have never treated children before, which is also going to have a negative impact, potentially. (CAM Participant 9, 2013)

Establishing...some level of standardization and I don't think that CAM works well when you make everything 100% standardized...I think that so many practitioners have different ways of practicing and different ways of delivering treatments and services...variability...you treat someone for something and as they change, as their body responds to treatment, you adapt your strategy and you adapt your treatment. (CAM Participant 10, 2013)

However, compared to the safety risks that CAM practitioners see presented from conventional treatments, they do not consider physical safety of the patients as one of the biggest considerations as far as CAM integration.

I don't see patient safety as being...a big risk...there are very safe modalities compared particularly to a lot of Western treatments, right? They're a drop in the bucket compared to what these kids are probably already going through. So I don't think safety is going to be huge. (CAM Participant 6, 2013)

I think this is so safe that this is not even an issue; you have to be a pretty big idiot to harm someone with [CAM] treatment, not to mention that there are way more dangers with Western medical things than there are in Eastern. (CAM Participant 9, 2013)

Some CAM participants, however, do not view their practice as alternative or complementary the same way that conventional professionals assume they are, particularly in their level of invasiveness to the patient. Some view their modalities or other CAM therapies just as invasive as conventional treatments, but in different ways. Due to the vulnerability of the population, what may be considered invasive may change. Most CAM participants agree that it really depends on which modality is being used for which symptom or condition, and so forth.

The degree of invasiveness is also relative to certain degrees among the different CAM modalities. For instance, acupuncture and massage are seen as more invasive than music therapy or reiki, but still less invasive than conventional hospital treatments. In general, however, CAM is seen as non-invasive compared to conventional treatments by most CAM practitioners. If we speak only to the physical, which is usually what is referred to as invasive by conventional standards, then CAM therapies are not considered invasive by CAM practitioners. However, the participants address the emotional, psychological, cultural, and spiritual invasiveness that are inherent in some CAM treatments. “You’re working on mental, emotional, spiritual aspects as well as the physical” (CAM Participant 5, 2013). Sometimes, even a modality considered non-invasive physically could be very invasive on other levels. Music, for example, can affect the mood and emotions of patients, while touch therapy or proximity such as in reiki, can be profoundly invasive culturally or spiritually speaking.

I think the caution though is that...there is still a risk of harm...we do need to be really sensitive to how invasive we are being, even emotionally...Even if it’s a positively

invasive [healing]. So if I have evoked a lot of feeling or grief, or anger, or sadness with patients...I can still work skillfully, even if it's been a very good release, you still have to kind of bring them back to a grounded state before you walk out the door. So you're not leaving them harmed. (CAM Participant 5, 2013)

CAM participants argue that the emotional and psychological effects of these experiences, conventional or otherwise, can be profound for the patient and their families. Positively or negatively, the child and the family could potentially be more affected by CAM service than other conventional treatments they have encountered physically. "We should not assume that just because the child is receiving reiki or a light massage with music in the background, that this is not affecting them in a deep way" (CAM Participant 5, 2013). Many CAM participants state that the challenges for the physicians and nurses are different than for other conventional health care providers, even if it is within the same environment and with the same patients. "[Allied health professionals] are entering in and out of the patient's care the same way that I am, rather than overseeing it...whereas the doctors and nursing staff are solid crew" (CAM Participant 6, 2013).

[Physicians] understand all of the people working under them, and all of the tools that they have to do their job. So whereas we're coming in with a foreign set of tools and a different concept that they're not going to totally understand...I think them not understanding the fundamentals of our medicine is going to be a challenge for them to be able to relax the control of the situation. (CAM Participant 6, 2013)

In the multidisciplinary world of health care, "Who's really responsible?"... (CAM Participant 4, 2013). "[There is] concern about co-treating and sharing liability too...we don't really know how everyone treats because we all come from a different place and different

standards of education” (CAM Participant 4, 2013). Traditionally, the physicians and front line nursing care are considered the primary care team for the patients. With new health care practitioners, there are new considerations for who is considered the primary care provider.

Through several personal and professional accounts by the administrative participants, it is clear that patient safety is a big consideration among all administrators. These participants frequently express concern regarding their patients’ safety and remember specific details about these experiences even years after they happened. There is a distinction made by several administrators between hospital and community-based CAM practitioners. According to the administrators, it is risky to receive CAM treatment in the community for children with cancer, unless that CAM provider is somehow affiliated with the hospital, by referral, or has a dual designation.

Anyone can put an ad out, saying that they’re, they can cure cancer with whatever they’re going to use, but it’s not regulated. We see, especially with families whose children are on palliative care...they often look to alternative therapies for the miracle. And a lot of places claim that it’ll be effective and these are things that are covered by Alberta Health Care; but a lot of families are spending more and more and more money on things that are not going to work. (Administrative Participant 4, 2012)

Administrators assert that CAM is not evidence-based and there is liability for treating patients who have had CAM and can present complications that the conventional health care providers then have to fix once the child comes back into the hospital. Subsequently, conventional health care staff do not feel comfortable with the patient’s use of CAM.

Recently, we had a patient who used a therapy who came in with significant electrolyte abnormalities, and it was almost undoubtedly from the therapy he was taking from the

community...They come in and then suddenly you're, you want to help the patient but you're actually treating them for something that was done by a health care provider that wasn't you. (Administrative Participant 4, 2012)

Currently, we have patients who are on alternative therapies and [supplements] who sometimes request that we administer those therapies in hospital and obviously, for many reasons we're not allowed to do that, nor would I think most physicians feel comfortable doing that because they're not...medication...It's not something we know has been experimentally proven to be safe or to work. (Administrative Participant 4, 2012)

Additionally, administrative participants agreed that investigating less intrusive means of treatment or at least symptom management for children would be beneficial for patients. "A lot of things we do...even the IVs, maintaining IVs...is pretty clinical and intrusive" (Administrative Participant 1, 2012).

Administrators think a benefit of a PIM service is that it would allow for more control over what patients are doing as far as CAM, and the conventional providers would therefore know and trust what CAM is being administered. As a result, the safety of the patients would be much better controlled in knowing that CAM practitioners are working to complement conventional therapies and not offer their services as an alternative therapy to conventional treatments. "You want to be working with CAM providers who don't dissuade people from their [conventional medicine]" (Administrative Participant 2, 2012).

A lot of families, especially in oncology, look towards alternative therapies anyways, and this would keep it sort of a little bit more under control, that we would be able to know exactly what they're taking and or doing...and we would also know that whatever we were offering at the Stollery would be safe to give and to do, and hopefully there would

be some evidence behind it versus what's happening with some of the patients now...potentially if they were offering it at the Stollery, the CAM providers would be, you know, certainly be reputable providers versus [unregulated entities] in the community. (Administrative Participant 4, 2012)

Redistribution of care. Some CAM practitioners hope and expect that CAM will decrease the workload for conventional practitioners, thereby creating a redistribution of care, and easing the caseloads off the physicians, frontline emergency, and nursing staff. This assumes patients are being seen by CAM practitioners for prevention, symptom management, and maintenance. "So if people are sleeping better and their appetite is a bit better and they don't have to prescribe all these extra drugs, it takes the workload off the physicians and nurses..." (CAM Participant 10, 2013). "Just take some of the burden off" (CAM Participant 10, 2013), and consequently, "Workload may decrease, as far as their active nursing" (CAM Participant 4, 2013). With time constraints on the conventional system as it is, CAM practitioners see their modalities as a benefit as far as being effective in not only their own treatments, but in helping the whole medical team be more effective. "Because time is precious, so you want it to be effective, you want it to be respectful" (CAM Participant 5, 2013).

I actually think the benefits for the physicians and the staff will be that they will have to spend less time thinking about how they are going to help these patients deal with...the pain, nausea, vomiting, and anxiety. Because we'll be effective, and if we are effective then that's going to make their jobs a lot easier...I think it's going to take a little bit of their workload off of them, actually. (CAM Participant 7, 2013)

There will be less strain on the health care system...I feel like we can help a patient recover faster...And they will go home quicker, and that will free up more space for the

next person...Shorten visits, shorten wait times. I think that is actually what we would find over a period of time. (CAM Participant 9, 2013)

I think definitely the workload, the fact that you could really triage in a different way...when you are triaging based on that I think that is only going to make the efficiency of Western medicine that much better...always complements...The bottom line is...Western medicine is very good at treating symptomology...but it is not necessarily great at treating the root of those symptoms...and I think that is where we can really help. (CAM Participant 9, 2013)

If patients are recovering quicker and experiencing fewer side effects of treatment because of CAM therapies, it takes pressure off of the existing system...the system is a little bit fragmented. It kind of helps fill those gaps...to maybe make it run a little more smoother. (CAM Participant 6, 2013)

The integration process may educate and provide a gateway for conventional health care practitioners to gain enough understanding and experience that they can begin to incorporate CAM into their own practice. In other words, the conventional professionals who are already employed may become interested in CAM approaches and incorporate them into usual care as a result of integration. "To incorporate some new age techniques that not everyone else has. So it could make the [hospital] more of a front runner, a pioneer" (CAM Participant 5, 2013). In effect, it is not only a matter of redistributing care, but also redistributing knowledge.

CAM practitioners identify that the obvious benefits for the patients is symptom reduction; "less medications...speed everything up in terms of their treatment and recovery, more peace, less nausea, anxiety, and pain leads to generally better sleep, improved energy, better focus...and clarity" (CAM Participant 6, 2013). "I think the benefits are going to be for

sure having the patient feel better. To have the family feel that they are doing everything they can” (CAM Participant 2, 2013). Furthermore, “As their child progresses, or feels less of these symptoms, it improves the parents’ outlook as well...It makes them more open to it, educates them at the same time” (CAM Participant 6, 2013). CAM practitioners speak about bringing children a sense of comfort and balance while being as non-invasive as possible, whenever possible. “I’m hoping that the child relaxes, and feels calm...If they [the parents] can see someone else can take some of the burden off of them for caring for their child, then they might just release some of their stress” (CAM Participant 4, 2013). Allowing a CAM practitioner to care for their child while in hospital may provide some respite for the parents and families, some education about different types of care, and the opportunity to have choices in care.

Some relief of their side effects...and feeling better without any more medications, and that the rate at which they’re going to be healing is going to be that much better...We’re in this young stage and maybe for the rest of their lives they’ll see health care in a much broader sense, and maybe what they choose as adults is going to be...a positive experience with something that they feel works and is very non-invasive. (CAM Participant 3, 2013)

Similarly, CAM practitioners point out the patients may benefit from a different kind of attention and nurturing. “Therapeutic touch, not just necessarily being poked and prodded...then create a connection, and the awareness and the comfort and trust with you” (CAM Participant 4, 2013). “...[T]he instant connectedness with another human being on a genuine level that is aside from the medical aspect” (CAM Participant 7, 2013). As one CAM practitioner expressed, “to see the parents’ face light up when they see the child feeling better, that is enough benefit for me” (CAM Participant 2, 2013). Some of “the parents were more than happy to sit back and let

other care providers take care of their children because [they're] exhausted...[their] child's very sick" (CAM Participant 6, 2013). It may be beneficial simply to see your child feel comfort and relief, regardless of where it is coming from. "If we're managing more of our symptoms before it gets critical, then we're not in need of such intense care" (CAM Participant 7, 2013).

Therapeutic milieu and patient-centered care. CAM practitioners are confident that CAM will positively affect the hospital environment and the milieu of the treatment spaces. CAM may provide a more relaxed, settled, and calm environment for patients, "It can be relaxing in the environment, it can have an environmental impact...could be an impact of the mood" (CAM Participant 5, 2013). "[CAM] creates an energy of calm. You can affect change for any of the people within that environment, whether that is the patient, the family, or the staff" (CAM Participant 4, 2013). "We can address a lot of the issues that our patients have rather than working directly with the patient all the time trying to manage the environment...some [issues] would just disappear" (CAM Participant 7, 2013). CAM in general can benefit the conventional health care team by relaxing the patients, making them easier to handle, communicate with better, and reduce some of the strain on conventional health care providers. "I think the benefit of having other people come in with fresh and different perspectives for them is so that they can deal with the families in a different way" (CAM Participant 7, 2013). "They can handle patients better...patients are very nervous and sometimes the conversation, or the working with, can be hard...so the communication can be better, that's a big thing" (CAM Participant 2, 2013).

It's another person offering care, attention and nurturing to someone who is suffering...let's face it, doctors are busy, right? CAM providers tend to spend more time with people and they tend to contact people...So there's a lot of human contact and I think that any doctors that are savvy to any issues about patient rapport and all that and

human contact and biopsychosocial...I think they can take solace in knowing that we'll know there's another level of support being offered...it's almost like a positive side effect. (CAM Participant 10, 2013)

So I think that it would be a ripple effect...having access to PIM. We know happy patients make healthier patients. How do you create a healthy, happy patient when the environment is stressed and toxic? I think that would be the immediate benefit; we would see this immediate ripple. (CAM Participant 7, 2013)

CAM practitioners appreciate that effectiveness can sometimes be associated with compliance due to "how well you feel cared for and if you think that your doctor is caring for you" (CAM Participant 9, 2013). Since some CAM practitioners have experience with children in their practice, they express that they expect children to be "more receptive, they recognize good intention, energies...and they don't have the baggage that an adult has" (CAM Participant 6, 2013). Additionally, with some relationship work with children, CAM therapies are expected to be more effective. "There is a little bit of relationship work you have to do and set the ground, but...it's possible" (CAM Participant 9, 2013). "You have to have a therapeutic relationship...with that child or that family...You need to be able to engage and build rapport with people whose worldview is very different from yours" (CAM Participant 5, 2013).

In hospital, you're knocking on everyone's door...we need to connect with them...It's very intense work, because you're always assessing...how they're receiving [CAM], how they're feeling...it's a privilege to be invited into a room of someone who is sick. It's a privilege to be a part of a journey of a child who has cancer. It's a very big privilege. (CAM Participant 5, 2013)

A patient-centered approach is considered important by CAM practitioners, and the benefits to the patients are touted as the main benefit for implementing PIM. “To bring it back, the focus on the patient and just help them feel good...to make them feel cared for” (CAM Participant 5, 2013). Overall, CAM participants “believe that complementary therapies can assist and conventional medicine can do a lot as well. But it’s the body itself that heals; everything else we’re doing is just supporting it” (CAM Participant 1, 2013). There is an expectation from CAM practitioners that CAM treatments, applied appropriately, are effective and will continue to be effective in treating pediatric patients.

CAM practitioners also discuss a sense of team and community for the patients, families, for the public, and for integrative medicine, and for the health care system in general. “It benefits [everybody], the nurses, the patients, the doctors” (CAM Participant 2, 2013).

One of the kids that they did acupuncture with is a kid who was having lots of pain problems; he was a really chronic cardiac patient that worked out quite nicely and he was also a cardiac patient with reiki and [it] was beneficial. I think there’s a whole bunch of kids that can feel a whole lot better. (Administrative Participant 2, 2012)

The bottom line is, you stick a needle or two in someone who’s got post-op nausea, vomiting, and anxiety, and they feel better within 5 minutes to 24 hours; then you know you have your results, and when you make someone feel better they tend to want to involve you more in their healthcare. (CAM Participant 9, 2013)

CAM practitioners expect another benefit for patients to have a more positive, less traumatic experience of the health care system.

An integrative service is a way to offset the experience of heightened trauma and crisis that people come in with, especially in oncology, in order to then be in a better position to

accept healing and get well and get well faster...Not only how fast are we going to get there, but how completely are we going to get there?...They're inherent risks to being in hospital, period, we know that and we know just what are the healing benefits of being at home with your family...Those are huge, too; you can't necessarily quantify them but we all know our personal balance lies there. Everybody aches to go home and just trying to get back to normal life as much as possible being surrounded by not only your family but the comforts of their own home...where healing can take place more effectively. (CAM Participant 3, 2013)

A therapeutic milieu decreases risk and trauma from the hospital experience. CAM practitioners discuss that reducing the use of medications may improve quality of life of patient while in the hospital. As a result "reducing cost...maybe the child won't need as much medication...discharged sooner" (CAM Participant 5, 2013). "Just avoiding multiple levels of polypharmacy...so you've got a medication for anxiety...a medication for sleep and a medication for nausea or constipation...there's three less drugs and three less complications or potential interactions" (CAM Participant 9, 2013).

Based on the above considerations from the perspectives of CAM practitioners and children's hospital administrators, the following chapter reviews the major themes and implications as they apply to the IM and CAM literature. The discussions pertain specifically to children and families receiving treatment from a conventional children's hospital, in this case, the Stollery Children's Hospital. After taking on a critical analysis of the data, much of the discussion also speaks to the broader, systemic, and ideological under-workings of the current health care systems at play.

Chapter 5

Discussion and Conclusion

Considerations for Implementing PIM

Current literature suggests that CAM therapies may have gained greater acceptance in mainstream conventional medicine, but they are yet to penetrate the professional culture in the hospital setting (Kundu et al., 2011). There are many important considerations voiced by CAM practitioners and administrators regarding IM for pediatric hospitals. Firstly, CAM practitioners have varied attitudes, levels of exposure, and experience within the conventional system; and similarly, administrators have varied levels of exposure and experience with CAM. Secondly, there are varied levels of communication between conventional and CAM practitioners. Thirdly, regarding attitudes, both groups view CAM integration as positive, and there is a positive attitude as far as expectations for PIM. Even though there may be some healthy skepticism, CAM services are broadly looked at in a positive light and most people are curious, open, and willing to learn more, if not experiment with CAM. This could be due to professional curiosity, public demand, and a growing body of evidence supporting CAM use. Regarding PIM, CAM practitioners and administrators consider differing attitudes; experiences and expectations of CAM; resistance to change; funding, gaining knowledge and experience with CAM; differing fundamental health care philosophies; practical considerations for adapting to new health care professionals; creating a therapeutic milieu that supports patient-centered care; and the redistribution of care and safety, as being important considerations.

Reservations About PIM

However, both CAM practitioners and administrators express reservations about PIM. Due to a lack of experience with CAM, administrators report their reservations regarding which

CAM modalities patients use and who administers them. Conversely, due to overall higher levels of experience, exposure, interaction, and communication with the conventional system and with conventional health care professionals, CAM practitioners express reservations regarding whether integration is realistic in the current health care environment. CAM practitioners express that they feel hesitation and anxiety towards IM for fear of assimilation. This may be due to the reality that this is a highly complex issue and process that, from their point of view, would need to take place at the socio-cultural, systemic, and ideological levels in order to truly be considered integrative and cooperative, as opposed to assimilative and standardizing by the current conventional health care system.

Consistent with the current IM literature, there remains much resistance and hesitation towards integration of CAM services into pediatric hospitals. As with conventional health care providers, reservation about IM is apparent with both groups of participants in this study as well, but from their own respective viewpoints. Reservations towards IM in general, therefore, may stem from the difficulty in understanding the other professional's perspective and approach to patient care. A lack of true integration of CAM may also be due to a lack of willingness or commitment to give up parts of a professional role or identity by conventional health care providers. It is a great professional feat from either end to meet in the middle about PIM, even if it is for the potential best interest of the patient and family. From the critical perspective, based on the fact that conventional health care providers and administrators in this study prioritized the how's (funds, space, risk management, scheduling), whereas the CAM practitioners focused more on why we need CAM in the hospital (patient-centered care, education, exposure, redistribution of care, quality of life); the conventional medical system is much less willing to move towards a truly integrated, cooperative, and multidisciplinary system. This may also mean

loss of space, power, control, and possibly a sacrifice of part of their professional identity as primary care providers in the case of IM.

Reservations about PIM also stem from the larger environmental issues sometimes presented in a conventional hospital, such as scheduling in one-on-one time spent with patients in consult, care, and follow-up. Currently, patients and families do not receive much of this level of care from physicians and other conventional health care providers due to the already overburdened public health care system. Administrators acknowledge that this level of intimacy in care is beneficial, albeit unrealistic in most cases. Therefore, IM is conceived as a possible solution to providing patients with more personalized, intimate level of attention and care, particularly for chronically ill children. PIM could be one way of providing safe CAM options within the hospital, with CAM practitioners who can provide that level of one-on-one time with their patients; or is it? The reality of implementing PIM, according to the participants, is much more complex because, once a health care professional is practicing within the public system, the nature of that conventional system itself becomes a barrier for CAM practitioners to practice the way they did privately in the community. Much of the reason why the public seeks CAM in the community is because the conventional system cannot provide personalized schedules, care, and attention at the level that CAM services can. This study highlights that administrators may not be as aware of these complexities and nuances as CAM practitioners are. On the other hand, administrators, from their perspective and position in the conventional system, may prioritize access to safe, accessible, and subsidized services over private, individualized, and time-consuming care. Therefore, there appears to be more hesitation towards PIM from the CAM practitioners than from the administrators.

Risks of PIM. Pediatricians and hospital administrators need to be open-minded and willing to discuss possible benefits, risks, and costs of CAM with patients and their parents (Gottschling et al., 2006). Unregulated public CAM use, according to the administrators, creates a safety risk that the conventional health care system is currently trying to address with IM. As an additional note regarding the PIM trial, I learned that many CAM practitioners originally recruited to participate had opted out due to specific requirements of being involved as a professional in the conventional hospital environment, for instance, getting vaccinated. It appears that the two systems have opposing viewpoints about what is considered a health and safety risk in the first place. According to Fearon (2003), safety was clearly an important issue, and concerns also center more on other issues, such as lack of research to demonstrate effectiveness. Safety, liability, and standardization of CAM are important considerations for both administrators and CAM practitioners in this study. However, as CAM is becoming more in demand, and accepted throughout the medical community, issues around safety and efficacy are becoming less problematic (Sencer & Kelly, 2006). Patients trust hospital staff to make them feel safe; therefore, risk management as it pertains to CAM use and the PIM trial for pediatric patients is an important consideration for participants, but also creates hesitation at the same time. A lack of rapport and communication among professionals, both conventional and CAM, can pose a safety risk. Safety considerations can therefore be exacerbated by the lack of communication and interaction between CAM practitioners and the conventional health care system.

The introduction of CAM points to the complexities of health care ethics. Ethical considerations are intimately related to the issues of safety, risk management, and liability within the conventional health care environment. The more professionals are introduced into patient

care, the more diluted the responsibilities become. Who is ultimately responsible for the patient? In the conventional system, the physician is the provider who oversees patient care and is ultimately responsible for the care outcomes. However, regarding CAM interventions, CAM practitioners view their patients as being ultimately responsible for their own, or their families' health. This is further complicated by the fact that in the relatively small sphere of pediatric health care, patients cannot be legally responsible and liable for their own health outcomes; they are, after all, under-aged children. Therefore, in this case, it is ultimately the family that is responsible for maintaining their child's safety while receiving CAM. The conventional health care system perceives this as an ethical and safety concern when considering severely and chronically ill children. Therefore, administrators concentrate on practical, safety, and space issues as if they are forced to create that space and time within the already overburdened system and take on an increased level of responsibility. This responsibility of regulating, standardizing, and supervising CAM practitioners, as well as the safe delivery of CAM services, is what CAM practitioners suggest is not the ethical responsibility of the administrators in the first place.

CAM participants agree that safety is a factor to consider; however, administrators prioritize safety as a major consideration, along with the practicalities, policies, and funding, which could be a barrier to implementing CAM. Administrators hesitate in considering CAM to be safe for use by pediatric patients because of possible adverse effects; possible interference with conventional treatments; abuse of CAM in the community; lack of communication about CAM use; and perceived lack of evidence for CAM. Therefore, there exists a lack of trust about CAM within the conventional system. Lack of trust may lead to a lack of communication with CAM practitioners and those seeking knowledge and experiences with CAM, as well.

Assimilation versus integration. Assimilation rather than integration is an important distinction that CAM practitioners make regarding how CAM treatment could potentially change as a result of integration. CAM practitioners question whether it is worth it. CAM practitioners agree that there are many benefits and opportunities to IM. These include working with pediatric patients in the conventional system, professional development, exposure within new systems of care, the opportunity to educate others about CAM, working with other practitioners, and helping more patients that cannot afford private CAM services. However, with regulation and standards of care within a hospital setting, will CAM practitioners be required to change how they deliver treatment? Will the nature of the hospital environment effectively strip CAM of its uniquely holistic approach to health?

CAM practitioners have faced both challenges and successes with the conventional health care system and understand in depth the complexities that could be involved with CAM integration. They understand that risks exist to their profession, but they fear that CAM may lose the essence of what makes them holistic if they truly are assimilated into the conventional environment by the standards and policies of hospital administration. CAM practitioners do not trust that the hospital environment will adapt to their ideological holistic model of patient-centered care through integrating their services. At least not as much as CAM practitioners would adapt toward the conventional medical model in order to facilitate service delivery to hospitalized pediatric patients that may not otherwise have access to CAM. This, ironically, illustrates the strong commitment to patient-centered care by CAM practitioners, even while undergoing the possibility of sacrificing other essential components of what makes CAM modalities uniquely effective. CAM practitioners are willing to follow their patients into an

environment where they feel anxious, undervalued, and misunderstood by other health care professionals.

Patients and families being more free to actively choose which health care approach is most appropriate for them or for their child conflicts with the current conventional paradigm of health care. Currently, the administration, physicians, nurses, and other key stakeholders, such as funding organizations, hold decision-making power regarding delivery of care. The conventional health care system would have to surrender or share space, power, and control within a truly integrated health care system. Otherwise, as CAM practitioners illustrated, it would simply be a process of assimilating or standardizing CAM services into an already existing health care structure and hierarchy of which CAM practitioners would become a part, in the name of public safety and risk management. From the CAM practitioners' perspective, patient care would not be optimized under such circumstances; therefore, they tread carefully towards the concept of IM. Administrators, because of their privileged positions, present a more limited view of why integration would be problematic from a systemic point of view. As the ones in power, it is doubtful that they would be willing to give up that power for simply having CAM as an available option for their patients within their institution. Administrators, therefore, positively reflect on and conceptualize an ideal of IM. However, the many practical, safety, and funding considerations that are prioritized by administrators, imply that, from their perspective, IM would not be truly realistic within the construct of the current conventional health care structure, at least not in the foreseeable future.

Opposing health care ideologies. While integration is becoming an increasingly accepted practice and is currently being developed and practiced in the treatment of lower back and neck pain, multiple sclerosis, AIDS, and cancer, including hospice and palliative care,

several studies have described various limitations of integration in theory and practice. Bell et al. as cited in Ben-Arye et al. (2008) specifically argued that “combination medicine [CAM added to conventional medicine] is not integrative”, and Hollenberg (2006) examined two integrative health care settings in Canada and found that when attempts were made to integrate biomedicine and CAM, dominant biomedical patterns of professional interaction continued to exist (Ben-Arye et al., 2008). The dichotomy of assimilation and integration, as discussed in the previous section, could be a reflection of the underlying opposing ideologies between the two health care approaches. One serves the public sector, and the other that caters to those who seek out private health consultations and pay for the time, convenience, and access to CAM services. Again, CAM practitioners consider their CAM modalities as relatively safe and non-invasive compared to conventional treatments for pediatric patients such as chemotherapy, polypharmacy, IVs, radiation, and so on. Administrators are more concerned with the practical, logistic, structural, and functional considerations of CAM integration. While CAM practitioners agree that these are all valid considerations and do need to be addressed in the process, they concentrate much more on the issue of creating common ground between two fundamentally different ideological health care paradigms, in order to facilitate successful integration of CAM.

CAM practitioners speak about deeper levels of implications of integrating CAM for pediatric hospitals. This may be due to more experience with the opposing system, or due to being the ones faced with sacrificing a level of their practice as far as space, time, scheduling, structure, and autonomy in order to serve more chronically or acutely ill patients that may otherwise not have access to CAM. Administrators understand the philosophy behind patient-centered care, and some physicians or nurses themselves, care deeply about patient welfare. Patient-centered care is a growing buzzword in recent health care literature and in health care

teaching institutions. Placing the patient in the crux of the health care team exposes underlying ethical and structural issues present within and between both philosophical systems. Prioritizing the patient at the center of the health care team is an intrinsic, fundamental principle of CAM practices. Even though this principle is becoming more integrated among the conventional health care community, simply introducing one concept from one system into the other is not integration. Just like introducing CAM practitioners into the conventional system as an adjunct service is not integration. What the administrators call integration at this point, CAM practitioners would view as assimilation. I think this is what CAM practitioners suggest when speaking about the incommensurability of the opposing health care paradigms and how far we still have to come regarding PIM, if we are to get there at all.

The potential complexities of integration planning and PIM implementation rests on the many considerations brought up by participants in this study, but only after some reconciliation of the opposing health care philosophies. One reality is that neither should be expected to completely surrender to the other. Another reality is that the conventional public health care system is intimately integrated within the political, economic, and even ideological systems of the overarching governing structures. Now that more perspectives are beginning to receive voice about IM in the literature, more complexities about IM can also begin to receive attention, particularly in pediatric hospitals. These are hospitals where children suffering from severe or chronic health conditions can have the option of receiving CAM in a timely, safe, and effective way. Unless both CAM practitioners and administrators shift their current positions towards each other, to accommodate each other's approach to health, a truly integrated health care system, such as in a PIM model, is not a likely reality.

Integration Through Patient-Centered Care

From the critical perspective, when one system is in the position of power and privilege, it becomes much more difficult to see and address the consideration from the viewpoint of those otherwise non-privileged groups within the same system. However, the group that does not hold much of the decision-making power, in this case the CAM practitioners, understands and accepts the position and perspective of the administrators. Because of the CAM practitioners' position within the existing health care system, they also have a perspective of the underlying considerations that could potentially be the determining factors in successfully implementing CAM into a children's hospital. This way, their perspectives need to be seriously considered when hospitals begin to invest in integrating CAM services into children's hospitals.

One of the other perspectives already explored within the literature is that of the patients and families. From the perspective of the CAM practitioner, the key to successful integration is the patient. This patient-centered approach to health care depends on the relationship between the patients and their health care providers. The patient and families have a lot of power (even if unaware of it) when given choices and can become an active part of the care team. Within the current health care establishment, patients and families are given very little choice over their care while in the hospital. Refusing to care for a child could even result in legal action against the hospital. Therefore, there is a redirection by families towards CAM to supplement existing care. Considering this, what is the responsibility of CAM practitioners? From the perspective of CAM practitioners, more responsibility is placed on the patient. In other words, patients play a more central role in their health and healing process. CAM practitioners consider themselves partners in their patients' healing process. In this way, patient-centered care is the key consideration to allowing CAM practitioners to integrate into the mainstream health care system. CAM

practitioners have already experienced much push-back when administering care to their patients within the hospital environment. However, over time, once professional relationships are developed and sustained with the common purpose of optimizing patient care, the concept of PIM can go from an idealized health care concept to practical reality. The most important consideration voiced throughout this study by all participants, the one that can create some common ground between all health care professionals, is the patient.

Limitations

Participants were pooled from the list of CAM providers who have agreed to participate in the PIM trial at the Stollery through the University of Alberta's CARE program, and therefore may present a bias. Participants might be overly optimistic or hopeful about the effectiveness of CAM in this environment due to their personal and professional levels of investment in the study. Some participants are also employees at the Stollery Hospital. Confidentiality was ensured for all participants. However, their level of involvement may still have affected their reported opinions, views, and expectations about the PIM study and about CAM integration in general.

Another limitation in this study was that ten CAM practitioners from various CAM modalities were interviewed, whereas only four were included from the administrators' group. Data may have been more informative from the CAM practitioners as there was simply more data. Participants from the administrators' group were much more difficult to contact and schedule and therefore, fewer participants were interviewed.

Implications and Future Research

The perspectives of CAM practitioners and administrators of children's hospitals about CAM use and integration have not been extensively researched in the pediatric medical research. CAM use in the pediatric population, especially the perspectives and experiences about CAM

use in this population, also has not been extensively researched. With this study, gaining these perspectives has shed light on the fact that there are other perspectives when considering integrating CAM into the conventional medical system. This implies that further research and effort towards CAM integration consider these perspectives. There may be risks involved if these considerations are not taken into account. Future research regarding integrating CAM into pediatric hospitals needs to be sensitive to many considerations, such as varied attitudes; levels of experience; knowledge and experience with CAM; the many practical considerations involved in successfully integrating CAM into the mainstream medical system; funding; and safety.

Additional implications include exploring fundamental issues of systemic and ideological change that would be encountered when integrating two health care systems. After all, it is not just about integrating CAM into the conventional system, as much as it is integrating two systems with each other. Consequently, every perspective is valuable and critical. Every professional perspective that is not considered can negatively affect patient care when multiple professionals are treating patients. This begins in the realm of research and knowledge transfer, before it is applied in the structural, practical, administrative, and applied levels of patient care. Therefore, further exploration into CAM use for pediatric patients is required in order to integrate CAM into current children's hospitals. Evaluating current programs, which are attempting to integrate CAM services into existing health care structures, may be a productive place to start.

Conclusion

As current research suggests, the attitudes of health care professionals, such as physicians and nurses, about CAM are generally positive. Most professionals express positive direct or indirect experiences and knowledge of the benefits of various CAM services. However, also

consistent with the literature, despite these positive outlooks about CAM and CAM use in the general public, there are reservations and concerns about integration. There are practical discrepancies, such as space, funding, redistribution of care, liability, and safety. There are ideological issues about the efficacy of CAM. CAM practitioners and administrators express different expectations and therefore have different concerns about PIM. CAM practitioners focus on how their respective modalities may change and how patient care may change due to integration. Administrators focus on the practical and political nature of the process of integration. Because the administrators are in the position of power and privilege in the health care system, their level of concern about integrating CAM does not involve concerns about specific CAM services or practitioners. Rather, administrators are concerned primarily with how CAM would affect distribution of patient care; how CAM would be funded; whether CAM is safe for chronically ill patients to use; how CAM would be regulated within the current health care space; scheduled appropriately; and so forth. CAM practitioners address these same considerations. However, because CAM practitioners are in a subordinate position, their perspective is primarily patient-centered, and subsequently, that of maintaining the integrity of their own unique CAM practice in order to continue to provide effective CAM services. This tension between the two opposing discourses must be addressed when focusing on whether integration is possible. And, if integration is possible, the issue becomes how to shift these two perspectives towards each other in order to then make a PIM service possible.

From the CAM practitioners' perspective, considerations are viewed from the outside in, the emic perspective of the system. Those on the inside, the administrators, who currently hold the decision-making power and occupy space and funds within the system, perceive integration from an etic perspective, one of the insider, opposed to that of the CAM practitioners. From the

outsiders' perspective, CAM practitioners see the current trend as more assimilative rather than integrative, into which their services, skills, and expertise are becoming a part of the larger conventional structure. From the administrators' perspective, CAM is being integrated into their system. As long as these positions are maintained, integration cannot happen because there must first be agreement on a definition of what integration means in the current context of health care. The process of defining integration is likely to raise ideological and ethical issues, and many of the considerations discussed in this study. However uncomfortable or awkward this process may be, it is a necessary step to take for a truly integrated health care system, in which PIM is only a part.

CAM practitioners are more aligned and familiar with the reality, the messiness, and the intimacy of these considerations; whereas administrators are more impersonal in their considerations; yet, administrators have higher hopes and a more positive outlook about IM. It is not so much what the considerations are, because both groups of participants agree to differing levels about those considerations; rather, it is about beginning the process of finding common ground about how to address these considerations and create an environment through which more understanding, acceptance, and respect can be created among all key stakeholders. It is most important to begin creating a dialogue, a common discourse among key players for the purpose of co-creating a truly collaborative and integrative health care system, through which there is more distribution of power, space, funding, resources, and access. Within this environment, decisions about PIM can be made that would more likely benefit all involved, collaboratively and especially for the optimal care of pediatric patients.

There are issues of making space for CAM within a pediatric hospital, safety and risks associated with CAM integration, ethical considerations of the delivery of CAM, and issues of

responsibility. With the public demanding individualized approaches to care, and CAM being one of those approaches, patient-centered care hinges on the central premise that patients are ultimately responsible for their own health. Therefore, there has become an increasing redistribution and compartmentalization of health care services to meet such individual demands. In other words, health care has become multidisciplinary. The hesitation towards PIM lies within the fact that the same considerations do not apply for pediatrics as they would with public and adult use of CAM, and IM in general. Considering the fact that children and families are seeking CAM in the community, questions arise: Is it more ethical from the perspective of the conventional health care to integrate with CAM for this specific population? Is it worth the time and money-consuming, tedious, complex, messy, and awkward process to achieve integration for pediatric patients? I think participants would agree that it would be; and this is perhaps why PIM is becoming increasingly complex and visible. Therefore, PIM is a much-discussed topic in today's health care literature and health care institutions.

The construction of our health care system is a reflection of our values and ideas about health. It is in part a reflection of how we live our lives and the way we have constructed our communities and relationships within those systems. We know it has never been a perfect system. People are continuously looking for ways to improve and live a healthier, more productive life. CAM, in many ways, has empowered the public with options for doing just that. As discussed in the literature and in this study, change is often difficult. Holding many perspectives at once to come to a mutually agreed on decision will require time, resources, further research, funding, and, most importantly, movement by all perspectives towards one another. This is an intimate process, in which many boundaries would be crossed, blurred, tested,

changed, and ultimately restructured in order to accommodate this increasing demand for CAM services for pediatric patients, and for the public overall.

Seeking and maintaining a balanced perspective and respecting different points of view throughout that exploration, is, in my opinion, the ethical, responsible approach towards PIM. An approach that regards multiple perspectives and viewpoints regarding pediatric integrative services is required. It is necessary to create an effective, collaborative, patient-centered, and safe approach to health care for pediatric patients, regardless of whether that approach ultimately integrates CAM into children's hospitals.

References

- Ben-Arye, E., Frenkel, M., Kleinc, A., & Scharf, M. (2008). Attitudes toward integration of complementary and alternative medicine in primary care: Perspectives of patients, physicians, and complementary practitioners. *Patient Education and Counseling*, *70*, 395–402. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/18201857>
- Bienko, I. (2012). *Identifying challenges and benefits of implementing pediatric integrative medicine services at the Stollery Children's Hospital: An exploration of experiences, perceptions, and expectations regarding implementing PIM therapies for inpatients at the Stollery Children's Hospital*. (Unpublished report). Edmonton, AB, Canada: University of Alberta.
- Carspecken, P. (1996). *Critical ethnography in educational research: A theoretical and practical guide*. New York, NY: Routledge.
- Cook, K. E. (2005). Using critical ethnography to explore issues in health promotion. *Qualitative Health Research*, *15*(1) 129-138. doi:10.1177/1049732304267751
- Cuzzolin, L., Zaffani, S., Murgia, V., Gangemi, M., Meneghelli, G., Chiamenti, G., & Benoni, G. (2003). Patterns and perceptions of complementary/alternative medicine among pediatricians and patients' mothers: A review of the literature. *European Journal of Pediatrics*, *162*, 820–827. doi:10.1007/s00431-003-1313-9
- Dixon-Woods, M. (2003). What can ethnography do for quality and safety in health care? *Quality and Safety in Health Care*, *12*, 326–327. doi:10.1136/qhc.12.5.326
- Faubion, J. D., & Marcus, G. E. (2008). Constructionism in anthropology. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of constructionist research* (pp. 67–84). New York, NY: Guildford Press.

- Fearon, J. (2003). Complementary therapies: Knowledge and attitudes of health professionals. *Pediatric Nursing*, 15(6), 31. doi:10.7748/paed2003.07.15.6.31.c867
- Gergen, K. J., & Gergen, M. (2004). *Social construction: Entering the dialogue*. Taos, NM: Taos Institute.
- Gordon, J. S. (2008). Mind-body medicine and cancer. *Hematology/Oncology Clinics of North America*, 22, 683-708. doi:10.1016/j.hoc.2008.04.010
- Gottschling, S., Langer, A., Tautz, C., & Graf, N. (2006). CAM use in pediatric oncology. *Current Pediatric Reviews*, 2, 362-368. doi:10.2174/157339606778699626
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). London, England: Sage.
- Higginbottom, G. M. A. (2011). The transitioning experiences of internationally-educated nurses into a Canadian health care system: A focused ethnography. *BMC Nursing*, 10(14), 1-13. doi:10.1186/1472-6955-10-14
- Hollenberg, D. (2006). Uncharted ground: Patterns of professional interaction among complementary/alternative and biomedical practitioners in integrative health care settings. *Social Science and Medicine*, 62, 731-744. doi:10.1016/j.socscimed.2005.06.030
- Jones, S. (2001). *Embodying working-class subjectivity and narrating self*. In *Subjects to subjectivities—A handbook of interpretive and participatory methods* (pp. 145-162). New York, NY: University Press.
- Kelly, K. M. (2007). Complementary and alternative medicines for use in care in pediatric cancer. *Support Care Cancer*, 15, 457-460. doi:10.1007/s00520-006-0162-2

- Kelly, K. M., Jacobson, J. S., Kennedy, D. D., Braudt, S. M., Mallick, M., & Weiner, M. A. (2002). Use of unconventional therapies by children with cancer at an urban medical center. *Journal of Pediatric Hematology and Oncology*, *22*, 412-416.
doi:10.1097/00043426-200009000-00005
- Kemper, K. J., Vohra, S., & Walls, R. (2008). The use of complementary and alternative medicine in pediatrics. *American Academy of Pediatrics*, *122*, 1374-1386.
doi:10.1542/peds.2008-2173
- Kemper, K. J., & Wornham, W. L. (2001). Consultations for holistic pediatric services for inpatients and outpatient oncology patients at a children's hospital. *Archives of Pediatric and Adolescent Medicine*, *155*, 449-454. doi:10.1001/archpedi.155.4.449
- Kincheloe, J. L., & McLaren, P. L. (1994). Rethinking critical theory and qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 138-157). Thousand Oaks, CA: Sage.
- Knoblauch, H. (2005). Focused ethnography. *Forum: Qualitative social research*, *6*, Art. 44.
- Koehn, S. D., Kozak, J. K., & Drance, E. (2011). "The problem with Leonard": A critical constructionist view of need-driven dementia-compromised behaviours. *Dementia*, *11*, 725-742. doi:10.1177/1471301211421264
- Kreitzer, M. J., Mitten, D., Harris, I., & Shandeling, J. (2002). Attitudes toward CAM among medical, nursing, and pharmacy faculty and students: A comparative analysis. *Alternative Therapies in Health and Medicine*, *8*(6), 44-47. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/12440838>
- Kundu, A., Tassone, R. F., Jimenez, N., Seidel, K., Valentine, J. K., & Pagel, P. S. (2011). Attitudes, patterns of recommendation, and communication of pediatric providers about

- complementary and alternative medicine in a large metropolitan children's hospital.
Clinical Pediatrics, 50, 153–158. doi:10.1177/0009922810384724
- Latimer, J. (2008). Critical constructionism in nursing research. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of constructionist research* (pp. 153–169). New York, NY: Guildford Press.
- Lechte, J. (1994). Fifty key contemporary thinkers: From structuralism to postmodernity. London, England: Routledge.
- Lock, M., & Scheper-Hughes, N. (1990). A critical-interpretive approach in medical anthropology: Rituals and routines of discipline and dissent. In C. M. Johnson and C. F. Sargent (Eds.), *Medical anthropology: Contemporary theory and method* (pp. 47-72). Westport, CT: Praeger.
- Martel, D., Bussieres, J. F., Theoret, Y., Lebel, D., Kish, S., Moghrabi, A., & Laurier, C. (2005). Use of alternative and complementary therapies in children with cancer. *Pediatric Blood Cancer*, 44, 660-668. doi:10.1002/pbc.20205
- Mayan, M. J. (2009). *Essentials of qualitative inquiry*. Walnut Creek, Calif: Left Coast Press.
- McFadden, K. L., Hernández, T. D., & Ito, T. A. (2010). Attitudes towards complementary and alternative medicine: Influence and its use. *Explore*, 6, 380-388.
doi:10.1016/j.explore.2010.08.004
- Miller, L. (2008). Foucauldian constructionism. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of constructionist research* (pp. 251–274). New York, NY: Guildford Press.
- Muecke, M. (1994). On evaluation of ethnographies. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp.187-209). Thousand Oaks, CA: Sage.

- Myers, C., Stuber, M. L., Jennifer I. Bonamer-Rheingans, J. I., & Zeltzer, L. K. (2005). Complementary therapies and childhood cancer. *Cancer Control, 12*, 172-180. Retrieved from http://www.medscape.com/viewarticle/510218_2
- National Centre for Complementary and Alternative Medicine. (2012). Home page. Retrieved from <http://nccam.nih.gov/>
- Ott, M. J. (2006). Mind-body therapies for the pediatric oncology patient: Matching the right therapy with the right patient. *Journal of Pediatric Oncology Nursing, 23*, 254-257. doi:10.1177/1043454206291359
- Post-White, J. (2006). Complementary and alternative medicine in pediatric oncology. *Journal of Pediatric Oncology Nursing, 23*, 244-253. doi:10.1177/1043454206291357
- Post-White, J., & Hawks, R. G. (2005). Complementary and alternative medicine in pediatric oncology. *Seminars in Oncology Nursing, 21*, 107-114. doi:10.1016/j.soncn.2004.12.007
- Richards, L., & Morse, J. M. (2007). *Readme first: A user's guide to qualitative methods* (2nd ed.). Thousand Oaks, CA: Sage.
- Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research*. Thousand Oaks, CA: Sage.
- Savage, J. (2006). Ethnographic evidence: The value of applied ethnography in healthcare. *Journal of Research in Nursing, 11*, 383-393. doi:10.1177/1744987106068297
- Scrace, J. (2003). Complementary therapies in palliative care of children with cancer: A literature review. *Pediatric Nursing, 15*(3), 36-39. doi:10.7748/paed2003.04.15.3.36.c846
- Sencer, S. F., & Kelly, K. M. (2006). Bringing evidence to complementary and alternative medicine for children with cancer. *Journal of Complementary and Alternative Medicine, 28*, 186-189. doi:10.1097/01.mph.0000210402.36309.1e

- Sewitch, M. J., Cepoiu, M., Rigillo, N., & Sproule, D. (2008). A literature review of health care professional attitudes toward complementary and alternative medicine. *Complementary Health Practice Review, 13*(3), 139-154. doi:10.1177/1533210108325549
- Tacon, A. (2003). Meditation as a complementary therapy in cancer. *Family & Community Health, 26*(1), 64-73. doi:10.1097/00003727-200301000-00008
- The International Society of Pediatric Oncology. (2010). Home Page. Retrieved from <http://www.siop-online.org/>
- Vohra, S., & Cohen, M. (2007). Ethics of complementary and alternative medicine use in children. *Pediatric Clinics of North America: Complementary and Alternative Medicine, 54*, 875-884. doi:10.1016/j.pcl.2007.10.004

Appendices

Appendix A

Invitation Letter [e-mail]

Subject: Izabela Bienko–Research Project

My name is Izabela Bienko and I am a graduate student at the University of Victoria completing my thesis in the Child and Youth Care MA program. I am also involved in an upcoming Pediatric Integrative Medicine (PIM) Trial at the University of Alberta’s Stollery Children’s Hospital, working with Dr. Sunita Vohra for the CARE Program.

For my thesis, I am exploring considerations and implications of implementing integrative services for pediatric inpatients at the Stollery Children’s Hospital, according to the perspective of CAM practitioners. Therefore, I would like to invite you to participate in a research interview that will help add the perspective of CAM practitioners to the current literature and ongoing discussions regarding integrative medical services for pediatric hospital patients, specifically at the University of Alberta’s Stollery Children’s Hospital.

I would like to schedule a time to meet with you at your convenience. Attached are the information letter, which provides details pertinent to the study and the interview, and a consent form for your participation. I will go over these with you when we meet should you have any questions or concerns.

Thank you. Your input is very much appreciated.

Izabela Bienko
(xxx) xxx-xxxx

Appendix B
Information/Consent Letter

Project Title: Considerations and Implications of Implementing Integrative Services for Pediatric Inpatients at the Stollery Children’s Hospital, according to the perspective of CAM Practitioners. One-on-One Interviews

Primary Investigator: Izabela Bienko

Primary Supervisor: Dr. Daniel Scott

2nd Research Supervisor: Dr. Maria Mayan

Project Title: Considerations for Implementing a Pediatric Integrative Medical Service

Primary Investigator: Izabela Bienko

Primary Supervisor: Dr. Daniel Scott

Committee Member: Dr. Maria Mayan

Purpose of this Interview: I would like to invite you to participate in a research interview that will help add the perspective of CAM practitioners to the current literature and ongoing discussions regarding integrative medical services for pediatric hospital patients, specifically at the University of Alberta’s Stollery Children’s Hospital.

Relevant Definitions: The National Center for Complementary and Alternative Medicine (NCCAM, 2012) defines CAM as follows: A group of diverse medical and health care systems, practices, and products that are not presently considered part of conventional medicine. “Complementary” typically refers to those methods that augment conventional therapies, and “Alternative” refers to methods used instead of mainstream treatments. Integrative medicine, and

in this context, Pediatric Integrative Medicine, combines treatments from conventional medicine and CAM for pediatric patients (NCCAM, 2012).¹

Relevant background regarding the upcoming Pediatric Integrative Medicine (PIM) Trial:

This study (PIM Trial) involves offering complementary and alternative (CAM) therapies (massage therapy, music therapy, reiki, and acupuncture/acupressure) to inpatients in participating divisions of the Stollery Children's Hospital through a consult service called the Pediatric Integrative Medicine (PIM) service. This study will evaluate provision of three CAM therapies through the PIM service to determine their effectiveness in reducing pain, nausea/vomiting, and/or anxiety, in hospitalized children when compared to usual care alone.

Complementary and Alternative Services for Pediatric Patients

The use of CAM is relatively new, especially in its use with children, and is still a controversial modality in conventional medical settings because there are few clinical trials of safety or efficacy. Little information is available to guide clinical practice, and training and licensure standards are not consistent (Cuzzolin et al., 2003; Kelly, 2007; Post-White, 2006; Scrace, 2003). Complementary and alternative services for the treatment of adult patients has been researched much more extensively than in pediatric populations. Nonetheless, complementary and alternative therapies are gaining popularity in their application to pediatric patients. According to Vohra and Cohen (2007), usage data confirm that CAM is sought by a broad section of society, including children and adolescents. Complementary therapies are increasingly being offered in conventional medical settings, and dedicated funding for CAM research has been created within the National Institute of Health (NIH), primarily at the National Center for Complementary and Alternative Medicine (NCCAM) but also at various other centers and institutes, such as the Office of Cancer and Complementary and Alternative Medicine at the National Cancer Institute (Vohra & Cohen, 2007). Furthermore, limited research in integrative health care focuses on the perspectives of CAM practitioners regarding integrating their services with mainstream and conventional approaches to health care in hospital and clinical settings. Going forward, I believe a balanced and thorough perspective which respects different points of view would be a

¹ National Centre for Complementary and Alternative Medicine. 2012. Retrieved from <http://nccam.nih.gov/>

responsible approach regarding pediatric integrative services, and is required for successfully creating an effective and well-rounded approach to health care and wellness of pediatric patients at the Stollery's Children's Hospital.

What is involved in this interview? This interview has four parts. In part one, we will ask you about your professional experience in providing your therapies/services for pediatric patients, your expectations, opinions, and insights about the effectiveness of CAM services. Part two will explore your perceptions regarding benefits and challenges of CAM services for pediatric patients. Part three will ask you to identify potential challenges and benefits to implementing a PIM service at the Stollery Children's Hospital. Part four will concentrate on communication practices with conventional health care professionals. This interview will be private and will be digitally recorded. The interview will occur at a time and place convenient for you and should take approximately an hour to complete.

Risks and Benefits: There are no known risks associated with participating in this research. The benefits of participating are increased knowledge about how you and your peers experience the PIM service and may be used in consideration of future provision of the PIM service.

Voluntary Participation: Participation is entirely voluntary. During the interview, you may change your mind at any time and opt out of the interview with no repercussions. Other than the researchers and anyone you choose to tell, no one will know whether or not you have participated. During the interviews, you may choose to answer some or all questions. You also have the right to withdraw up to two weeks after the interview. If you choose to withdraw before the two-week period, I will clarify if you want the entire interview destroyed or just parts of the interview. If you choose to withdraw two weeks or more after the interview takes place, the data will have already been transcribed and possibly analyzed. There will be an effort to omit your data from analysis; however, depending on the stage of analysis, this may not be completely possible. I will follow through with whatever you allow me to use from your interview. The information you provide may be used to produce reports, presentations, and publications; but again, your anonymity will be protected. For example, a phenomenon will be described as

“Health-care providers/administration reported that...” so that individual identity will not be disclosed.

Despite these measures, due to the nature of the questions and the limited number of people who could provide the information we are seeking, participant responses may be recognizable by some.

Confidentiality: After data collection, the interviewer will promptly secure the data to a password-protected and encrypted computer file from which the data will be transcribed, analyzed, and stored. Consent forms and notes from each interview will be stored in a locked filing cabinet at the researcher’s private residence. All of the raw data collected is confidential and anonymous. Data will be kept for five years following the completion of the study, as well as on a password-protected computer. After dissemination, electronic data will be kept for five years, then destroyed by being permanently deleted and removed from researchers’ personal computer files, back-up files, and archived files. Paper data will be kept for five years and then shredded. Data will be kept for future research in anonymous form, stripped of all identifiers with no links, codes, or keys that allow for re-identification of the participants, and analyzed by other researchers. We will not share the information with anyone other than the research team and your name and other identifiers will not be attached to the data or appear anywhere in publications or presentations.

If you have any questions or concerns regarding your rights as a participant, or how this study is being conducted, you may contact the Research Ethics Office at xxx-xxx-xxxx. This office has no affiliation with the study investigators.

If you have any concerns or questions about this research study, please contact:

Izabela Bienko

University of Victoria Masters Student in the Child and Youth Care Program by Distance.
Human and Social Development Department, 6703–19 Avenue NW, Edmonton, AB. T6K 2B2.
xxxxxxx@gmail.com; xxx-xxx-xxxx

Dr. Daniel Scott

Associate Professor and Director of the Child and Youth Care Graduate Program at University of Victoria. School of Child & Youth Care, Human and Social Development Building, University of Victoria, P.O. Box 1700, STN CSC, Victoria, BC V8W 2Y2

xxx@xxxxxxx; xxx-xxx-xxxx

Dr. Maria Mayan

Associate Professor, Faculty of Extension, Assistant Director, Women and Children's Health Community University Partnership for the Study of Children, Youth, and Families
2-281–Enterprise Square, 10230 Jasper Avenue, Edmonton, AB T5J 4P6

xxx@xxxxxxx; xxx-xxx-xxxx

In addition, you may verify the ethical approval of this study by contacting the Human Research Ethics Office at the University of Victoria

xxx@xxxxxxx; xxx-xxx-xxxx

Appendix C
Consent Form

Project Title: Considerations and Implications of Implementing Integrative Services for Pediatric Inpatients at the Stollery Children's Hospital, according to the perspective of CAM Practitioners. One-on-One Interviews

Primary Investigator: Izabela Bienko

Primary Supervisor: Dr. Daniel Scott

2nd Research Supervisor: Dr. Maria Mayan

Do you understand that you have been asked to be in a research study?

yes no

Have you received and read a copy of the attached Information Sheet?

yes no

Do you understand the benefits and risks involved in taking part in this research study?

yes no

Have you had an opportunity to ask questions and discuss this study?

yes no

Do you understand that you are free to withdraw from the study at any time

without having to give a reason and without repercussions?

yes no

Has the issue of confidentiality been explained to you?

yes no

I agree to take part in this study

yes no

Signature: _____

Date: _____

Appendix D

Administrator's Semi-Structured Interview Questions

Part I

1. What has been your professional experience with complementary and alternative medicine (CAM) such as music or massage therapy, biofeedback, reiki, or acupuncture? In pediatrics or otherwise, if any.
2. Do you expect the PIM therapies to be effective in reducing pain, nausea/vomiting, and/or anxiety for children in hospital during the PIM study? Explain.
3. The PIM trial will evaluate the effectiveness of CAM in reducing pain, nausea/vomiting, and anxiety; patient safety; cost-effectiveness; and parent/patient and staff/physician satisfaction. From these, which result would you consider to be most significant in efforts to improve inpatient care?
4. a) What potential challenges do you foresee for Stollery staff and/or physicians during the study?
b) What do you see as being potential benefits for Stollery staff and/or physicians?
5. a) What potential challenges do you foresee for the CAM providers such as the acupuncturist, reiki, music, and massage therapists, and so forth, during the study?
b) What do you see as being potential benefits for the CAM providers?
6. a) What potential challenges do you foresee for the patients receiving CAM therapies during the study?
b) What do you see as being potential benefits for the patients?

7. a) What potential challenges do you foresee for **parents** of patients who receive CAM therapies treatments during the study?
- b) What do you see as being potential benefits for the parents?

Part II:

8. Do you think there would be benefits to implementing a Pediatric Integrative Medicine (PIM) service at the Stollery? Explain.
9. What would you expect to be some challenges and/or barriers to implementing a PIM service at the Stollery? Specify and explain.
10. What results, from the PIM Study, do you think are the most important to validate implementing a PIM service at the Stollery?

Appendix E
CAM Practitioner's Semi-Structured Interview Questions

Part I: Experience with Conventional Health Care and Complementary and Alternative Medicine (CAM)

1. What has been your experience within a conventional health care environment, specifically in a children's hospital?
2. How would you describe the general attitude of conventional health care professionals towards CAM?
3. Would you consider CAM services to be non-invasive compared to conventional treatment? Explain.

Part II: Identifying Expectations, Challenges, and Benefits of PIM Services

4. From your professional perspective, would you expect therapies such as massage, music, acupuncture, or reiki, to be effective in reducing pain, nausea/vomiting, and/or anxiety for children in hospital during the PIM study? Explain.
5. a) What potential challenges do you foresee for Stollery staff and/or physicians during the PIM study?
b) What do you see as being potential benefits for Stollery staff and/or physicians?
6. a) What potential challenges do you foresee for the CAM providers such as the acupuncturist, reiki, music and massage therapists, and so forth, during the PIM study?
b) What do you see as being potential benefits for the CAM providers?
7. a) What potential challenges do you foresee for the patients receiving CAM therapies during the PIM study?

- b) What do you see as the potential benefits for the patients?
8. a) What potential challenges do you foresee for **parents** of patients who receive CAM therapies treatments during the PIM study?
- b) What do you see as the potential benefits for the parents?

Part III: Implementing a Pediatric Integrative Service

9. Do you think there would be benefits to implementing a Pediatric Integrative Medicine (PIM) service at the Stollery Children's Hospital? Explain.
10. What would you expect to be some challenges and/or barriers to implementing a PIM service at the Stollery? Specify and Explain.
11. The Pediatric Integrative Medicine (PIM) trial will evaluate the effectiveness of CAM in reducing pain, nausea/vomiting, and anxiety; patient safety; cost-effectiveness; and parent/patient and staff/physician satisfaction. From your perspective, which of these results would you consider to be most significant in efforts to improve inpatient care, and in turn, validate implementing a PIM service at the Stollery Children's Hospital?
12. How would your expertise/experience be an asset to a PIM service at the Stollery Children's Hospital?
13. From your perspective, what CAM provider/service do you think could be an asset to the PIM service in addition to the four included in the PIM study?

Part IV: Professional Communication

14. What is the level of communication with physicians and nurses regarding diagnosis, treatment, and prognosis of pediatric patients that you provide CAM services for?

15. How would you describe your interactions with hospital professionals and staff?

16. Do you have any recommendations, suggestions, or advice for conventional health care providers to help in facilitating effective cooperation with CAM practitioners for the future?