Nurses’ perceptions of complementary alternative medical care in clinical settings
A qualitative interview study with nurses in Karnataka, India

Sjuksköterskors upplevelser av komplementär och alternativ vård i klinisk verksamhet
En kvalitativ intervjustudie med sjuksköterskor i Karnataka, Indien
Abstract

**Background:** Globally the use of complementary and alternative medicine (CAM) has dramatically increased in the last few decades. In India CAM is used both as medical treatment and health care methods enhancing wellness.

**Aim:** To explore nurse’s experiences of complementary alternative medical care as care methods in clinical settings in Karnataka, India.

**Methods:** A qualitative interview study with semi-structured interviews was carried out. Four individual interviews were conducted with nurses working in two clinical settings in Karnataka, India. The data was analysed using a content analysis.

**Results:** Two main themes emerged from the content analysis: *Caring as a challenge* and *Dealing with challenges.*

**Discussions:** The result is discussed using Travelbee’s’ theory on interactions.

**Keywords:** Nursing, India, experience, complementary alternative medicine, integrative care
Sammanfattning

Bakgrund:
Globalt har användningen av komplementära och alternativa vårdmetoder ökat dramatiskt under de senaste årtiondena. I Indien används KAM metoder både som medicinsk vård och för att öka välbefinnande.

Syfte:
Att undersöka sjuksköterskos upplevelser och erfarenheter av komplementära och alternativa vårdmetoder på kliniker i Karnataka, Indien,

Metod:
En kvalitativ intervjustudie med semistrukturerade intervjuer. Fyra individuella intervjuer genomfördes med sjuksköterskor som arbetar på kliniker i Karnataka, Indien. Data analyserades med hjälp av innehållsanalys.

Resultat:
Två huvudteman framkom under innehållsanalysen: Vårdande som utmaning och Hantering av utmaningar.

Diskussion:
Resultatet diskuteras i relation till Travelbees interaktionsteori.

Nyckelord:
Vårdande, Indien, erfarenhet, komplementär och alternativ medicin, integrativ vård
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Introduction
This study was conducted in clinical settings in the state of Karnataka, India during spring 2014, as a Minor Field Study, financed by SIDA scholarship. The study deals with nurses' perceptions of integrative care in clinical practice. The idea aroused when listening to a documentary about integrative medicine with Dr Naveen, Bangalore in India, covered by Swedish Radio. The rising interest in complementary and alternative care methods in Sweden prompted for a study of how it is being used by nurses in its original context, like in Karnataka, India. Also this study describes what caring can be like for nurses in a clinical setting using complementary and alternative caring methods.

Background

Complementary and integrative care in a global perspective
Use of traditional medicine has expanded globally and has gained popularity, not only for primary health care of the poor in developing countries, but has also been used in countries where conventional medicine is predominant in the national health care system (World Health Organization, 2000). The use of complementary and alternative medicine (CAM) has dramatically increased in the whole world in the last few decades (Somani, Ali, Ali, & Lalani, 2014). An estimated 70% of people in the developing world use CAM in an attempt to resolve health issues. CAM is mostly used for non-communicable diseases which cause about 47% of the global burden of disability and premature death, and in high-income countries, up to 80% of all Disability Adjusted Life Years (DALYs) lost (Lindstrand et. al, 2006). In the western cultural context yoga is mostly considered to be wellness therapy and exercise, as in opposition to how yoga is and has been used in India over a long period of time; as a medical treatment and cure for diseases. Yoga as a wellness therapy/method, an offspring of the Indian traditional medicine systems, has prepared the way for acceptance for various other CAM-methods in the west. In middle and high-income countries complementary and traditional care methods are most popular among highly educated women (Lindstrand et al, 2006). In the US, a consortium of academic health centres for integrative medicine comprises 50 highly esteemed academic medical centres, including Harvard, Stanford and Yale (Sundberg et. al 2014). The European Information Centre for Complementary & Alternative Medicine (EICCAM) states that over 100 million Europeans are currently users of CAM, i.e. one fifth of Europeans regularly uses CAM.
Different countries have different approaches. Globally high numbers of users integrate and rely on diverse traditional and complementary health practices. According to WHO up to 80% of populations in low and middle-income countries use traditional medicine for primary health care (Sundberg et. al 2014). Since 1991 WHO has started to develop guidelines, but they are not yet sufficient to cover the many challenging issues of traditional medicine. Focus for these guidelines are safety, efficacy and issues concerning the evidence base (World Health Organization, 2000).

Definitions
In this study at hand the term CAM (Complementary Alternative Medicine) will be used for the care and care methods used by the interviewed nurses in their clinical settings.

**Complementary Alternative Medicine (CAM)** is a term used for both medicine and caring/methods. According to a WHO definition the terms "complementary medicine" or "alternative medicine" are used inter-changeably with traditional medicine in some countries. (World Health Organization, 2000). Complementary therapies can be adjunctive therapies aimed at symptom management and enhancement of quality of life and has been further clarified by Cornmer and Harewood (2004) by categorizing it into *alternative treatment*, when treating underlying disease, or *complementary therapies*, supporting ongoing medical care by easing symptoms and improving well-being (Carter & Mackereth, 2008). The National Centre for Complementary and Alternative Medicine (NCCAM) defines Complementary and Alternative Medicine (CAM) as: ‘A group of diverse medical and healthcare systems, practices and products that are not presently considered to be part of conventional medicine’ (Somani, Ali, Ali, & Lalani, 2014) and has categorized CAM therapies into five major domains: *Whole medical systems* (homeopathic medicine, naturopathic medicine and traditional Chinese medicine), *Mind-body medicines* (meditation, prayer and art therapies), *Biologically based practices* (dietary supplements, herbal products and botanical products), *Manipulative and body-based practices* (chiropractic, osteopathic and massage) and *Energy medicine* (biofield therapies like Gi Gong, Reiki and therapeutic touch and bio electromagnetic-based therapies (Somani, Ali, Ali, & Lalani, 2014).

**Integrative Care (IC)** is a health care model aiming to meet the growing demand for person centred health care services and a response to the increasing use of Complementary and Alternative Medicine (CAM). The concept of integrative medicine/care is often referred to as the new medicine, typically signifies a combination of safe and effective Traditional
Medicine (TM) or Complementary and Alternative Medicine (CAM), and state-of-the-art conventional medicine (Sundberg et. al 2014).

**Traditional Medicine (TM)** is based on the religious beliefs and philosophies of those cultures (Somani, Ali, Ali, & Lalani, 2014). Traditional medicine systems in India consists of Ayurveda, Yoga, Naturopathy, Unani, Sidda and Homeopathy (AYUSH) systems of medicine (Patil, 2013). In the General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine TM is defined as theories and concepts of prevention, diagnosis, improvement and treatment of illness. (World Health Organization, 2000).

**Allopathy** is a term often used in India when referring to conventional Western medicine, when having the perspective from the Indian traditional systems of medicine. The term allopathy is remnant from the early homeopathic medical system terminology, when there was a terminological dispute between the homeopathic and the conventional systems of medicine, both trying to set the benchmark as the authoritative system of medicine. *Allopathy: A method of treating disease with remedies that produce effects antagonistic to those caused by the disease itself* (The American Heritage Medical Dictionary, 2007).

**Complementary and integrative care in India**

Traditional and complementary forms of medicine are popular in low-income countries. In India the Ayurvedic system is widely used for conditions where evidence-based treatment is not available or affordable by the family or community (Lindstrand et al, 2006). What to an outsider seems to be a plethora of treatments, supplies of herbal pharmacies, alternative clinical treatments and ayurvedic medicines are in fact organized in traditional systems of medicines in India. Traditional medicine systems in India consists of Ayurveda, Yoga, Naturopathy, Unani, Sidda and Homeopathy (AYUSH) systems of medicine (Patil, 2013). In India Complementary and Alternative Medicine (CAM) is used both as medical treatment and wellness health care methods. Traditional medicine is used alongside with allopathy, i.e. conventional western medicine and yoga is one of many alternative methods with its position as a medical treatment (Somani, Ali, Ali, & Lalani, 2014). In WHO’s statistics India belongs to the South East Asia Region (SEAR). WHO divides some of its health data into high-income and low- and middle-income countries, and India belongs to the middle-income countries. In Unicef statistics and according to the World Bank regional summaries, India is part of South Asia (Lindstrand et al, 2006). Sometimes traditional practices can be more expensive than biomedical treatments for poor families that spend most of their economic
resources on food, education and health care (Lindstrand et al, 2006). UNDP (United Nations Development Programme) publishes reports called HDI-reports (Human Development Reports). HDI-reports measures the nations level of development by the three main components socio-economics’, health and education. An IHDI-index is supplemented with an inequality adjustment. The Inequality-adjusted Human Development Index for India’s States (Suryanarayana, Agrawal & Seeta Prabhu, 2011) provides estimates for the IHDI for Indian states and shows that for the region of the state Karnataka (where this study was made) it is rated to 0,508, compared to 0,519 for all of India. This shows that the level of inequality is very high in India.

**Nurses attitudes and knowledge of complementary and integrative care**

Studies of nurses and use of CAM have both qualitative and quantitative approach and cover both nurses’ attitudes, confidence in and knowledge about CAM. Research on nurses’ using of CAM is carried out not only in the traditional medicine context (low-income-countries), but also in conventional Western medicine contexts. Somani, Ali, Ali, & Lalani (2014) concludes that nurses have positive attitudes and experiences of CAM, but lack knowledge. Rojas-Cooley et al (2009) conducted a descriptive, cross-sectional study involving 850 oncology nurses whose CAM knowledge mean score was 70%. Most of the participants correctly identified conventional medicine, but only 50% correctly identified the term ‘CAM’. Brolinson, Price, Ditmyer & Reis, (2001) explored nurses’ in United States perceptions and found that about half of the respondents perceived that five therapies were effective: biofeedback, chiropractic, meditation/relaxation, multi-vitamins and massage therapy and also perceived five therapies as safe: hypnotherapy, chiropractic, acupressure, acupuncture and healing touch. The majority (79%) of nurses perceived their professional preparation in this area to be poor. The same study showed that nurses’ expectations of safety for the patients using CAM therapies, were most likely to perceive therapies that were external as safest. Nurses’ attitudes towards CAM in Karachi are described in a quantitative study with 132 oncology nurses. This survey showed that 71% of the nurses agreed that CAM stimulates the body’s natural therapeutic powers. 78% of the nurses agreed that CAM had a positive psychological impact on patients. The explanation could be that nurses in the current study had used some CAM therapies themselves and might have had a good experience. 56% of the nurses believed that ‘CAM could be a supplement to allopathic treatment’. The study argues that health professionals need to raise their knowledge about CAM, to avoid a communication
gap with their patients and discusses that healthcare providers need to have knowledge about CAM to be able to analyse evidence of effectiveness of those therapies. In a questionnaire-based study among qualified nurses it is concluded that the use of CAM is high among nurses and that patients are increasingly relying on nurses for advice and therefore it is important for nurses to be educated about CAM (Buchan, Shakeel, Trinidad, Buchan & Ah-See, 2012). 80% of the respondents admitted to using CAM, using massage, cod liver oil and cranberry juice, mostly used for relaxation, joint pain and urinary tract infection. The study shows that 93% did not have any formal education of CAM and that most nurses would consider some education on CAM to enable them to better counsel their patients (Buchan et al 2012).

**Complementary and integrative care in Scandinavia**

In Scandinavia Norway has national government-funded research, while Sweden lacks national policy for integrative care and is dependent on financial support from private charitable research foundations, such as the Ekhaga Foundation to enable research. (Sundberg et. al 2014). In Sweden CAM is regulated by law and nurses need to relate to the description of their competence which includes the ability to use, administer and use different methods, evaluate effects and side-effects, also when it comes to CAM care methods (Bergh, 2009). There are few reports of serious side effects of CAM due to little research which leads to insufficient knowledge about the effects of CAM. Exceptions from this is acupuncture and TENS that has since 1984 by Socialstyrelsen been considered to agree with reliable science when treating patients for pain. These methods can since 1993 be used as any other methods in Swedish health care. The most common CAM methods in Sweden, according to the study *Pain in Europe* are physiotherapy, acupuncture and massage (Bergh, 2009). SBU states that scientific groundwork has to be strengthened and guidelines have been made to strengthen the quality of studies that evaluates studies of CAM (Bergh, 2009). Karolinska Institutet has set up a research group for integrative care (Karolinska Institutet, Research Group Integrative Care, 2014) which studies on integration between different systems of medicine, and how this integration affects the patients’ freedom of choice, safety, effectiveness, health and wellness, including biological, psychological, social and spiritual aspects. The goal is to increase academic knowledge about potentials and pitfalls of integrative care from various stakeholder perspectives. The group is also exploring integrative cares’ relevance for different health care professionals and arranging integrative care courses for medical and nursing students. They
are also engaged in the core planning group of the new WHO global strategy for TC/CAM 2014-2023 (Karolinska Insititutet, Resach Group Integrative Care, 2014).

Problem area
Traditional Medicine (TM), Integrative Care (IC) and Complementany Alternative Medicine (CAM) is a challenge for future health systems to explore. Patients receiving care in the Swedish health care system, where all medical and therapeutic treatment have to be registered or evidence based, are already also using non-approved or non-registered CAM care methods and therapies, such as herbs or alternative medical products. Due to this nurses need to improve knowledge about CAM when considering risk- and beneficial factors such as e.g. risks for pharmaceutical interactions, indications and contraindications. Nurses also need knowledge for recognizing symptoms that may make the CAM treatments or drugs inadvisable to use or the CAM methods inadvisable to employ. Knowledge also should cover benefits like positive effects, well documented fields of applications and advisable employment of different complementary care methods. This study aims to explore the experiences of nurses working with these methods in clinical practice, in Karnataka, India, in order to get a better understanding of how these concepts are used, experienced and perceived among nurses.

Aim
The aim of the Minor Field Study was to assess nurse’s perceptions and experiences of caring for patients in clinical practice using Complementary Alternative Medical (CAM) care methods.

Theoretical framework
Travelbee’s theory on interactions
Several nurse theorists address nursing as a process of interaction and nursing care as a human relationship (Meleis, 2012). Travelbees’ theory on interactions describes nursing as an interpersonal process between two human beings, one needing assistance because of illness and the other being able to give such an assistance (Meleis, 2012). Travelbee defines the term interaction as any contact containing two individuals having reciprocal influence on each other and their verbal communication (Travelbee, 1966). The term of consensus care is
therefore central in Travelbee’s theory Interpersonal aspects of nursing (Travelbee, 1966). Communication is the vehicle through which nurse-patient relationships are established according to this theory and relationships are described as series of experiences between a nurse and a patient (or a family member). Communication is also the key tool for nurses to prevent communication breakdown by perceiving patients as human beings, recognizing levels of meaning when communicating, listening with reflection, undue interruptions and avoiding clichés and automatic responses (Meleis, 2012). Nurses and patients go through several stages to achieve to goal of the established nurse-patient relationship. Each stage has certain tasks. A healthy development of the relationship is accomplished by mastering each task and the stages are Phase of the original encounter, Phase of emerging identities, Phase of empathy, Phase of sympathy, Phase of rapport according to Meleis (2012). When relationships are established the nurse can help the patient to accept and find meaning in their experiences. Travelbee based the theory on assumptions like for instance that the nurse-patient relationship is the essence of the purpose of nursing and that when humans undergo certain experiences they search for meaning in them. These experiences could be considered as coherent wholes and could be illness, anxiety, joy, harm etc. Therefore, Travelbee explains, likeness and similarities between human beings are in the nature of their experiences. (Meleis, 2012). The implications of these assumptions, as well as the communication process and the interpersonal process are part of every care context and thus also in CAM, and therefore this theoretical framework was chosen for the study.

**Method**

**Study context**

A qualitative design approach and research method was chosen for the study, with semi-structured interviews as data collection tool. The interview as a data collection tool is adequate when wanting to understand phenomena or situations for the participants (Danielsson, 2012). The nurses’ role, in the clinical settings where the study at hand was made, were to act upon the physician’s diagnoses and provide the patient with the treatment and helping the patients using the care methods the physicians prescribe, i.e. yoga and ayurveda alongside with traditional care. Yoga was employed as medical treatment and also as wellness health care method. The medical yoga treatment was practiced with the nurses/therapists in these settings and the nurses role when doing the medical yoga therapy, and approaching the patients, is similar to the physiotherapists’ role in a Western context.
This reflects on the names of the work/professional titles of the nurses who work in the clinical setting in the study at hand. In one of the settings the practice of calling the nurses therapists was used, and the patients are called participants. This is part of the approach in the CAM philosophy, with the aim to emphasize and put focus to the fact that the treatment is depending on the patient’s own participation. Thus, being a nurse in the clinical settings where this study was made, the nursing role for a nurse is a lot about being a therapist and giving care to an active participant, rather than a passive care-receiving patient.

Participants

Data was collected in the two clinical settings, one holistic research- and health clinic and one department in a multispecialty hospital, meaning several different areas of medical diseases is treated by the medical team. Selection of participants was made with suitability in regard since the aim of the study was to get knowledge of a homogenous group (Danielsson, 2012). To recruit the participants the author contacted researchers and chief medical officers of the clinical setting where the interviews took part, first by e-mail, to receive permission to visit to the clinics to describe the study. Approval was given by chief medical officers to conduct interviews and a written and oral information was given to the staff about the aim of the study. Recruitment of participants was done by the medical officers and/or chief nursing superintendent in the clinics. The inclusion criteria’s for the participants were to be registered nurses, English speaking and agreed upon and signed the consent form for the participation in the study. The four participants were between 23 and 48 years old, (m=25,7 years). Two participants had a working experience of at least one year while two of the participants had 6-7 years’ work experience. Two nurses worked as nurses/therapists in a holistic health clinic and the other two nurses worked in a psychiatry department in a multispecialty hospital.

Procedure

Semi-structured interviews were held with four nurses. The interviews were held based upon the premade questions in the interview guide (appendix 1) and were held as normal conversation between the author and the nurses. The participants were interviewed separately to assure integrity. All interviews were held in a separate office, located inside the clinical settings and were recorded since it is a less intrusive method than taking notes during interview session and a reliable way to register verbatim during interviews. The qualitative interview is made with a small group of people and is focusing on the meeting between the
interviewer and the participants (Danielsson, 2012). Two recording devices were used to minimise the risk of losing data due to technical problems. The interviews lasted between 26 and 36 minutes and the average time for an interview was 32 minutes.

**Data analysis**

The interviews were transcribed verbatim soon after they were carried out. The data collected comprises totally 17742 words. The method of data analysis was qualitative content analysis. Inductive work method was chosen since there were no similar studies for the selected phenomena and the knowledge is fragmented. The inductive work method was chosen since it is suitable for analysing written, verbal or visual communication (Elo & Kyngäs, 2007). This study searched for what was the content of the interviews and categorized the content i.e the data (words and phrases). As a result patterns emerged from the interviews. (Elo & Kyngäs, 2007). A matrix for analysing the result was created and used as a tool during the data analysis process (Appendix 3).

**Ethical considerations**

A consent form (appendix 2) was created and an ethical approval was obtained from the Ethical Committee of Ersta Sköndal University College (Dnr. 1401/A). The participants were orally briefed about the purpose of the study, the procedure, risks and benefits taking part in the study and the consent form was distributed to every participant before the start of the interview. The names of are not mentioned in the study to diminish the risk of compromising with the participants’ confidential identity. The recorded interviews were kept safely until the thesis was approved to enable to control the result and after that disposed.

**Result**

Two main themes emerged during the phase of data analysis: *Caring as a challenge* and *Dealing with challenges*.

**Caring as a challenge**

The analysis of the interviews shows that nurses meet challenging obstacles. These obstacles influence the way the nurses approach the patients who are to be treated with CAM. Two subthemes were identified under this theme: Lack of patient participation and Meeting unrealistic expectations.
Lack of patient participation

The nurses express that the patients’ lack of participation is a challenge. The nurses in the study share the opinion that a high degree of patients own participation and an openness to the CAM care method are important in order to work with these care methods:

*But the system is there and sometimes the patient can be cooperative. [You have to] make sure that the patient is cooperative, especially in psychiatric care.*

Patients are often in an upset mood or depressed, or in a state of pain when they arrive at the clinic for care and treatment. Nurses describe how challenging it is to start caring for patients when they express anger directed at the nurses. The anger and pain makes the patients’ attitude to treatment negative and thus challenging:

*Uhm...the challenges are people, the patients, they come with such anger. Such pain. Directed at us. And the only thing, the first time I felt it, I was appalled, I was [asking myself]: “What is this??” And then I realized...It is a pattern.*

Nurses experience that the patients’ emotional state and wellbeing can be challenging due to the fact that the patient is not ready, and that patients with a severe depression are unable or not ready yet to receive treatment:

*I think the patients with a serious depression.... They are more hard. They are not ready to ventilate their problems. It is most about they won’t get up, they are feeling sad, they won’t eat, they won’t drink, so they, uh, are sitting in one place for long time for thinking something. So they are [caught] in very negative problems and they are not ready to speak to you.*

Meeting unrealistic expectations

Even if the patients have chosen themselves to come to a clinical setting where CAM is used, the patients’ expectations are often that the effect from the CAM care should appear sooner than it does in reality. Nurses meet patients that expect the complementary care to be a quick remedy and want to hear from the nurses that the healing will be fast:

*...so what you don’t want to hear is: “I want to be cured in a fast way”. They’ll ask you “I want to know” and just ask the quick, they just ask for everything, but they can’t do this slowly...They want to hear “fast”. That’s all they want to hear, everything comes in a way of fast, and it is like: “No more medicine. ‘I’m having medicines, too much medicines”...But after that you will have to give all that education: “But you need [to do] everything slow. Walk like a turtle.*

This unrealistic expectation differs from the interviewed nurses’ own knowledge of CAM care since they believe that the results of such methods will show gradually and slowly, and only if the patients themselves participate.
Dealing with challenges

Nurses experience they have developed coping strategies which can either be to help the patients in challenging situations, or help nurses to deal with challenges. The analysis shows four subthemes: Creating comfort, Empowering the patient, Having credence in CAM and Having the competence.

Creating comfort

Nurses emphasize the importance of getting consent from the patient before starting treatments in order to create comfort in the situation. They talk about how it is not possible to force patients into any treatment without getting patients consent:

You can’t push them. You can’t force them. Patients do not want to be forced. That’s my meaning. You have to know that...and...when you force them, they will start to recent you, they’ll start [to think]: “Oh, how can you say that?

Nurses hold the opinion that the patients themselves must be interested in the treatment, such as yoga:

Forcing somebody, and pulling somebody will make [them] feel bad and [the result] wont happened....they should have this [motivation] from their own mind...You say: “Yesterday we did some yoga because it has some benefits”. That, interest, the patient should have. We can force them to eat tablets but we can’t force them to do yoga.

Nurses find it essential to try and create a comfort zone for the patients: “so we get the comfort, we get the comfort zone, or for them to be comfortable with us ”. Nurses also point out how the caring relationship starts with the nurse comforting the patients: “When they first come we should comfort them”. The patients, after some days, usually will want to participate, if they are not forced. Nurses talked about that the patient-nurse relationship is a heavy factor for creating comfort and for the care to function well. They stressed that for all kinds of therapies it is important to set up an interpersonal relationship with the patient and make sure you smile at the patient to show friendliness, concern and engagement:

For therapies it is most important that you have relationship. The interpersonal relationship will be very adequate and the fact is when patient come we need to tell them hi and smile and [ask] how is it. At least have a smile at your face. You should have a smile for them!

The nurses state that it is clearly the nurses’ responsibility to make sure the relationship develops between her and the patient. Even if the patients do not seem to want to have a relationship it is the nurses duty to keep on trying until they both connect and have a good relationship:
If the patient can’t properly talk to you… Ok I’ll come back tomorrow, so tomorrow I will talk to you again. But I’ll feel very bad [because of this] because the patients usually talk to me… “Why are you not talking to me?...You are good patient I am a good nurse, then why you are not talking to me?” After a while patients usually are talking to me.

Nurses also hold a strong opinion that they need to feel free: “I must be free to have a relationship. I must be very free.”

Nurses experience that if the patient does not share the problems with a nurse they cannot have a good relationship. They do not wish the patient to be a stranger to them and unless they have shared the problems they will not have a good relationship. Nurses experience that the nurse-patient relationship can sometimes mean that the nurse will take the family’s place, or the position of a friends’, if the patient does not have any family. This can be very therapeutic and comforting for the patient:

...we use to spend time with the participants, like a father, mother or their family, because sometimes they don’t have a family...we ought to be there [because we] need each other, we can be friends and nurses and make them enjoy [the treatment] much more.

However they sometimes need to get rid of their pre-understandings or personal feelings.

Being neutral is an important coping strategy to create comfort, meaning that they do not follow the patients’ moods but remain neutral regardless the patients expressed emotions.

Neutralizing the mind is nurses’ own strategy in challenging situations. When patients are angry they have a negative approach for care offered at the clinic, the nurses’ strategy can be to stay neutral and calm in the situation:

I’m totally neutral... I’m supposed to be neutral about it. I’m supposed to listen to them, yeah. I’m supposed to be calm.

Another coping strategy for nurses is to calm the patient. Nurses describe how to handle the situation if a patient is aggravated and make the other person calm. After an emotional outburst and after having calmed the patient the nurses can comfort the patient and explain the angry behaviour by talking to the patient about what triggered the anger:

At times, in some situations we need to make them calm first, and, somehow, [help them to explain] how they can motivate their...that anger... The physical outlet. Then we can approach him again: “What made you get this type of anger?” “Why did you get it?” Then, in a calm way we can make him to understand the situation...

The nurses’ experienced that one strategy to choose can be to remain positive instead of being negative. The positive approach reflects on the outcome of the situation when using this coping strategy:

Yes the thing is, if one look at the world in a positive way, everything is possible. If you would think of all in this negative way also the persons you meet will become negative. And that is the difference.
Empowering the patient

Nurses experience that interaction with patients is a key to empower the patients. Interaction could in this case consist of speaking to the patients with the aim to support and empowering the patient. Communication is the most important form empowerment: “Communication still is the most important. How you communicate with your patients.” Greeting the patient is a good start and sometimes the nurse need to not give up:

Yeah usually we go in and we do greeting, actually. We great him!...“Good morning, how are you?”...Yeah, they also respond but sometimes, it depends on their mood, they will not respond, but still, we greet them and then after some time we greet them and again and approach them: “How are you? “How are you feeling, mam?” “What did you have for breakfast this morning, what did you take?”

Another form of empowering the patient is giving the patients the opportunity to share their problems and sort out the nature of their problems and conditions:

...they need to ventilate their problems...You should make them speak up about their problems first. Unless someone helps them to ventilate their problems first we can’t get into something. Not unless the patients first talk about their problems properly.

Empowering patients also includes non-verbal communication, like physical touching or holding the patient: “We are touching, holding them...It is our job to take care of them... and it comes thru by giving my vivid hands...” Nurses believe that it is the nurses’ job and part of their competence to empower the patients by talking to the patients supportively in order to strengthen their self-confidence in exercising the CAM method:

You can say: “Try one of this things” Just a few words can give them self-confidence: “This is ok. Try and work against it. This is ok. All steps you take are start for the future and it starts with you exercising”. Our job is to give courage and to provide support and to give them hope. The person needs self-confidence first. So I think the best we can do is to support them, to be there with the person all times, we can empower the patient.

Having credence in CAM

All the nurses have credence in CAM. Nurses experience that they can offer for example a patient suffering with cancer relaxation by providing yoga therapy along with the chemotherapy treatment:

Cancer patients who are not yet at the dying stage. We can’t make them to be in another place. We can’t say that. So, along with providing chemotherapy drugs, you can provide some other therapies, like yoga. We are providing other types of therapies and we can see that they are very good really. Patients relax.
Nurses experience that even if CAM cannot cure the patients from cancer they can provide the patients with pain- and mind relief at the final stage of cancer and that can sometimes make fast changes for the patients’ wellbeing:

*Especially in that metastases stage or when the prognoses is weak. We can’t cure it. But we can provide them with some therapies and release some pain at least and sometimes we can provide mind relief. Some therapies like yoga, relaxation therapy, diversion therapy, psychological support, it can sometimes be good to change the patient’s situation.*

Nurses talk about their own expectations and credence in CAM. Getting to know more about the complementary care methods, they can give the patient a better treatment which is experienced joyful:

*...I usually get very happy using these methods, they are coming very well, and we are getting better in treatment, are getting better here. That gives me a very happy feeling inside.*

Nurses believe that patients will in every case respond for example to yoga therapy by having their mind relaxed.

**Having the competence**

Having competence is part of the working role and the nurses’ competence can be incomplete or limited. When it comes to complementary care nurses thinks it is important that nurses themselves know how to exercise yoga before they employ this kind of care to the patients:

*“Unless I like myself doing yoga I can’t motivate the patients. So my competence is limited of course, I have never gone deep into that topic.”* Experience and practical knowledge as well as a strategy to deal with challenges are the main assets for a nurse: *“Practical knowledge is the main thing that will put everything right.”* The nurses experience that apart from having a certain level of knowledge, they also must be aware of the patients’ level of knowledge. They talk about the importance for nurses of educating the patient and how it is the nurses’ role to be the educator: *...we need to educate but take it to their [patient’s] level, for there will be the second level to educate them. So we need to be the person who educate.*

**Discussion**

This section holds discussion on the chosen method for the study and the result of the study grounded in the chosen theoretical frame. To distinguish and clarify when referring to this study it will be mentioned as “the study at hand”. Subjective interpretations will be mentioned as “the author”.

Method discussion

Since the aim of the study was to examine perceptions the author chose to use the qualitative research interview. No approached nurses for participation renounced the invitation, even though there could have been nurses who refrained to participate without the author’s knowledge. One of the interviews, originally five interviews, had to be excluded from the data collection of the study due to technical problems with recording the interview, in combination with the participants’ very poor English speaking level, limiting the authors’ comprehension of what was said in the interview. The interview guide was prepared in advance and finalized during the first interview sessions at the holistic health clinic, where the first interviews took part. To address language difficulties as well as the different cultural notions during the interviews the author at times needed to develop and reformulate the questions, giving examples to clarify and check the correct understanding was done. This could be considered as controlling of the conversation, but to repeat questions during the interview and rephrasing questions could be of value to secure the reliability of the reply to the questions, and a fashion to control the validity of the answers. The author spent two full days on site before the interviews at the holistic clinic to collect knowledge about the topics for the study and to get insight in the verbal- and non-verbal communication in the current context and culture. The hospital setting was visited a full day two weeks in advance before the time of the interviews for the same reasons mentioned above. This was also part of considering the quality and outcome of the study’s result as getting to know the culture to be able to make deference and adopting the correct dress code. In the data analysis phase the author found meaning carrying units. The author let the supervisor also take part of the collected data to get a second opinion and an extra perspective to be able to extract the themes. The coding and categorizing was made several times until the author was satisfied with the interpretation and the final thematic structure. The result would probably have been different if the nurses would have worked in a context where the society or/and the health care model would have been strictly conventional western. The nurses believe that the CAM therapies, regardless the diagnoses, will have relaxing, and thus empowering effect on the patients once they participate in therapies. It can be assumed that since the nurses interviewed in this study, having chosen to work in a clinical setting where the traditional medical approach of health care is implemented and used along with the modern western medicine system has an important impact on the nurses thinking, experience and perceptions of CAM care, the care they give the patients.
**Result discussion**

The result of this study should be seen as an insight in what nurses perceptions are like in a clinical setting context where CAM therapies are traditionally used along with the modern western system of medicine. The cultural aspect is a heavy factor considering that every caring interaction consists of one nurse and one patient, each of them having his/her own opinions and experience/knowledge of traditional medicine and care methods. A study among people with type 2 diabetes attending diabetic clinics in three census regions in Taiwan (Chang, Wallis & Tiralongo, 2012) concludes that complementary and alternative medicine use in people with type 2 diabetes is influenced by people’s experience, beliefs and attitudes towards complementary and alternative medicine. The authors of the article emphasize that nurses and healthcare professionals should consider the patient’s background, health history, health beliefs and cultural background when planning specific strategies designed to modify lifestyle. The study also concludes that in order for health professionals (e.g. diabetes nurses and educators) to be successful, they need to establish policies and guidelines for complementary and alternative medicine. The study at hand showed that one of the most important factors when working with the patients using CAM therapies is that the nurses themselves have knowledge of the methods and the effects of the CAM care. Where a majority of nursing faculty and students have expressed positive attitudes towards CAM and a desire to learn more about effective strategies to integrate CAM knowledge into standard health curricula (Booth-Laforce et al, 2010). The result of the study at hand also corresponds with an article discussing popularity of CAM in the UK and other industrialised countries as well as the nurses’ need for CAM therapy competence in response to the public’s use of it (Little, 2013) Nurses need a fundamental knowledge of CAM concepts and an understanding of how CAM and conventional health care might affect one another and is desirable, according to the article, to embed CAM and integrative health care (IHC) into nurses’ education. Integrative health care has, the author argues, the potential to contribute to the preparation of a modern nursing workforce that values patient choice in the context of responsible and well-informed practice (Little, 2013). A study of perceived knowledge about CAM among registered healthcare professionals in surgical departments in Sweden (Bjerså, Stener Victorin & Fagevik Olsén, 2012) shows that CAM usage is reported to be common among surgical patients and that the therapies the health professionals recommended by 40 % of the participants were massage and acupuncture. It was also believed by 61, 2% that more
research funding should be addressed to CAM research and half of the participants (1757 registered physicians, nurses and physiotherapists) were positive to learn such therapy.

**Main findings in relation to Travelbee’s theory on interactions**

Participation of the patients was in the result of this study at hand very central. The patients’ participation relies on the interactive strategies the nurses use. The challenges for nurses to involve patients were about creating contact, establishing a nurse-patient relationship as well as communicating with the patient. Without any nurse-patient relationship nurses could not carry out any of the CAM treatments and the phases in interaction, elaborated by Travelbee (1966), could have been applied on what nurses in this study narrated about. Ultimately caring is about interacting with the patients until such a relationship is created, like Travelbee’s theory on interactions impose (Meleis, 2012). Travelbee discusses and defines the term nurse-patient interaction” (Travelbee, 1966). The theory refers to that any contact between a nurse and an ill person is characterized by the fact that both individuals perceive the other in a stereotyped manner (Travelbee, 1966). This was also shown in this study at hand, in the way the patients communicated or had expectations on the nurses’ interventions, a hope for fast recovery without giving any importance to the process of communication or interaction itself as a healing factor. The nurses’ expectations on and credence in the CAM therapies are different than the patients, who expect a much quicker result than the methods actually provide. According to Travelbee (1966) there are all kinds of interactions. Some are helpful and useful to ill persons, some are not and one of the ill person's needs may be met during the interactive process (Travelbee, 1966). In the interaction these needs are not met consistently and unconditionally, according to Travelbee (1966). The human-to human relationship, in nursing situations, is differentiated from the nurse-patient interaction in that the nursing needs of the ill person are met consistently and unconditionally (Travelbee, 1966). In the study at hand it has been shown that nurses play an important part in supporting, empowering and helping the patient to participate in their own CAM treatment. The result shows that despite the nurses or the patients’ attitudes towards CAM the relationship between the patient and the nurse is central to begin with in order to create comfort for the patients and to empower the patients to take part in the CAM-therapies. The nurses cannot provide CAM therapies unless the patient is participating. The theory on interactions by Travelbee discusses how interactions occur when the nurse communicates with the ill person, gives medications and performs nursing procedures and that nurses interact with ill persons when giving direct physical care and engage themselves in health teaching and directing the ill persons's
activities (Travelbee, 1966). The same view by the nurses was shown in the result of the study at hand, for example the CAM care used by the nurses in the study at hand was mainly yoga therapy, meditation and Ayurveda. The result shows that the nurses experience obstacles when using CAM methods in clinical practice and therefore nurses have developed coping strategies to help both the patients and themselves.

Nurses competence of CAM care methods
The result of the study at hand showed that nurses interviewed felt a limitation in their knowledge and competence of CAM, and lacking knowledge even if their professional and cultural context is well familiar with the traditional systems of medicine. The nurses experienced that a general belief in CAM is playing a part of the patients’ wellbeing or improved health condition as well as safe methods to use. As mentioned in background nurses lack knowledge. Central to provide nursing practice and client-responsive health care is achieved using CAM related to social trends and patient choice and it requires a responsibility on health professionals to engage with patients who show interest in CAM, according to Little (2013). A study in Italy, among oncology nurses, shows that common primary source of information for CAM was other healthcare workers, the internet, workshops and seminars and only 5% used professional journals as a source. The study concludes that the fact that nurses are responding to demands for CAM therapies without a solid knowledge base makes it important that the nursing curriculum is expanded to include CAM (Zanini et al., 2008).

Attitudes and expectations of CAM
The attitudes and expectations of CAM care methods has two sides: the nurses’ perspectives and the patients’ perspectives. In the study at hand it shows that regardless of the perspective, both perspectives exist in a caring situation. A study investigating the knowledge and attitudes student nurses have to the use of CAM in cancer and palliative care, concludes that raised awareness of CAM therapies and their potential is needed. The authors of the study also state that it is necessary to provide knowledge of the legal and ethical dilemmas of using CAM approaches to care (Laurenson, MacDonald, McCready & Stimpson, 2006).

Sundberg et. al (2014) suggest that the increasing levels of chronic illness and escalating health care costs calls for a revitalization of the modern health care system and suggest that an integrative health care system with a diversity of therapeutic options might be the best way to revitalize the health care system and reducing the costs (Sundberg et. al 2014). The question
for health care providers, according to the authors of the article, is how nations can harness the potential contribution to TM/CAM to people-centred, health and welfare through regulation, research and integration into the health system in line with the recent World Health Assembly (WHA) resolutions (Sundberg et. al 2014).

When it comes to the future and what role the CAM should play in the health care system and for nurses this issue is being discussed among researchers within the field of integrative care. To maintain a polarized situation between the health systems is unhelpful for the patients and may even be dangerous. This is clearly a challenge for future health systems to explore, as well as a way forward, which has also been identified by the Director General of WHO (Sundberg et. al 2014). Another important aspect is to explore the risks of CAM, since the field of CAM is characterized by uncontrollable use and potential risk of harm to patients due to interactions between herbs, CAM treatment and conventional medicines (Sundberg et. al 2014). In a recently held conference in Karnataka, India on alternative medicine, enriching healthcare by integrating alternative medicine with conventional medicine was discussed (Patil, 2013). It was concluded that integrative medicine (using both conventional and traditional systems of medicine) is lacking in providing complete healthcare as per the definition of WHO. Each stream of medicine has its own merits and demerits and therefore all AYUSH specialties are best explored before integrating them with conventional medicine. This conference also concluded that systematic research needs to be carried out, to explore their safety and efficacy before its implementation as well as the Indian Government and private organizations have to create a model for providing holistic healthcare. (Patil, 2013).

The nurses’ role using CAM in a clinical setting

The result of the study at hand shows that often nurses need to take the role as educator and teach the patient about CAM care due to the patients’ poor pre knowledge. The nurses’ role of CAM, the author believes, is to educate the patient and to be able to deliver a safe and high quality care. This corresponds with a study exploring people’s experiences of medical herbalism (Little, 2012) that states that health care is more likely to meet the expectations of the patients from the perspectives of both patient and health care professional. The role of the nurse when patients are using CAM is considered to be important, since nurses have a prime position to influence the knowledge base and future direction of integrative health care, especially in relation to patient perspective (Little, 2012).
Suggestions for further studies

The results of this study suggest in concordance with Brolinson, Price, Ditmyer & Reis (2001) future research of attitudes towards and level of knowledge of CAM methods among nurses working in clinical settings where complementary or alternative care methods are not part of their official educational curriculum or daily practice at work, since also many other studies show nurses perceive their professional preparation in this area to be fair or poor.

Clinical implications

The results of this study suggest that CAM care is employed in caring situations parallel and as part of all other care interventions. CAM care interventions can only be employed when there is a functioning nurse-patient relationship, or a therapeutic alliance, which nurses are responsible for to set up. CAM-care is best used with patients that participate on their own free will and only if there is consent from the patients.

Conclusion

Complementary and alternative care is a big challenge for future health care systems and professions, such as nursing. Nurses need competence to be able to meet up with patients’ expectations, wishes, needs and hopes when giving care or employing CAM treatments. Nurses also need competence to be able to treat patients according to safety and other regulations. CAM care is suitable when patients want to use the CAM themselves and when patients need and want to make lifestyle changes. Educating the nurses about integrative care and CAM is important since it is an ever growing part of the future health care and context, both in the western context and elsewhere.
Acknowledgements

The author would like to thank all the nurses in the clinical settings that participated in the interviews held for the study and openly contributed with their perceptions and own experiences. A special thanks to Dr. Naveen Visweswaraiah, Bangalore, who in so many ways contributed with assisting in finding contacts, setting up meetings with and enabling visits in clinical settings as well as being a notable source of knowledge and inspiration for research within the field of Integrative Medicine and Integrative Care.

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Finally the author would like to thank SIDA for the Scholarship for this Minor Field Study and for making the study possible financially along with the excellent preparation course in Härnösand to prepare for field studies abroad in developing countries.
References


Vetenskapsrådet (2014) http://www.codex.vr.se/


Appendix 1
Interview guide

Introductory questions
-Which is your current competence within the field of complementary and alternative care (Yoga, Ayur Veda or Homeopathics)?
-What kind of qualities do you think are important for a nurse to work with integrative care? If any in specific…

Interview questions
-Can you describe what a typical day in the clinic/department/hospital looks like for you?
-Can you tell me about a situation you used complementary care method treating a patient and it worked out very well? -What was the procedure? -Can you tell me about the situation?
-What did you do as a nurse?
-Can you tell me about when you used complementary care method treating a patient and it did not work so well?
-What challenges you in you work? Can you describe such challenges and situations?
-Are there any barriers between you, the patient and the caring? Any examples? Situations?
-How do you approach a patient? Can you describe how patients are being approached with the treatments?
Appendix 2

Consent form

This study is about nurse’s experiences in the field of integrative care using complementary care interventions in clinical practice in India. With this information we would like to ask you to take part in the study dealing with your experiences of caring for patients.

Participation is voluntary and you can at any given time decide to no longer participate without explanation. The interview will be conducted as a normal conversation during about 1 hour at a place you choose and will with your permission be recorded. The interviews will be transcribed to make data analysis possible. No names or other personal data that reveal the participants identity will occur in the text.

The student Lola Armonioso will conduct the interview and the recorded interview will be stored in an USB-memory stick. Collected data will be stored safely and no other person except the student and the supervisor will have access to the data. A report will be written and then the USB-memory stick will be destroyed. The report will be published electronically in DIVA at Ersta Sköndal Collage University’s library.

Research Ethic Committee at Department of Health Care Sciences, Ersta University College, Stockholm, Sweden has approved of this study 2014, Dnr 1401/A (2014-01-16)

The finished thesis will be presented at Ersta Sköndal University College to fellow students and lecturers. Should you have any questions you are welcome to contact us at any time.

Lola Armonioso, nursing student lola.armonioso@student.esh.se
Vera Dahlqvist, RN, PhD, supervisor vera.dahlqvist@esh.se
## Appendix 3 Matrix of result

<table>
<thead>
<tr>
<th>Main themes</th>
<th>Sub-themes</th>
<th>Coded unit</th>
<th>Condensed units of meaning</th>
<th>Unit of meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring as a challenge</td>
<td>Lack of patient participation</td>
<td>Patients’ obstacles</td>
<td>The patients should be interested in the treatment and caring method such as yoga and should participate on their own free will and not be forced into any treatment.</td>
<td>Forcing somebody, and pulling somebody will make feel bad and wont happened…they should have this from their own mind…You say: “Yesterday we did some yoga because it has some benefits”. That, interest, the patient should have. We can force them to eat tablets but we can’t force them to do yoga.</td>
</tr>
<tr>
<td></td>
<td>Meeting unrealistic expectations</td>
<td>Patients’ expectations and credence in complementary care</td>
<td>Patients expect the complementary care to be a quick remedy and want to hear from the nurses that the healing will be fast.</td>
<td>…so what you don’t want to hear is: “I want to be cured in a fast way”. So they’ll ask you “I’ll want to know” and just ask the, quick, quick, they just ask for everything, but they can’t do this slowly…They want to hear “fast”. That’s all they want to hear, everything comes in a way of fast, and it is like: “No more medicine. “I’m having medicines, more medicines”…But after that you will have to give all that education: “But you need everything slow. Walk like a turtle. This is just how it has to go.</td>
</tr>
<tr>
<td>Dealing with challenges</td>
<td>Creating comfort</td>
<td>Creating comfort for the patient</td>
<td>Nurses try to make and get into the comfort zone of the patients when the situation needs it.</td>
<td>And you can tell me “I’m having pain here and I’m having pain here” so we get the comfort, we get the comfort zone, or for them to be comfortable with us.</td>
</tr>
<tr>
<td>Empowering the patient</td>
<td></td>
<td>Empowering the patient by setting up a relationship</td>
<td>The greeting of the patient is an important strategy for the nurses to approach and set up a caring relationship with the patient.</td>
<td>Yeah as usual we go in we do greeting, actually. We great him!... “Good morning, how are you? ” however you calling this thing for you…Yeah, they also respond by that but sometimes, their mood depends, they will not respond, but still, we as usually we greet them and then after some time we greet them and again go and approach them: “How are you? “How are you feeling, mam?” “What did you have for breakfast morning what did you take?”</td>
</tr>
<tr>
<td>Having credence in CAM</td>
<td></td>
<td>Nurses own expectations and credence in complementary care</td>
<td>Nurses can provide the suffering cancer patient with relaxation by providing yoga therapy along with the chemotherapy treatment and consider the effect to be good for the patients.</td>
<td>But cancer patients will not yet be at the dying stage. But we can’t make them to be in another place, sometimes like, we can’t do anything. We can’t say that. So, rather than providing this chemotherapy drugs, also, you can provide some therapies, like yoga. We are providing other types of therapies also that could be very good really we can see. Patients relax also.</td>
</tr>
<tr>
<td>Having the competence</td>
<td></td>
<td>Nurses need competence before practicing it with patients</td>
<td>The nurses’ competence can be limited. It is important that nurses themselves know how to yoga before they work on the patients.</td>
<td>Unless I like myself doing yoga I can’t tell the patients. You should know how to yoga. I should know how to do yoga. So my competence is limited of course, I have never gone deep into that topic.</td>
</tr>
</tbody>
</table>