

Practitioners' Awareness of Complementary and Alternative Medicine Practices within Interprofessional Healthcare Teams in Institutions

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Abstract

OBJECTIVE The purpose of this research was to explore practitioners' awareness of Complementary and Alternative Medicine (CAM), broadly, and Music Therapy (MT) activity, specifically, within their healthcare institutions. The goal of this was to better evaluate their level of knowledge and understand their recommending practices of these modalities within their roles as interdisciplinary healthcare team (IDHT) members in those institutions for optimization of patient care decision-making.

DESIGN A quantitative, descriptive, exploratory and cross-sectional research design was used to measure practitioners' awareness of CAM and MT in their healthcare institution utilizing a principal investigator-created valid and reliable tool entitled the "Global Complementary/Alternative and Music Therapy Assessment (GCAMTA)."

SETTING/LOCATION Data were collected electronically using various social media platforms and from several professional healthcare associations.

SUBJECTS A sample of 499 healthcare practitioners participated.

RESULTS Solo/group practitioners of small, private practices revealed high awareness (82-94%) of institutional CAM being provided and recommended as opposed to practitioners in larger institutions. Almost half of practitioners (48%) in larger hospital institutions are unaware if CAM is being recommended to patients. Although practitioners have positive or neutral overall impressions of MT, 83% of practitioners do not recommend MT in their current practice. Results of the Chi-Square Analysis were significant; practitioners in smaller, private practices are more aware of their institutional CAM as opposed to practitioners in larger hospital settings ($p < 0.00001$, $\alpha = 0.05$, $\chi^2 = 67.0531$, 37.3433). In institutions providing CAM services, practitioners are highly apt to recommend these services to patients. In institutions not providing CAM services, practitioners may still recommend external CAM services if there is high awareness/knowledge ($p < 0.00001$, $\alpha = 0.05$, $\chi^2 = 229.0602$) of CAM. No associations were found between institution type/size and overall impression of MT ($p = 0.604306$, $\alpha = 0.05$, $\chi^2 = 1.0074$) or between institution type/size and whether the practitioner recommends MT ($p = 0.08286$, $\alpha = 0.05$, $\chi^2 = 4.9812$).

CONCLUSION A disconnect exists between practitioners' knowledge and awareness of institutional CAM activities and IDHT utilization/effectiveness of CAM in patient care. The effectiveness is reliant on intra-organizational awareness of CAM activities (e.g. MT). Focus on holistic education early in career and institution-wide educational workshops initiated by knowledgeable healthcare practitioners may prove beneficial in remedying this problem to improve patient outcomes.

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Implications for Interprofessional Practice

- Cooperative efforts among both Complementary and Alternative Medicine (CAM) and allopathic practitioners to provide a holistic approach to patient care is essential to improve patient outcomes.
- Awareness of institutional practices such as CAM by practitioners leads to increased knowledge and implementation into practitioners' practices through use of Interdisciplinary Healthcare Teams (IDHTs).
- Early education of CAM in the classroom and continuing educational workshops in institutions can minimize the disconnect of lack of awareness/understanding of specific modalities of CAM such as Music Therapy (MT).
- Strengthening IDHTs by regularly including external members can help educate the IDHT and inform of optimal steps moving forward.

Introduction

Overview

There is a paradigm shift occurring in healthcare today – there is a clear movement away from the solo practitioner into collaborative interdisciplinary healthcare team (IDHT) approaches focused around cost-effective and efficient patient care and outcomes. IDHTs, often referred to as interprofessional healthcare teams, are a type of integrated health care approach characterized by a high degree of collaboration and communication among health professionals from various professional fields to achieve common goals (APA, 2010; Mahdizadeh, Heydari, & Moonaghi, 2015). While this transformative change is occurring in healthcare on a gross scale, there is another transformation that is occurring that may not be obvious to allopathically trained practitioners: an institution-wide incorporation and implementation of Complementary and Alternative Medicine (CAM) services, such as Music Therapy (MT), to achieve patient goals as part of an IDHT approach. CAM, a classification for therapies that are different from and viewed as harmonious with conventional or allopathic biomedicine, has become assimilated and institutionalized in a variety of settings (Sharf, Martin, Hernandez, & Moore, 2012). One type of CAM, Music Therapy (MT), has received recent attention and is defined as the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship (AMTA, 2020). This implementation of these services or prevalent “revolution” positively impacts all practitioners, requiring their

understanding of social capital, behavioral economics and ability to work cohesively in IDHTs to achieve better outcomes and efficiencies (Lee & Cosgrove, 2014).

Practitioners who are unaware of what is happening in their institution(s) regarding policies, practices available and what activities, if any, the institution may already be engaged in, will be left behind. In order to remain relevant, understanding what practices may or may not be recommended and/or available in an institution(s), such as CAM, is vitally important, yet, to date, has not been extensively quantified.

MT is a burgeoning CAM therapy used as a complement to allopathic approaches and has been shown to improve quality of care for patients (AMTA, 2020; Khoran, Khorshid, & Uyar, 2011; Lai & Li, 2011; Stuckey & Nobel, 2010). CAM practitioners such as music therapists are also increasingly employed in healthcare institutions as part of an IDHT approach to optimization of patient care decision making (AMTA, 2020). Because CAM is a broad spectrum of many individual therapies, services and practices, this research incorporates MT as an example of one of those modalities under CAM. Including the MT element was essential in anticipation that some practitioners may not have a good grasp on what CAM is, but a specific therapy such as MT would be more relatable and in their professional vernacular. Therefore, the use of MT in this study is to further cement any findings regarding CAM in general and, subsequently, to provide a relatable, well known modality that is increasingly being employed within comparable institutions of those of the respon-

dents within this study. Finally, should a practitioner reveal lack of awareness of generalized CAM because of its broad spectrum, but awareness of MT because of its accessibility within the institutions, then this would show promise for that practitioner's social awareness of CAM. Conversely, MT is one of the greater utilized CAM therapies in healthcare institutions today and has been in place in many institutions' major departments (e.g. operating rooms, oncology departments, neonatal departments, waiting/holding rooms) (Sharf, Martin, Hernandez, & Moore, 2012). Therefore, should a practitioner not be aware of MT within that institution, then this particular therapy further highlights the problem by bringing the awareness issue into the foreground and demonstrates the need for an educational intervention for practitioners, especially those working within IDHTs.

An issue lies with some CAM practitioners not being consulted or included "in the discussion" interprofessionally, regarding their utilization in conjunction with allopathic practitioners, potentially due to misconceived perceptions. Also, for allopathic practitioners that may be associated with institutions involved in incorporating IDHTs, their awareness of these CAM practitioners is lacking. Therefore, practitioners of CAM may be underutilized, undervalued or not mentioned at all during allopathic practitioners' medical discussions with their patients. Although CAM and MT are being used as the modality for discussion of this article, the focus is on IDHTs being on the "same page" regarding policies and practices being instituted so that patient care decisions are optimized.

Music Therapy – What Is It?

Music is one of the CAM therapies that is increasingly being offered in hospitals and other medical establishments (AMTA 2020; Sharf, Martin, Hernandez, & Moore, 2012; Walker, 2012). MT interventions can be designed to promote wellness, manage stress, alleviate pain, express feelings, enhance memory, improve communication and/or promote physical rehabilitation (AMTA, 2020). Music is a conduit that has the power to lift, transport and engage attention and response (Magill, Levin, & Spodek, 2008). As therapy, music can empower people to find their artistic selves and use their musical expression as a means for exploration and health, and may provide an opportunity to communicate that which cannot be spoken (Richardson, Babiak-

Vazquez, & Frenkel, 2008). MT is used by therapists to achieve patient goals by recognizing the affective, cognitive and sensory attributes of music (Finnerty, 2011).

Where IDHTs are involved, CAM practitioners such as music therapists can play an integral role augmenting allopathic therapies by orienting patients to alternative approaches to deal with conditions such as chronic pain, stress, anxiety and other related syndromes (Lai & Li, 2011; Finnerty, 2011; AMTA, 2020).

IDHTs are assimilating CAM practices such as MT into a variety of healthcare settings to assist patients in meeting their health goals (HCR, 2017) (Table 1). There are two primary gaps identified in the current CAM/IDHT literature: 1) the extent to which the various medical institutions are providing and/or recommending CAM services (such as MT) by practitioners within IDHTs; and 2) understanding how practitioners work within their organization with regard to their awareness of, recommendations of and/or implementation of CAM within the traditional allopathic framework (such as recommending or using MT).

Therefore, the purpose of this study was to address these aforementioned gaps in the literature. This was accomplished by evaluating relationships between different types of healthcare institutions and practitioners' awareness of CAM and MT activities. Clinically, understanding these associations is important to all practitioners in IDHTs in order to collaborate and implement these services in their respective places of employment and/or recommend external services in order to enhance patient care.

Research Questions and Hypotheses

Since this study was based in concepts surrounding CAM, MT and IDHTs, the research questions with corresponding hypotheses underlying this study were as follows:

Questions about CAM (broadly) and Institutional IDHTs

RQ₁: Is there a relationship between type of institution and whether the institution **provides** CAM or not?

H₁: Larger institutions (hospitals) will provide CAM.

RQ₂: Is there a relationship between type of institution and whether the institution **recommends** CAM or not?

Institution Type	Designation in Study	Frequency	Percent
Academic Medical Center University Hospital Teaching Hospital Trauma 1 Hospital	Hosp 1	145	29.1
Community Hospital or Non-Federal Short-Term Hospital Non University Hospital Minor Teaching Hospital Non-Teaching Hospital Trauma 2 Hospital Trauma 3 Hospital	Hosp 2	116	23.2
Solo Independent Practitioner or Group Practitioner With Hospital Affiliations Without Hospital Affiliations	Prac	181	36.3
Other Long Term Care Nursing Facilities Sub Acute Care Non Acute Care Outpatient Center Standard Clinic Structure	Other	57	11.4
Total N		499	100

Table 1. *Group Demographics*

H₂: Larger institutions (hospitals) will recommend CAM.

RQ₃: Is there an association between whether an institution **provides** CAM and whether that institution **recommends** CAM or not to patients?

H₃: Institutions that provide CAM will also recommend CAM.

Questions about MT (specifically) and Institutional IDHTs

RQ₄: Is there a relationship between type of institution and whether a practitioner within IDHTs **recommends** MT or not to patients?

H₄: There is a relationship between type of institution and whether a practitioner within IDHTs recommends MT or not to patients.

RQ₅: Is there a relationship between institution type and a practitioner's **overall impression** of MT?

H₅: There is a relationship between institution type and a practitioner's overall impression of MT.

Materials and Methods

Design

This was a quantitative, descriptive, exploratory, cross-sectional and correlational study. Demographic characteristics of the sample were organized and summarized through a descriptive design. The correlational design was used to measure practitioners' (within IDHTs) awareness of CAM and MT in their healthcare institution of employment utilizing a principle investigator-created valid and reliable tool entitled the "Global Complementary/Alternative and Music Therapy Assessment (GCAMTA)" (Franco, DeLuca, Cahill, & Cabell, 2018).

The GCAMTA has 64 survey statements based on a 5 point Likert scale ranging from *Strongly Agree* to *Strongly Disagree*. Additional open-ended questions regarding practitioners' current and past referrals of individual CAM therapies such as MT are included. A high score on the total GCAMTA indicates higher favorability of MT as a potential recommended CAM by the practitioner. The tool is considered valid and reliable and averages a 12 minute completion time.

Validity of the GCAMTA. A panel of 5 experts was used to obtain consensus on the construct variables, survey statements and questions through a Delphi group facilitation technique (Hasson, Keeney, & McKenna, 2000).

Reliability of the GCAMTA. Cronbach's alpha for the

GCAMTA with all 5 constructs combined is $\alpha = .944$ which is considered *excellent* by George and Mallery (George & Mallery, 2011). Additionally, individual constructs obtained high reliability as well (Table 2) ranging from $\alpha = .806$ (Attitudes) to $\alpha = .924$ (Knowledge).

Variable	# of Likert Statements	Cronbach's Alpha (α) Score	George & Mallery (2011) Interpretation
<i>Recommending Practices</i>	12	.813	<i>Good</i>
<i>Knowledge</i>	22	.924	<i>Excellent</i>
<i>Attitudes</i>	11	.806	<i>Good</i>
<i>Beliefs</i>	12	.883	<i>Good</i>
<i>Expectations</i>	7	.874	<i>Good</i>
<i>All 5 Factors (Survey as a Whole)</i>	64	.944	<i>Excellent</i>

^aN=544 participants from initial reliability assessment, including physician and non-physician practitioners.

Table 2. Reliability Assessment of the GCAMTA^a

Participant Recruitment

Purposive and non-purposive sampling were used to achieve near equal sample group sizes. Upon achieving IRB approval, healthcare practitioners meeting the inclusion criteria were recruited through national nursing and physician associations. Additionally, non-purposive snowball sampling was used through social media platforms (e.g. Facebook™, Twitter™, LinkedIn®) to attract potential participants to a survey link, which was created on the SurveyMonkey® host site. Social media was used in harmony with the associations to recruit participants and achieve higher institutional group numbers. Social media is increasingly becoming an important tool as a diversified recruitment approach for human subjects research, by increasing online participant communication and thereby allowing participants to share their experiences online in ways that promote positive public perception of research and enrollment into research studies (Gelinis et al., 2017; Gorman et al., 2014).

To participate in the study, participants were required to be a physician (e.g. M.D. or D.O.) and/or non-physician practitioner who prescribes to patients (e.g. Nurse Practitioner, Physician Assistant, Certified Registered Nurse Anesthetist, Certified Nurse Midwife or Clinical Nurse Specialist). Furthermore, these participants were required to have a license to practice in the U.S. and be an English-speaking/reading adult over 18 years of age.

Data Collection

Social media acted as a direct conduit to healthcare practitioners in order to recruit them for participation in this study. Approval by Facebook™ closed group administrators was granted upon providing the parameters of the study. Invitations with survey link were posted, resulting in Facebook™ users “liking” and commenting on the post and “snowballing” the link, yielding higher participant numbers. Similarly, survey links were shared on LinkedIn® and practitioners on Twitter™ were tweeted using appropriate hashtags (e.g. #physicianassistants).

Results

Demographics

An *a priori* G*Power analysis for χ^2 Goodness-of-fit Contingency Test with medium effect was calculated to determine the sample size, requiring 143 healthcare practitioners to be adequately powered (Faul, Erdfelder, Buchner, & Lang, 2009). A sample size of N=499 was achieved, consisting of practitioners from various healthcare institutions (Table 1).

Outcomes

The GCAMTA revealed high awareness of institutional CAM being provided and recommended (82-94%) for solo/group practitioners of small, private practices

as opposed to practitioners in larger institutions (Figure 1). Almost half of practitioners (48%) in larger hospital institutions are unaware if CAM is being recommended to patients (Figure 2). Additionally, results of this study suggest that although practitioners have positive or neutral overall impressions of MT, 83% of practitioners do not recommend MT in their current

practice (Figures 3 and 4). Results of the Chi-Square Analysis were significant revealing that, although they do not provide CAM as readily, practitioners in smaller, private practices are more aware of what type of CAM their institution is providing/recommending as opposed to practitioners in larger hospital settings ($p < 0.00001$, $\alpha = 0.05$, $\chi^2 = 67.0531$, 37.3433) (Table 3).

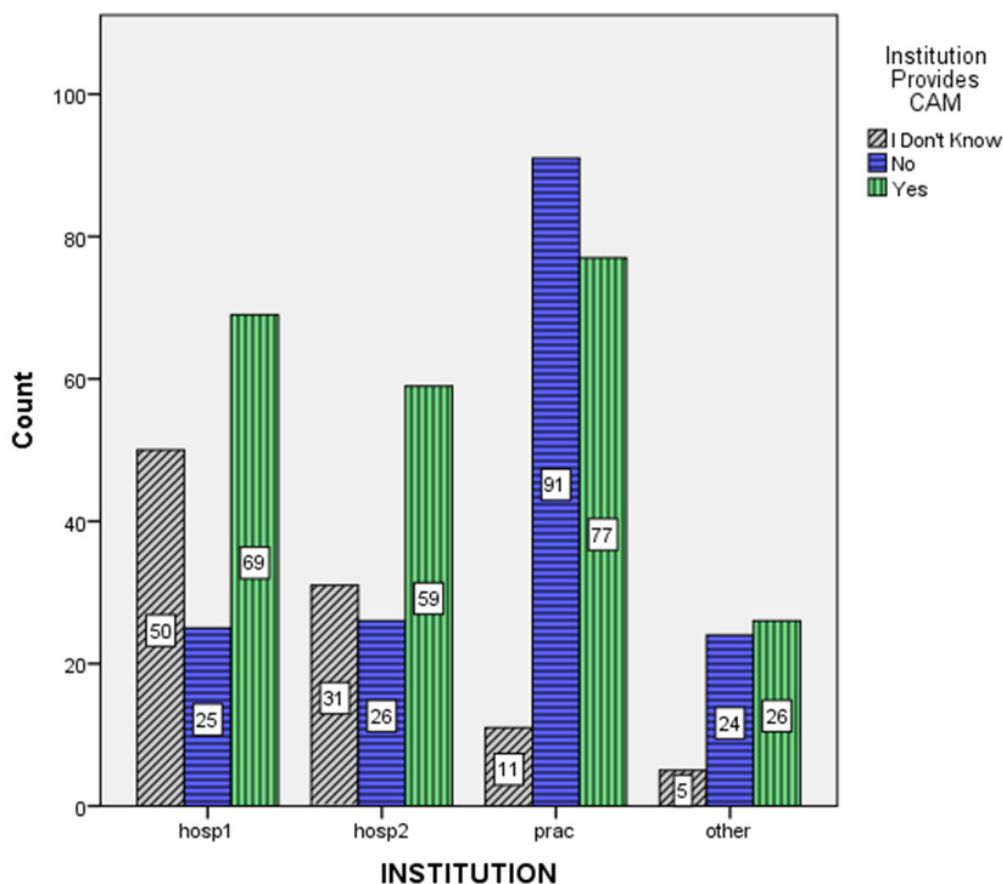


Figure 1. Practitioners' responses to whether their institution on the whole provides CAM services to patients. There was higher awareness (94%) of institutional CAM activity by the practitioner group as compared to the larger institutions.

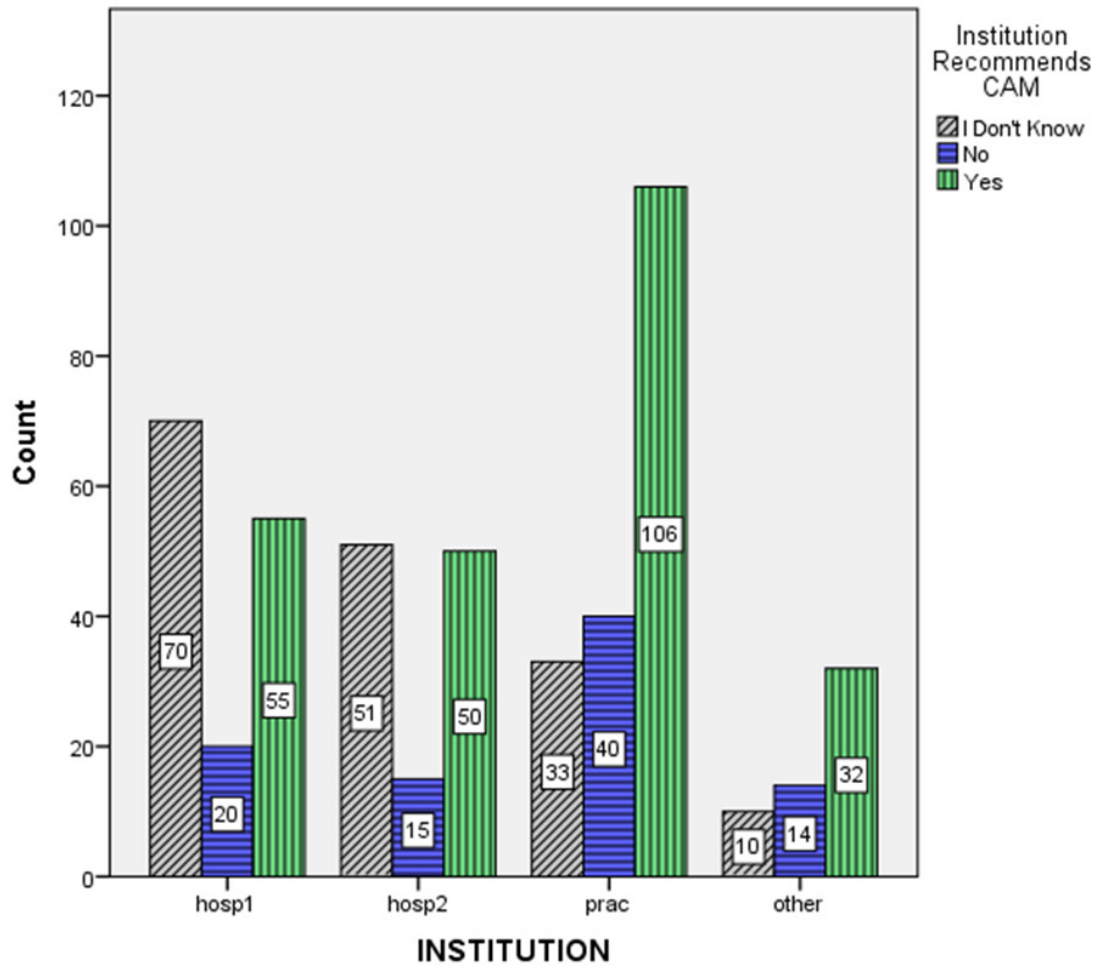


Figure 2. Practitioners' responses to whether their institution on the whole recommends CAM services to patients. Almost half of practitioners (48%) in larger hospital institutions are unaware if CAM is being recommended to patients.

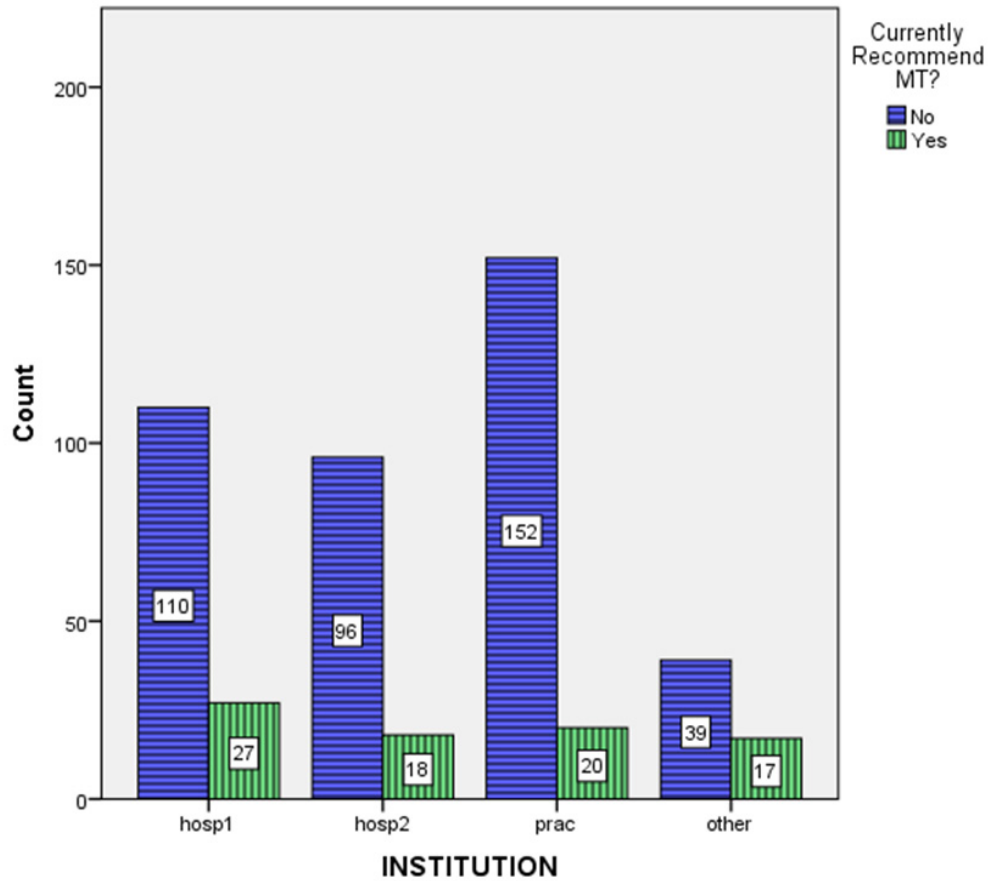


Figure 3. Practitioners' responses to whether they recommend MT or not separated by institution. 83% of practitioners do not currently recommend MT in their practice.

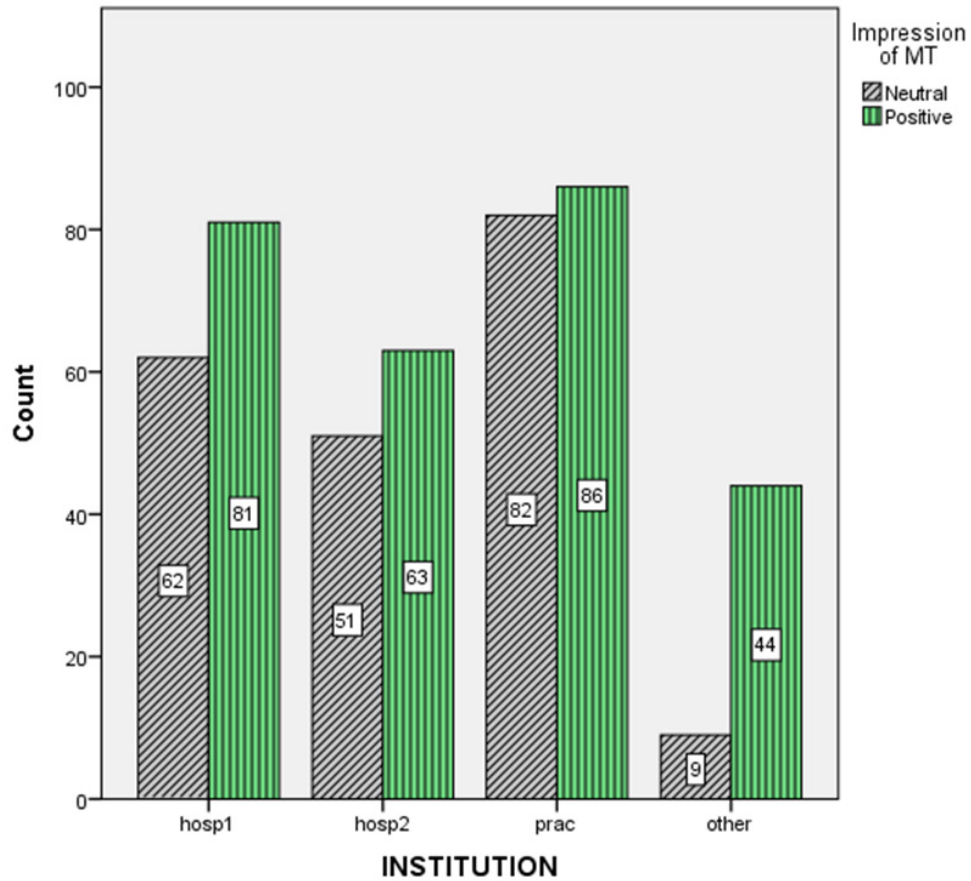


Figure 4. Practitioners' overall impression of MT. Responses were either positive or neutral.

RQ 1: INSTITUTION TYPE and WHETHER INSTITUTION PROVIDES CAM or NOT

3x3 Contingency	Yes	No	Does Not Know ^b	Row Totals
<i>Hosp1</i>	69 (67.24) [.05]	25 (46.58) [10.00]	50 (30.18) [13.02]	144
<i>Hosp2</i>	59 (54.17) [.43]	26 (37.52) [3.54]	31 (24.31) [1.84]	116
<i>Prac</i>	77 (83.59) [.52]	91 (57.90) [18.92]	11 (37.51) [18.74]	179
Column Totals	205	142	92	439 (Grand Total)
Chi-square Statistic	$\chi^2=67.0531$			
P-value	p < .00001			
Significance	SIGNIFICANT at p < .05, variables are dependent			
Hypothesis	Fail to Reject			

RQ 2: INSTITUTION TYPE and WHETHER INSTITUTION RECOMMENDS CAM or NOT

3x3 Contingency	Yes	No	Does Not Know ^b	Row Totals
<i>Hosp1</i>	55 (69.53) [3.04]	20 (24.72) [.90]	70 (50.75) [7.30]	145
<i>Hosp2</i>	50 (55.63) [.57]	15 (19.77) [1.15]	51 (40.60) [2.66]	116
<i>Prac</i>	106 (85.84) [4.74]	40 (30.51) [2.95]	33 (62.65) [14.03]	179
Column Totals	211	75	154	440 (Grand Total)
Chi-square Statistic	$\chi^2=37.3433$			
P-value	p < .00001			
Significance	SIGNIFICANT at p < .05, variables are dependent			
Hypothesis	Fail to Reject			

RQ 3: WHETHER INSTITUTION PROVIDES CAM or NOT vs. WHETHER INSTITUTION RECOMMENDS CAM or NOT

3x3 Contingency	Institution Recommends	Institution Does Not Recommend	Does Not Know ^b	Row Totals
<i>Institution Provides</i>	170 (112.69) [29.14]	22 (41.62) [9.25]	39 (76.69) [18.52]	231
<i>Does Not Provide</i>	61 (80.98) [4.93]	64 (29.91) [38.87]	41 (55.11) [3.61]	166
<i>Does Not Know^c</i>	10 (47.32) [29.44]	3 (17.48) [11.99]	84 (34.20) [83.32]	97
Column Totals	241	89	164	494 (Grand Total)
Chi-square Statistic	$\chi^2=229.0602$			
P-value	p < .00001			
Significance	SIGNIFICANT at p < .05, variables are dependent			
Hypothesis	Fail to Reject			

Table 3. Chi-Square Analysis^a

RQ 4: INSTITUTION TYPE and WHETHER PRACTITIONER RECOMMENDS MT or NOT			
3x2 Contingency	Yes	No	Row Totals
<i>Hosp1</i>	27 (27.67) [.02]	110 (109.33) [.00]	137
<i>Hosp2</i>	18 (23.02) [1.10]	96 (90.98) [.28]	114
<i>Prac</i>	17 (11.31) [2.86]	39 (44.69) [.72]	56
Column Totals	62	245	307 (Grand Total)
Chi-square Statistic	$\chi^2=4.9812$		
P-value	p = .08286		
Significance	NOT significant at $p < .05$, variables are independent		
Hypothesis	Reject		

RQ 5: INSTITUTION TYPE and OVERALL IMPRESSION of MT ^c			
3x2 Contingency	Positive	Neutral	Row Totals
<i>Hosp1</i>	81 (77.39) [.17]	62 (65.61) [.20]	143
<i>Hosp2</i>	63 (61.69) [.03]	51 (52.31) [.03]	114
<i>Prac</i>	86 (90.92) [.27]	82 (77.09) [.31]	168
Column Totals	230	195	425 (Grand Total)
Chi-square Statistic	$\chi^2=1.0074$		
P-value	p = .604306		
Significance	NOT significant at $p < .05$, variables are independent		
Hypothesis	Reject		

^aThe contingency tables provide the following information: the observed cell totals, (the expected cell totals) and [the chi-square statistic for each cell]. The 3 main institution groups are included in this chi-square analysis with omission of the fourth “other” group due to low sample numbers. Results are based on the social statistics chi-square calculator (Stangroom J. The Chi-Square Calculator. Social Science Statistics. 2017. Online at www.socscistatistics.com).

^bRefers to practitioners unaware of their institutional CAM/MT activity

^cOnly positive and neutral responses were selected. There were no “Negative” or “No Opinion” responses selected by the practitioners to this question.

Table 3. *Chi-Square Analysis^a (continued)*

Results also show that practitioners in institutions that provide CAM services to patients are highly apt to recommend these services to patients (Figure 5). Practitioners in institutions which do not provide CAM services may still recommend external CAM services if there is high awareness/knowledge ($p < 0.00001$, $\alpha = 0.05$, $\chi^2 = 229.0602$) of CAM. No associations were found be-

tween institution type/size and overall impression of MT ($p = 0.604306$, $\alpha = 0.05$, $\chi^2 = 1.0074$) or between institution type/size and whether or not the practitioner recommends MT ($p = 0.08286$, $\alpha = 0.05$, $\chi^2 = 4.9812$). The significant findings suggest to 'fail to reject' hypotheses 1, 2 and 3 and the non-significant findings suggest to reject hypotheses 4 and 5.

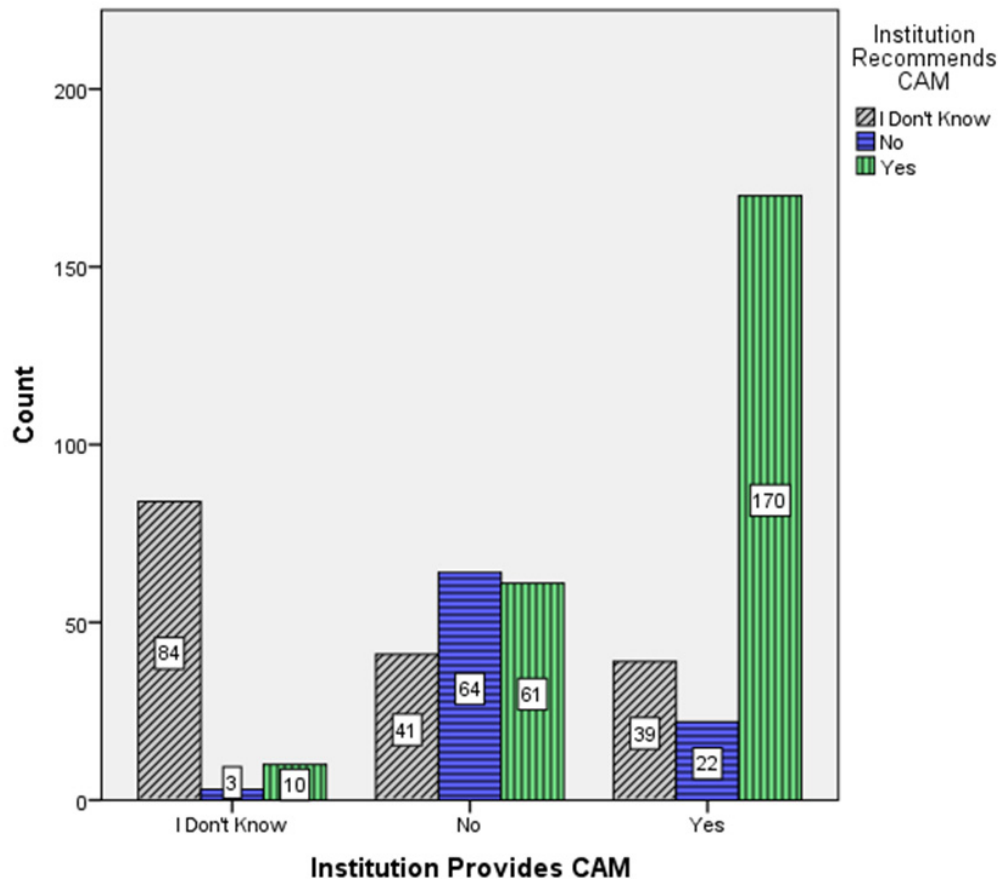


Figure 5. CAM Provided vs. CAM Recommended in Institutions. In institutions where CAM is provided, it is also recommended. However, in institutions where CAM is recommended, it is not necessarily provided.

Discussion

What Does the Current Scope of CAM Practice Look Like in These Healthcare Settings?

Understanding the current climate of CAM practice requires reviewing several interesting results obtained in this study. Unsurprisingly, practitioners in smaller institutions revealed higher awareness of CAM activity within their place of employment as opposed to practitioners in larger institutions. This can be explained as likely because the latter have more activity and moving parts on the whole that are unknown to the employees. Similarly, these practitioners in larger institutions are

seemingly unaware if CAM is recommended regularly to patients by other practitioners in their facility. These results help to illuminate the aforementioned disconnect which exists between practitioners' knowledge and awareness of institutional CAM activities and IDHT effectiveness in patient care. The greatest disconnect was found within the larger hospitals (hosp1 category) followed by the smaller hospitals (hosp2 category) (Table 1).

Furthermore, it was revealed that in institutions where CAM is provided, it is also recommended. In these institutions, available resources and the inculcation of

CAM within the institutional culture support the recommendation of CAM. Additionally, in institutions where CAM is recommended, it is not necessarily provided on site. Practitioners stated that unavailable resources and/or lack of internally trained staff within the institution to provide these services to patients renders recommendations of external CAM services appropriate.

Table 4 highlights the specific CAM therapies which are provided and/or recommended at healthcare institutions according to this study. It is important to note that just because a type of CAM is recommended at the institution, this does not mean that the CAM is provided internally at the institution. Also, if a certain CAM is provided at the institution by trained professionals, then practitioners are more apt to recommend that CAM, if they are aware of this institutional practice,

but it is no guarantee. Other factors such as personal views about CAM, bedside/office appointment time limitations and lack of overall knowledge/education may prevent some practitioners from recommending these services. The top CAM service that was found to be provided and recommended in institutions was lifestyle & nutritional counseling. Other types of CAM therapies frequently recommended and provided include prayer, MT, massage therapy, meditation, yoga, herbal/dietary supplements, acupuncture and chiropractic. These results are not surprising because these therapies have received the most media attention and/or have been well established within the medical community. Other CAM therapies mentioned by the practitioners are beginning to gain momentum, both in the literature as well as in public discourse (Table 4).

Therapy	# Institutions that <u>PROVIDE</u> CAM ^a	# Institutions that <u>RECOMMEND</u> CAM ^b
	N = 231 / 499	N = 243 / 499
Lifestyle & Nutritional Counseling	172	183
Prayer	102	65
Music	96	85
Massage	84	135
Meditation	77	114
Yoga	67	125
Herbal/Dietary Supplements	60	91
Acupuncture	45	94
Chiropractic	34	112
Other: Aromatherapy	10	7
Reiki/Healing Touch	9	6
Animal/Pet Therapy	6	1
Essential Oils	3	2

^a 231 practitioners stated that CAM was provided at their institution.

^b 243 practitioners stated that CAM was recommended at their institution.

The breakdown refers to the frequency of practitioners stating that the therapy is provided and/or recommended at their institution. Practitioners were given the option to select from a multiple choice list of common CAM therapies (Lifestyle & Nutritional Counseling to Chiropractic) and then they could list other therapies that they were aware of as an option. Frequency does not equal total N as they were allowed to choose more than one therapy. These therapies were not necessarily provided or recommended by the individual practitioner, but rather by the institution as a whole.

Table 4. *Therapies Provided and/or Recommended at Practitioners' Institutions*

Surprisingly, despite the current research strongly positing the effectiveness of MT for patients and despite having positive to neutral overall impressions of MT, the majority of respondents in this study revealed that they do not recommend MT in their practice.

Dyadic Communication: What does it mean to “recommend” and if CAM is not provided, how can it be recommended?

There are several forms of communication involved with practitioners and patients involved in this healthcare topic: the dyad of patient-provider, provider-provider and patient-patient.

Because most CAM therapies are not necessarily prescribed by a healthcare practitioner, but may be casually recommended in conversations with patients at bedside or during an office visit, and because prescribing holds a greater weight and connotation, the term “recommend” was used within the GCAMTA.

To operationalize this term within the context of this study, recommend can indeed mean support or order/prescribe, depending on the type of CAM (as there are so many) (Franco, DeLuca, Cahill, & Cabell, 2018; MW, 2020). With that said, recommend does not necessarily mean that the practitioner views the CAM positively, as several practitioner respondents of the survey said that they prefer silence over music in general, yet they would tell their patients about MT if they believed it would be a good option for them. Similarly, a physician or nurse practitioner may recommend MT to a patient for insomnia/restlessness but not recommend it for a dementia patient to minimize feelings of confusion for concern that it might trigger negative emotions in that patient, depending on the type of song played (Table 5). Also, there may be practitioners/institutions that view CAM positively but just have not recommended it for any of the reasons listed in Table 6.

This relates back to the objective about first and foremost understanding practitioners' awareness that these CAM services/professionals such as MT/music therapists exist within their own institutions and, potentially, within their own interprofessional teams. Secondly, if they do have awareness, are they recommending these services (why or why not) becomes the logical next question.

Therefore, in this context of patient-provider dyadic

relationships, recommending practices refer to suggestions or proposals as to the best course of action, especially one put forward by an authoritative body such as a healthcare practitioner (MW, 2020). Practitioners recommending CAM services such as MT to patients would be bringing these services up in discussions, assessing whether it is an appropriate fit as a complementary or alternative therapy, and then recommending that the patient utilizes these services within the institution (if it is provided there). If CAM is not provided within the institution, the practitioner can refer the patient outside institution to which the practitioner or patient is currently affiliated to external professional services.

The provider-provider dyadic relationship with regard to communication refers to two practitioners, particularly ones in the same IDHT, recommending that the other consider services such as CAM for their patients. The patient-patient dyadic relationship is regarding patients who, by word of mouth, recommend services such as CAM to other patients or individuals who may benefit from these services.

Despite Evidenced-Based Research, Why is CAM Not Provided and/or Recommended by IDHTs at Some Institutions?

Of the small percentage of practitioners who revealed themselves in this study as currently recommending MT to patients, they have provided a myriad of reasons as to why they recommend MT (Table 5). For practitioners who self-identified as not routinely recommending MT, when challenged as to whether they would or would not recommend MT in the future, these practitioners failed to have awareness of key reasons why MT would be effective. Specifically, 417/499 respondents self-identified as not currently recommending MT and, interestingly, none mentioned caregiver stress & anxiety, comfort/palliative care, autism spectrum disorders, or panic attacks as reasons they would consider recommending MT in the future. This key finding further illustrates the disconnect between IDHT practitioners and the evidence-based literature clearly supporting the use of MT as CAM.

Table 6 highlights the top reasons why CAM is not provided and/or recommended at their institutions. Many of the responses were reasonable and understandable; particularly, if practitioners had concerns referencing the need for more staff and/or a lack of equipment to

MT Used as Treatment for the Following Health States/Reasons	Why MT was Recommended in the Past by Practitioners ^a	Reasons MT Is Currently Recommended in Practice	Reasons Practitioners Who Do Not Currently Recommend MT Might Consider Recommending in the Future ^b
	N = 75 / 499	N = 82 / 499	N = 417 / 499
Stress	X	X	X
Anxiety	X	X	X
Pain management	X	X	X
Insomnia / restlessness	X	X	X
Depression	X	X	X
Mobility in stroke patients	X	X	X
Caregiver stress & anxiety	X	X	
Burn dressing changes	X	X	
Comfort / Palliative Care	X	X	
Dementia	X	X	X
Distraction purposes	X	X	
End of life / Hospice	X	X	X
General well-being	X	X	
Feelings of loneliness	X	X	
To enhance relaxation	X	X	
Labor pain	X	X	X
Pre-op and post-op surgery	X	X	X
To aid in illness coping	X	X	
Long Term Care (LTC)	X	X	
ICU treatment adjunct	X	X	
Oncology treatment adjunct	X	X	X
Severe sleep disorders	X	X	X
To improve breathing after cardiac surgery	X	X	
In place of pharmacological pain measures	X	X	
Coma stimulation for Traumatic Brain Injury (TBI) patients	X	X	X
Chronic pain	X	X	
Patients on vents with minimal sedation	X	X	
Pre-op Coronary Artery Bypass Grafting (CABG) relaxation	X	X	

Table 5. *Examples of MT in Clinical Practice and Practitioners' Recommendations and Reasons for Implementation*

MT Used as Treatment for the Following Health States/Reasons	Why MT was Recommended in the Past by Practitioners ^a N = 75 / 499	Reasons MT Is Currently Recommended in Practice N = 82 / 499	Reasons Practitioners Who Do Not Currently Recommend MT Might Consider Recommending in the Future ^b N = 417 / 499
Memory stimulation	X	X	X
Autistic children	X	X	
Relaxation for tobacco addicted individuals	X	X	X
Panic attacks	X	X	
To increase or decrease circulation of oxytocin	X	X	
Inpatient head injury patients	X	X	
To aid in vocalization		X	
Getting patients ready for bed		X	
Schizophrenia		X	
Obsessive Compulsive Disorder (OCD)		X	
Geriatric patients in nursing homes		X	
Meditative purposes		X	
During exercise/weight loss		X	
General motivation			X
Grieving			X
Calming agent to improve breathing			X
During MRIs			X
To reduce confusion & chaos			X
Post Traumatic Stress Disorder (PTSD)			X

^aRepresents only a portion of the practitioners who have reported recommending MT in the past. This column represents the reasons why MT was recommended by those practitioners in the past. Not all individuals who currently recommend MT have recommended MT in the past.

^bThese are the reasons for which practitioners most strongly might consider recommending MT to patients. Practitioners may decide to recommend for other reasons in the table but did not state this within the survey.

X = at least one practitioner stating that MT was recommended for the listed health state/reason OR could indicate many practitioners (up to N) recommending MT for the listed health state/reason.

Table 5. *Examples of MT in Clinical Practice and Practitioners' Recommendations and Reasons for Implementation (continued)*

Why is CAM Not Provided and/or Recommended? ^a	Frequency of Responses 127/499 ^b	Institution Types of Respondents ^c
Lack of overall knowledge / education / awareness; facility unfamiliar with therapies	25	Hosp1, Hosp2, Prac, Other
Cost / financial concerns	16	Hosp1, Hosp2, Prac, Other
Not enough science and research; need evidence-based research	12	Hosp1, Hosp2, Prac, Other
Physicians look down upon CAM and do not accept this as a viable option	10	Hosp1, Hosp2, Prac, Other
Time issue/ Limitations of short appointments with patients	9	Hosp1, Hosp2, Prac, Other
Lack of champions for CAM	8	Hosp1, Hosp2
Reimbursement concerns / limited profitability concerns	7	Hosp2, Prac
Literally no idea why it isn't provided or recommended	6	Hosp1, Other
Lack of access to specialists to provide in the institution	5	Hosp1, Prac, Other
Implementation concerns; not easy to provide the services; more staff needed	4	Hosp2
Low priority by leadership	4	Hosp, Prac
Lack of resources	4	Hosp2
Lack of equipment	3	Prac
Lack of supervision	3	Other
Space does not allow for expanded practice	3	Prac, Other
State budget	3	Other
Liability concerns	2	Prac, Other
Cultural issues	2	Other
Hospital has enough problems providing the "necessary" treatments, so they won't bother venturing into CAM	1	Hosp2

^aThis list (in descending order of frequency) compiles practitioners' top reasons that they believe CAM is not provided and/or recommended in their institutions.

^bThis question was optional at the end of the survey and, thus, the total N= 127/499. Respondents were not prompted with these answers as choices but rather asked to list the top reason in open-ended format in the survey.

^cThe top 5 reasons are particularly relevant because they were stated from practitioners working at all institution types.

Table 6. *Top Reasons CAM is Not Provided and/or Recommended at Institutions*

appropriately provide these services. However, other responses speak to a greater issue of misunderstandings about CAM and why IDHTs are necessary to reinforce the education and ease of implementation of these services. Some practitioners stated that CAM is not provided and/or recommended due to a lack of evidence-based research, lack of knowledge, and that physicians “look down upon CAM.” Also, for any practitioners expressing financial concerns over CAM, they are not aware that cost-efficient CAM services such as MT are available. These concerns expressed by the participants in this study accompanied by their lack of CAM knowledge are supported in the literature to date as an argument for why IDHTs are not easily established in institutions (Huljev & Pandak, 2016; Leipzig, Hyer, & Ek, 2002; O’Brien, Martin, & Heyworth, 2009). The aforementioned reasons further exemplify the need for IDHTs consisting of physicians and non-physician practitioner counterparts to work together along with CAM practitioners. Since leaders and practitioners share the same goal to optimize patients’ outcomes, these individuals must also work collectively to ensure that patients’ welfare is front and center. Therefore, leaders and practitioners must act as collaborative IDHTs to demonstrate how proposed changes can improve efficiency in patient outcomes. By doing this, they will establish an organizational orientation focused on patients and confirm that group action is the best way to achieve their shared goals and objectives toward patient care (Lee & Cosgrove, 2014). Subsequently, the gap or disconnect is bridged accounting for the hesitations or misunderstandings about what is occurring in their institutions and how patient outcomes are affected.

Practical Recommendations and Clinical Focus: The Need for IDHTs to Recognize Institutional Activities and Embrace Collaborative Services such as CAM and MT

Interdisciplinary collaboration is the trend in healthcare and, to this extent, cooperative approaches among CAM and allopathic practitioners to provide a holistic approach to patient care is essential, further improving patient outcomes (Huljev & Pandak, 2016; Mahdizadeh, Heydari, & Moonaghi, 2015). Practitioners need to become aware of and/or more accepting of CAM practices because the Patient Protection and Affordable Care Act (PPACA) provides reimbursement and encourages the use of strategies such as MT in patient care (ACA,

2013; CWF, 2013; HCR, 2017; OPC, 2015). Support for IDHTs comprising CAM and allopathic practitioners derives from evidence-based practice and reporting on their successes and failures.

To borrow a musical reference, today, the transition of practitioners from soloists to members of an orchestra has gained national momentum through healthcare reform with substantial interprofessional policy and practice development within the last decade (IPE, 2011). The Institute of Medicine’s best practice guidelines address the basic principles and values guiding team-based care along with supporting IDHT strategies (IPE, 2011; Mitchel, Wynia, & Golden, 2012; Moore, Butcher, & Corbett, 2014). Healthcare policy dictates the importance of IDHT practice to improve patient outcomes. This study speaks to the disconnect between knowledge and awareness of IDHT practitioners about CAM/allopathic team benefits and services provided where CAM is concerned, as well as the disconnect between the practitioners who are aware of and prescribe CAM and the institutions who may or may not know of CAM, or are aware of it but traditionally do not recommend it.

Therefore, by reading this article, practitioners will hopefully recognize activities across departments, such as around CAM practices, that have a beneficial place in practice in general and can be incorporated into their practice efficiently, whether onsite or not, through IDHTs, in order to improve provisions of healthcare in the United States and in continuing research initiatives.

Macro and Micro Strategic Approach for Practitioners to Work Together to Increase Awareness, Elevate Levels of Knowledge and Implement More Cohesive IDHT Implementations of CAM Going Forward

This paper evidences an apparent need for increased awareness of CAM practices in institutions overall. This need can be addressed by including education of practitioners in healthcare institutions, regarding: 1) specifics of CAM practices and their implementations (especially those that are readily available and at low cost such as MT); and 2) increased consciousness and recognition of individuals in their own institutions or IDHTs that have the capabilities to provide these services as part of the IDHT approach.

Furthermore, based on Table 6 alone, it is also clear that there are misconceptions with regard to CAM use

and implementation, as evidenced by the financial concerns of practitioners. These misconceptions are from a variety of healthcare practitioners located in many institution types as evidenced in Table 6. One common thread throughout this article is that CAM does not need to be provided within an institution in order for a practitioner to recommend it. These professionals, although educated in their own right, may need a “boost” or “leg-up” into the stratosphere of current holistic practices. As mentioned earlier, MT is low cost, and could be readily and easily implemented without financial strain for the patient and/or institution. Many CAM practices can be executed within the patient’s homeplace without the need of equipment or supervision (e.g. singing or meditation). Better education on CAM therapies such as MT could drastically increase its probability for implementation in institutions or, at the very least, recommendation by these healthcare practitioners to patients for external use with CAM professionals.

The literature is growing with respect to CAM practices, its benefits and relevance for IDHTs. So, what can healthcare practitioners, solo or within IDHTs, currently do to increase their role in this aforementioned revolution in healthcare? There is a macro level approach that involves teaching students and practitioners early on in health sciences education about CAM practices such as MT and how these therapies benefit the health of patients. The second approach is at the micro level in proposing that healthcare institutions implement and execute better onboarding of practitioners that are aware of both allopathic and CAM approaches for patients both internally, within the institution, and in the local communities. Figure 6 (following page) highlights a concrete plan for practitioners and leaders of IDHTs, along with other suggestions, to help them become involved in the process in addressing the problem, which will also increase their knowledge and well-roundedness of medical practices and holistic approaches available today, even if they are not the ones performing the CAM practice on their patients.

Future Directions for Research

The data analysis in this study was initially engaged in to assess the awareness of CAM and MT practices within institutions large and small. However, the results of this study lead to the next question which is whether or not institutions with high CAM activity on

site actually have IDHTs of both allopathic and CAM practitioners functioning regularly for patient care. Future studies should focus on the current activities of IDHTs and the integration of CAM and allopathic practice within those teams regularly in order to assess patient outcomes.

Conclusion

It is important for practitioners to become aware of CAM services such as MT that may or may not be provided in their institution in order to more effectively treat their patients on a holistic and collaborative level. Albeit some medical facilities do not have resources or access to provide CAM, so recommending external CAM services to patients is possible to achieve patient-physician goals as part of the IDHT approach. The evident lack of practitioners’ knowledge and awareness of their own institutional CAM activity should be addressed by the healthcare community to remain current with this trend being reported in the healthcare literature. The discord of some institutions who are at the forefront in providing and recommending collaborative services, such as CAM, versus those who are unaware that CAM (such as MT) exist, is concerning and should be evaluated by both objective practitioners of CAM and allopathic medical practitioners who are in healthcare leadership roles. Additionally, healthcare education programs should incorporate CAM learning early to develop awareness and a foundational educational level for prospective practitioners. Institution-wide educational workshops initiated by knowledgeable CAM practitioners may prove beneficial in remedying this problem to enhance overall patient outcomes.

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ACA: Summary of the Affordable Care Act, House and Senate

MACRO APPROACH | Focus on Education Early in Career



1. **Establish and improve courses in holistic medicine** – beginning with the pre-med and allied health sciences undergraduate courses, include teachings on CAM and/or electives in specific modalities such as MT. Guest lecturers and/or adjunct professors with expertise in CAM can be employed. Allopathic medicine in conjunction with holistic medicine teachings could be the starting approach.

2. **Inculcate evidence-based practice (EBP) research** into the curricula on CAM health benefits and encourage autonomous thought on the topic. Medical professors should avoid their personal biases and present studies on these areas of the literature.

3. **Constructivist learning** – students can experience for themselves some of the CAM modalities in group learning settings for exposure to their effectiveness.

4. **View CAM in action** – require field work assignments for students (e.g. MT in nursing homes, Animal/Pet Therapy in bereavement groups, Reiki in sleep clinics, weighted blankets in hospice, positive affirmation in depression support groups, Art Therapy for dementia patients or Autistic children in schools).

5. **Opportunities for shadowing a senior healthcare professional** to see how CAM such as Lifestyle & Nutritional Counseling is discussed and recommended to patients. Communication tools are essential.

MICRO APPROACH | Focus on Awareness and Continuing Education Currently in Career

1. **Better onboarding** of new healthcare professionals by institutions – it is imperative that current practitioners have at least an awareness of several CAM modalities. Awareness can lead to increased knowledge.

2. **Remove the stigma and close the gap** – many healthcare professionals still don't believe CAM has a place within the patient-provider appointment time slot. The stigma is not necessarily abolished through education but through understanding peoples' lived experiences. IDHT meetings are crucial for allopathic practitioners to meet with holistic practitioners to understand their perspectives on how their patients/clients have benefitted from CAM.

3. **Institution-wide educational workshops** should be frequent and convenient (in-person and/or virtual) and encompass practitioners of all fields to keep up-to-date with research trends and EBPs. Institution-wide research forums should also be encouraged on a quarterly basis for larger institutions.

4. **Increased communication efforts** – it is the independent responsibility of each healthcare professional to allot the time and communicate effectively with their patients, colleagues and loved ones to learn, grow and recommend a modality that could positively impact and improve one's quality of life.

5. **Strengthening of IDHTs** – underutilized and undervalued practitioners of CAM not included in the "discussion" is just one example of an ineffective and broken IDHT. Managers/leaders aimed at regularly including external members can help educate the IDHT and inform them of optimal steps moving forward.



Figure 6. Strategic Guideline Proposal Plan for Practitioners

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