

Use of Complementary and Alternative Medicine in primary healthcare in Florianópolis, Santa Catarina, Brazil: user perception

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Abstract *This is a partial analysis of the outcome of a survey looking at user perception of the institutional use of Complementary and Alternative Medicine (CAM) in Florianópolis healthcare centers. Structured interviews were applied to users treated with CAM in the locations offering this option most often, using data-based theory as a theoretical-methodological reference. For the most part, the use of CAM was proposed by basic health professionals (the operators of biomedical care), initially as a preferred alternative to biomedicine. Interviewees preferred CAM, associating it to fewer side-effects. Users mentioned enhanced dialog with professionals to negotiate treatment forms. The hypothesis emerged that CAM could be the initial treatment option in a large number of cases, saving conventional treatment for subsequent use if necessary, or in some cases as the single or complementary treatment. This enables drafting an expanded flow using CAMs in primary health-care. New studies and institutional experience are required to investigate this hypothesis, expanding the use of CAM in an ecology of institutional care.*

Key words *Integrative medicine, Complementary therapies, Primary healthcare*

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Introduction

Complementary and Alternative Medicine (CAM) is widely used around the world^{1,2}. It includes medical care practices and rationales³ that are not part of conventional medicine⁴. They are frequently used in high-income nations, and have always been widely used in other nations⁵⁻⁷.

The use of CAM in countries with ample access to biomedicine has been attributed to diagnostic and therapeutic limitations, iatrogenesis and situations related to biomedical care, as well as the virtues associated with CAM: enhanced value of the [patient/healthcare professional] bond, expanded listening and an approach that considers the various patient dimensions. Other virtues include an improved relationship with users, encouraging their involvement, and the potential for rebalance and self-cure, facilitating the meaning and experience of disease, centering care on the person and 'health' rather than on the disease⁸⁻¹³.

In Brazil, the Federal government calls such practices integrative and complementary practices (ICPs), and the National ICP Policy¹⁴ recommends they be included in the Unified Healthcare System (SUS), especially in primary healthcare (PHC). However, there are no specifics as to how CAM should be included in the services provided. When present in PHC services, they are either provided by the biomedical professionals themselves, hence being known as hybrid according to Barros¹⁵, or performed by professionals who provide only alternative or complementary treatments (acupuncturists, homeopaths and the like), which we will call exclusive CAM practitioners. This is important in Brazil, from the point of view of providing universal access to biomedical care and CAM. The preferred option by exclusive practitioners would require that they be incorporated into PHC services. The option for hybrid services on the other hand, would require that the family health (FH) professionals and teams be trained (continuous education), with this theme as a heavy component of their training.

Studies of CAM in PHC in Brazil have addressed general aspects^{12,16-19}, their availability at healthcare services^{20,21}, or the point of view of professionals^{22,23}. Studies that focus on the point of view of PHC users are scarce, and generally concentrate on a specific CAM, checking into the reason why it is sought after, understanding the practice, results and perceptions of treatment^{9,24,25}. These studies have addressed users of

homeopathy or other practices^{19,26} provided by exclusive CAM practitioners.

Since 2011, there has been a systematic process to incorporate CAM in Florianópolis-SC. CAM is practiced by FH (hybrids) teams that have been previously trained or are qualified in any of CAM via continuing education²⁷.

The goal of this article is to submit part of the results of a survey that analyzed user perception of their experience with CAM at PHC services in Florianópolis, SC. This part deals specifically with the institutional use of CAM. We will not discuss data related to independent use of MAC, perception of the nature of disease, the importance of CAM, or the results obtained, except for some aspects that put them into context and help understand the institutional use of these therapies.

Method

We conducted a descriptive, qualitative study involving CAM users served by FH teams in Florianópolis, SC. We chose four Healthcare Centers (HCs) with the highest use of CAM according to the municipal information system (InfoSaúde®), encoded as A, B, C and D. Users were approached directly by the interviewer in the waiting room of these services, and invited to participate. Those who answered yes when asked if they were or had received any CAM in the past three months, and were 18 years or older, were invited to participate in a semi-structured interview.

The theoretical-methodological and analytical approach used was Data-Based Theory²⁸, which allowed us to build hypotheses, concepts and theories based on data, without subscribing to pre-determined theories. This approach is sufficiently flexible to progressively approach the phenomenon. Between September 2013 and May 2014 we completed three rounds of data collection at the services, which made it easier to improve the interviews and answer questions as they emerged. During the analytical phase we did not use the full potential of data-based theory, as the purpose was not to develop a new theory, but develop hypotheses, articulating the main findings with those of other studies and theoretical propositions underlying the institutional use of CAM at PHCs. This was also due to the methodological and contextual limits of the survey, which focused exclusively on users (with no investigation of medical files or the professionals involved), and how the participants were select-

ed. Nevertheless, we opted for an exploratory investigation of a relatively unknown and recent reality - expanded use of CAM due to on-the-job education. Unlike Florianópolis, very few cities with major, well organized FH and PHC coverage choose to implement CAM at PHCs with systematic educational activities.

Interviews were recorded, transcribed and analyzed as they took place by the same researcher, using open encoding (data was grouped, classified and summarized based on affinities and divergences). We considered data saturation at interview twenty²⁹. We used axial encoding (categories and sub-categories) followed by selective encoding (refining of the main categories and sub-categories, some of them guided by the objectives, and others emerging)³⁰.

Nine participants came from Healthcare Center (HCC) A (providing more CAM care), four each from HCC B and D, and three from HCC C. They were encoded with the letter assigned to the HCC and the sequential number of the interview. Interviews lasted 25 to 35 minutes and took place at community centers, the HCC or participant homes, before or after they were seen by the healthcare professional. The interviews were preceded by a warm-up period where participants were shown ten pictures of CAM commonly used in Brazil, asking them if they were familiar with these and if they used them at home or at the PHC center. This was followed by a conversation based on the interview script, covering type of access, reasons for use, form of use, results, differences between conventional care and CAM, preference for CAM only professionals or HC team and why. This study complies with CNS Resolution 466 (REC-UFSC Opinion n. 19744513.9.0000.0121).

Results and Discussion

We interviewed users seen by five physicians and one nurse in six FH teams in the four services, all of them hybrid. Three of the physicians had specialized in acupuncture, and two had received introductory training in acupuncture sponsored by the City Department of Health²⁷. The nurse had been trained in auriculotherapy. Only two of the physicians had been with their respective services for a long time (over ten years of biomedical and CAM practice). All others were relatively new to their services or CAM (fewer than five years). Although acupuncture is the most often used alternative practice, other forms of CAM

emerged, mostly consisting of educational activities provided by the institution: acupuncture, auriculotherapy, florals, teas (medicinal plants) and homeopathy, alone or in association.

All interviewees were women aged 36 to 64 in varying occupations. Most were housewives, seamstresses and kitchen helpers, and declared themselves to be catholic or evangelical. Interviewees lived in the neighborhoods where the selected HCC was located. They had had at least three CAM visits. Sixteen were in treatment and four had completed or interrupted treatment within the past three months.

Putting the data below into context, the main reasons given for using CAM were body aches (musculoskeletal pain), anxiety, mood and stress disorders, often associated among themselves and/or with other disorders. All of the interviewees reported an improvement in the problem for which CAM had been prescribed, at least for a time. The efficacy of CAM is linked to its “inside-out” mode of action, and related to stimulating the power of self-cure, rather than the outside-in approach of traditional drugs identified with conventional care^{31,32}. These findings agree with those of other studies^{9,23,24,30,33,34} and are not discussed in this paper as they are outside its scope.

Recognizing unseen preferences

In most cases (15 interviews), CAM was used at the initiative of the professionals, who either suggested or initiated treatment during the visit. This is typical and/or almost exclusive of the hybrid use of CAM in PHC. Seven interviewees reported that the initial suggestion made by the professionals was that they use CAM before and as an alternative to conventional treatment: *I was experiencing strong pain, so I came in and spoke to him and he suggested I try acupuncture [before medication] (A5). He never had to give me any medicine, acupuncture was enough (A4)*. In such cases there was a choice and value assigned to CAM as the preferred option over conventional care, keeping conventional care as a backup to be used subsequently, if necessary. This practice appears to be uncommon among biomedical professionals. This may be explained by the type of hybrid professional guiding/providing such treatment. They often have some CAM competence because they took a personal interest and sought courses provided by the city, or had already specialized in this area (which is common among SUS experts in some CAM^{9,21,35}). Howev-

er, physicians in other institutional environments who use or recommend CAM don't seem to do so in the same manner. The trend in the biomedical institutional environment is to use CAM as a complementary measure^{10,15}. We were unable to find sufficiently similar studies (in terms of context and focus) to enable a comparison.

This finding is important as healthcare professionals in general, and those in PHC in particular, seem to be increasingly involved in CAM. In recent decades, a significant share of PHC services and/or professionals around the world and in Brazil have started to use or recommend CAM^{11,36}. This requires additional research to check if this is a general phenomenon and its magnitude. One factor that is doubtless involved is the environment in which care is provided. PHC is the destination of people who often present with non-specific or associated illnesses. They are accessible and used for long-term care of all sorts of problems^{37,38} to which CAM is well suited (we will come back to this).

Half of the interviewees said they would prefer to use CAM before drug treatment. They were considered the preferred treatment for home use - *I will take a tea first, something natural. I only go to the doctor when [...] I really can't take it* [B1] -, and for medical care - *[the doctor] starts with this treatment [MAC]..., and then if it doesn't work he/she will prescribe a chemical for me* [D1]. The prevalence of using CAM in the home environment, as an alternative, complementary or sequential element of biomedical treatment is well known^{39,40}, and enables numerous practices typical of self-care³¹. We point out however, that user preference has extended to professional care. We have found no other studies with comparable data. This would seem to reinforce what Helmann⁴⁰ called "therapeutic pluralism", where biomedical resources are sought and valued, simultaneously with an intense search and acceptance of other types of care⁴¹.

It is worthwhile pointing out the most significant difference between CAM and drugs mentioned by interviewees and the literature, which is the increased frequency of adverse reactions from conventional drugs compared to CAM, making it easier to understand user preference for the former: the great presence of adverse reactions in the use of conventional medicines; and less frequent in CAM, according to several interviewees and a large international literature¹: *When we take a drug we feel other things that may be because of the medicine you took* (C1). *I used to take pain medication and it gave me heartburn, I also have an*

allergy problem, which makes you insecure... With acupuncture and auriculotherapy there is none of that. Acupuncture produces only good things (C3). Numerous users mentioned CAM as being natural and harmless. This requires further training of PHC teams on this topic (and its inclusion in their training) so that they may offer guidance as CAM is not risk-free (for instance medicinal plants). Today this type of competence is rare and most Brazilian PHC professionals ignore CAM. This is further complicated by the fact that users often neglect to report that they are using any such substances on their own. It is precisely for this reason that the systematic and progressive inclusion of CAM in the training and practice of PHC professionals is important and desirable. This would build and disseminate at least a bare minimum of expertise on this topic among PHC professionals. Increased institutional use of CAM among (hybrid) professionals and biomedical care providers demands a minimum level of expertise, which would provide a measure of safety to their use, as many of these substances or not regulated or scientifically legitimized. If they are used under the guidance of PHC professionals they will be the ones to care for any adverse event that may emerge.

Recognizing previously uncommon dialogs

We found that the existence of CAM facilitates dialog and improves the relationship between professional and users when negotiating their therapeutic conduct. *He wants to remove all of the drugs [and use only CAM] and I don't, it is taking me time to accept it. I have reduced, but I can't stop* (C2). Some of the interviewees criticized the professionals for not prescribing more drugs or asking for tests, yet these reports involved an addition to the dialog: *He talked a lot, asked me if I was taking any medication, said there is medicine that will improve one thing but make another worse, he suggested I start out with the tea and go back if it didn't work* (B3).

The literature contains numerous reports of dissatisfaction with biomedical care, complaining of approaches described as mechanical, invasive, interventionist, cold, symptom-bound, disease-centered, with massive use of diagnostic equipment and limited personalized approach to treatment^{8,10,12,32,39,42}. Stewart et al.⁴³ for instance, found that 54% of the disorders perceived by patients were not considered by the physicians during medical visits. This suggests the need for improvements, with more candid dialogs and

careful listening of the user, so that both converge towards the same point during the interaction. Given the virtues of CAM mentioned in the introduction to this paper, in theory if PHC teams were to use them, their approach would be broadened, favoring better listening and consideration of subjective and psychosocial aspects. However, these statements also mentioned something else - negotiating whether to use CAM or traditional medicine.

This dialog is possible because of the existence of more than one therapeutic approach. This finding means a different positive force acting on CAM and the interaction between health-care professionals and users: something that is not specific to any one CAM, but is the result of its existence and difference, requiring dialog on which approach to use. This exists primarily in hybrid PHC, where the decision to use biomedicine or CAM, and the assessment/follow-up, are shared by the professional and user. It is known that outcome and satisfaction improve when professionals and users share visions, interpretations, expectations and decisions regarding disease and treatment⁴⁴. This facilitated sharing is one of the virtues of CAM, and also the basis of new biomedical approaches by the PHC, as a clinical approach that is focused on the individual⁴³, and Brazilian discussions of expanded clinical practice⁴⁵.

Inserting and organizing CAM in PHC and the SUS

The possibility of incorporating CAM into PHC has been discussed outside of Brazil, addressing the collaborative action of professionals^{46,47}, focused on the perspective of clinicians who use CAM as part of the care they provide⁴⁸. Very few surveys look at the user point of view^{47,49,50}. Responses vary when asked about the best professional to perform such practices. Some would like the family physician to provide CAM⁵⁰, others would like them to explain about the therapies available^{47,49}, and still others would prefer to be referred to a specialist in this area⁴⁷. However, all said they would like PHC physicians to play an active role in CAM^{47,50}. We found no surveys in Brazil with this focus.

When we asked about the best way to access this type of treatment (CAM), nine interviewees would prefer that the FH team use CAM. [...] *it would reduce the need to go from one place to another, to go first to a GP for a referral, it would avoid some of the time waiting in line and wear and tear [...]* (I1). Those who prefer to be seen

by a specialist (eight) believe that it's too much for a single professional to do everything, and as there are a lot of patients, they can't use both approaches for all of them. They also mentioned that if care is provided by separate professionals, they can dedicate themselves and specialize in one of them. *They have to be separate. He treats pain more, but doesn't really treat phobias, so it would be interesting if there were also someone to treat that side* (D4).

Among the interviewees, those using specialized services used the CAM offered by PHC as a complementary measure, and would rather be treated separately by experts dedicated only to CAM. The fact that these users are associated with specialized outpatient units and do not feel they were being treated with drugs at the PHC was stated as having influenced their preference: *I never looked into any other treatment with the doctor, because I am still being treated by my regular doctors [focal specialists], I do follow-up with them, I come here [BHC] to check my pressure and now to get acupuncture for my sciatica* (A5). On the other hand, if the severity of a situation demands specialized biomedical care, this would explain their preference for dedicated (and specialized when available) CAM practitioners: their problems should be explored in greater depth by CAM due to increased clinical need/severity. Thus, these treatments, as well as biomedicine, should not only be available at BHC units, but also have a place in specialized care. This is made up of ambulatory, hospital and BHC support teams, such as the Family Health Support Centers (FHSC) (*Núcleos de Apoio à Saúde da Família - NASFs*⁵¹), which may include (dedicated) homeopathy and acupuncture practitioners. These could be a specialty reference for the more serious cases referred, exploring these CAM in greater detail.

These FHSC should provide customized and specialized care and technical support (continuing education, case discussions, and regulations) for a group of FH teams. They would work as a team of specialized (non-generalist) professionals embedded in BHC teams, working closely and coordinated by them. This would seem suitable for a number of CAM, especially medical rationalities based on vitalism² such as homeopathy, traditional Chinese medicine/acupuncture and anthroposophical medicine. This consideration reinforces that it is desirable that CAM be integrated into FH teams (hybrid professionals), and in specialized services in a matrix arrangement, and provided by dedicated practitioners.

Looking at the flows for institutional use of CAM in BHC and the SUS

User preference to use CAM prior to conventional treatment, mentioned during the interviews and by hybrid BHC professionals, is associated with a more open dialog resulting from its very existence. This supports the hypothesis of a possible inversion in the direction of flow of the position of CAM within BHC. In some situations, CAM would take a certain precedence in BHC, and would be used as the preferred initial treatment approach, complemented when necessary by biomedicine. Drug therapy would then be complementary, used in situations resistant to initial care with CAM, and/or those that are more serious, or the preferred approach in other cases, possibly complemented with CAM. This inverted preference within the institutional environment of BHC might be desirable and technologically appropriate if users are open to it, leading to the use of CAM as an initial option, as it is the family and community environment, where CAM abounds, despite increasing (bio) medicalization of society in general⁵².

One argument in favor of this hypothesis is the convergence in the type of disease presenting at BHC, often in the initial stages and difficult to place within biomedical nosology, and presenting numerous problems, and the virtues of CAM summarized in the introduction. This convergence is strong enough that McWhiney³⁸, in his *Textbook on Family Medicine*, recognizes BHC as a preferred location for inserting CAM in health-care systems, and it is likely that 70% of its “spontaneous” presence within SUS is in basic care¹⁴.

Another strong argument is frequent iatrogenesis and excess interventions in biomedical care, which is so significant that it has given rise to the concept and practice of quaternary prevention in Family and Community Medicine - identifying people at risk of over-medication and iatrogenic damage, offering them ethically acceptable options⁵³. This means putting into practice the principle of *first do no harm* (*primum no nocere*), which requires special knowledge and skills focused on protecting users from the current trend of over medication in diagnosis and therapy, both curative and preventive⁵⁴. In many cases, the careful and preferential use of CAM in BHC could be considered quaternary prevention - an intermediary and protective filter (supposedly with less iatrogenic effects) - placed between the recognizably important^{39,55} first filter of family and autonomous care, where CAM is

abundant, and the biomedical filter used by BHC professionals^{55,56}.

Articulating these results enables creating a hypothetical flow of institutional care, incorporating CAM in a manner consistent with the care environments and types of disease, which constitutes a proposal for implementing plurality of care within SUS, as one hypothesis emerging from this study and illustrated in Figure 1.

Figure 1 shows that in BHC, CAM is present in two flows, practiced by hybrid professionals, in some cases as the preferred initial approach (momentarily alternative and possibly sufficient), in a role of filter prior to biomedical care, and in others as complementary care. A third group of users would receive only biomedical care (far more common today). CAM could also be part of specialized care, provided by dedicated experts or practitioners. These flows consistently articulate the results of this study and other consolidated knowledge: the approximation of BHC professionals and MAC and their wide acceptance and use by the population, the frequent adverse effects of drug therapy, the non-differentiated, combined and complex types of disease presenting at the BHC, easy access to BHC, and the virtues of CAM. Furthermore we have the possibility of increased safety of CAM use by hybrid professionals within context of longitudinal care, and the desirability of increased dialog between professionals and users regarding treatment and the use of CAM, further adding to the virtues of CAM summarized in the introduction.

The hypothesis raised leads to complex questions that we have merely pointed to here. For instance, there is often a requirement to provide scientific evidence of the safety and efficacy of non-conventional therapies, and this is not available, controversial or not well developed for most CAM. There is recent evidence of good results obtained at BHC by hybrid professionals using some MAC - lower hospital and drug costs, and decreased mortality⁵⁷. Despite a growing body of studies about numerous MAC, medical rationales based on vitalism should at least be recognized and legitimized, even if there is no consensus on biomedical evidence to support them. Legitimacy would come in part from ample and socially recognized approval and efficacy, with few risks compared to conventional treatments, and in part from the incommensurability (compared to biomedicine) of CAM knowledge and techniques, with their own paradigms and different concepts of disease and cure. On the other hand, as mentioned above, safety in use is enhanced

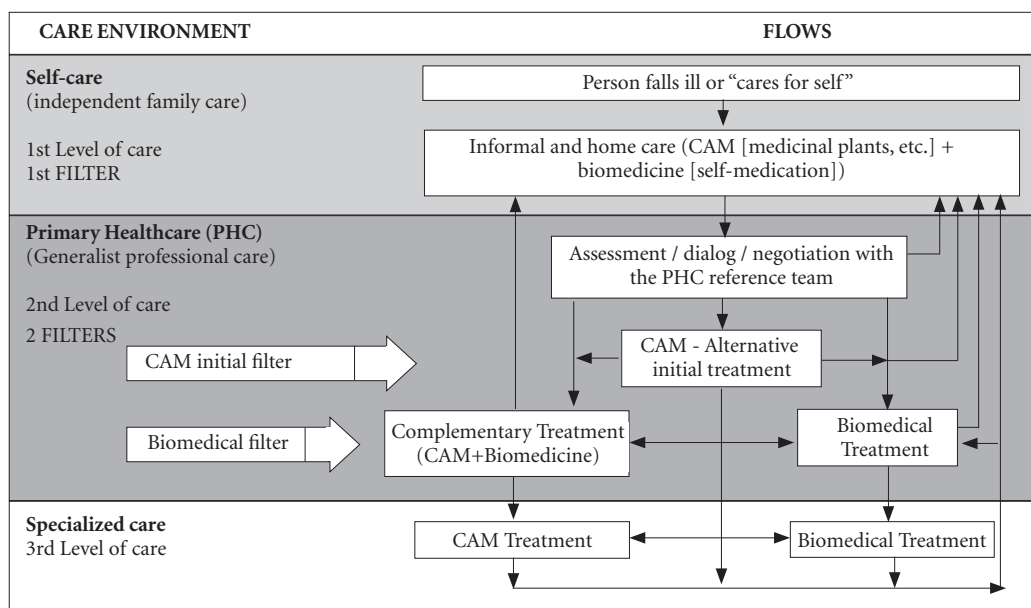


Figure 1. CAM in the ecology and organization of care

Arrows show possible direction of flows.

Source: prepared by the authors based on the results and inspired by Green et al.³⁹ e Menendez³³.

by the institutional context, providing biomedical follow-up at the BHC and, in the more severe cases most likely within specialized services, which would certainly function as a mechanism to protect users of any potential adverse effects of CAM.

There are also political conflicts involved. The medical establishment in Brazil tends to be self-centered and resistant to recognizing one or more CAM¹⁰. On the other hand, it is aggressively monopolizing these practices once they are accepted (the legal conflict surrounding acupuncture in Brazil is a typical example). These problems should not impede the use of CAM, on the contrary, they are generally mitigated by increased institutional experimentation with CAM. Furthermore, there are no significant conflicts associated with numerous CAM practices, in particular those that promote health¹⁶ and group practices.

The political aspects should also include what Santos and Meneses⁵⁸ calls abyssal lines typical of modern thinking - imaginary lines beyond which there is a relationship with what exists in terms

of appropriation and/or violence. In the case of health, on this side of the abyssal lines are professional and scientifically instituted healthcare knowledge and practices. Most MAC would be on the other side of an invisible abyssal line, and thus considered merely in terms of appropriation (raw material for bioscience/biomedicine) or violence (fighting, disqualification and suppression). "Beyond these possibilities, which are currently realities, another meaning of our hypothesis is to consider it an exercise in 'sociology of absence and emergences' in order to build an ecology of knowledge⁵⁹. Synthesized to the extreme, this proposal is based on the finding that social experience is far broader and varied than scientific tradition is aware of and considers important, including healthcare. The goal is to transform objects seen as impossible (incomprehensible, irrelevant, pre-modern - the use of many CAM) or possible and, based on this, transform absence into presence, centering in the fragments of social experience that the hegemonic outlook neither values nor focuses on.

The sociology of absence seeks to replace the

monoculture of scientific knowledge (this side of the abyssal lines) with the ecology of knowledge, while the sociology of emergences investigates options that are within the horizon of concrete possibilities. Our hypothesis could be considered a possible option to the monoculture of biomedical knowledge within BHCs (and SUS). This is the real experience of some BHC professionals and users in a single city, however it will remain invisible and irrelevant if not discussed and brought out into the open. Thus we can defend the recognition and possibility of a range of relatively low risk CAM care (medicinal plants, bodily practices, medication and energy, homeopathy, acupuncture, anthroposophy, massage) that could capture a larger share of care (including in some cases as first-line care) at BHC centers and SUS.

The greatest limitation of this study is likely the bias when selecting participants, most of them under continued care with MAC, which presumes a level of acceptance and satisfaction with the therapy. For this reason, our empirical data cannot be generalized nor may one conclude that a share of users would opt for the initial alternative use described. On the other hand, they enable hypothetical generalization with relevant theoretical, institutional and social meaning within the context of the emergences and pos-

sibilities⁵⁹ mentioned above, and should be the object of future studies.

Final considerations

Beyond their alternative or complementary use, in some of our interviews we found BHC users and professionals who prefer to start out using CAM, which when combined with other findings allows us to propose a flow BHC and SUS of care that includes CAM. This flow strengthens the concept of having MAC practiced by hybrid professionals (biomedical practitioners) at the BHC, with a progressive movement towards professional training in MAC and BHCs that offer an institutional plurality of care. Consistent with the limited number of similar studies and broad acceptance of CAM by users (and progressively by professionals), this suggests significant use of such an initial option, that would be suitable for a share of the cases to be sized. If this hypothesis is consistent with new studies and institutional experimentation, it will pose an additional challenge to the development of BHC in Brazil - in addition to expanding and qualifying (biomedical) professionals, it will also require significant expansion in the almost non-existing current training in CAM for students and working professionals.

Collaborations

A Faqueti worked on design, analysis and data interpretation and CD Tesser worked on methodology, analysis and on article final writing.

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