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Are Healthcare Professionals Ready To Adopt Yoga In Their Clinical Practices?

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It is hard to provide a complete answer to this question. Nevertheless, it can be viewed from various perspectives.

First of all, we need to define who the healthcare professionals are. In Hong Kong (a region of China), the general public probably name a number of people working in medical fields such as doctors, nurses, pharmacists, physiotherapists and occupational therapists. It reflects that they have already had a perception that healthcare professionals are those responsible for curing or treating patients. They hence have the ideas that the treatment modalities should be something very medically related such as drugs, surgical operations, radiation, ultrasound, manipulation and splints etc. Yoga on the other hand seems to be simply regarded as merely one of the many types of exercise done in leisure time and places (such as fitness centre or club house) for keeping general health or even just fun. In this connection, the therapeutic values of yoga have been undermined or even masked.

Besides, healthcare professionals are indeed quite "patient-oriented". It is unlikely for them to prescribe yoga to their patients. The term "prescription" represents something that a particular healthcare professional decides on his own authoritative capacity. Even though they know that yoga is therapeutic to their patients, they may still have the reservation of prescribing it. It is because if they really do so, they may put themselves at risk for failing to justify their unique professional status being assigned traditionally or historically. Perhaps, it is the result of the professionalism. Yoga can be recommended by virtually everybody around us. Healthcare professionals may think that it probably makes no difference whether it is your 15-year-old younger sister, your lecturer or your physiotherapist who asks you to practice yoga. To them, it seems so devastating that they will automatically be downgraded to a layman once they prescribe yoga.

Even though the healthcare professionals are so open-minded (or postmodern) that they do not care about the professionalism, they still have barriers in bringing yoga to their clinical practices. Due to scarce budget, new clinical interventions have to be well justified in terms of a number of aspects including but not limiting to the effectiveness, side-effects, clinicians' skills, and resources (such as equipment and places). Evidence-based medicine model which guides the process of evidence-based practice of healthcare disciplines can serve as a framework for analysis. It applies to yoga. There is a 5-A cycle in this model with five "As", namely, Assess, Ask, Acquire, Appraise and Apply respectively [1]. Assess aims to investigate the clinical situations and identify the problems. Ask means to decide a research question in a "PICO" format. PICO stands for Patients, Interventions, Comparison and Outcomes respectively. It is in line with a controlled trial. For example, patients are the people with depression. Interventions can be yoga, physical exercise, counseling or cognitive-behavioral therapy etc. Comparison is to compare the effectiveness of the interventions (for example, yoga versus no yoga, or yoga versus counseling) between two groups according to the outcomes concerned (such as elevation of mood, relapse rate, quality of life etc). As for the subsequent three "As", acquire is to search the related sources of information about the intervention effectiveness mainly from research evidence including primary sources (such as randomized controlled trial studies, quasi-experimental studies, cohort studies, case-control studies) and secondary sources (such as meta-analyses or systematic reviews of randomized controlled trials, and systematic reviews of other types of studies). After acquiring the relevant information, its quality has to be evaluated (appraisal). The research study design affects the trustworthiness of the findings. For example, in a non-blinded study, the subjects are not blinded to the treatment allocation and hence they may know which group (intervention group or control group) that they have been assigned to. Results may then be biased. Those in the intervention group may over-report the treatment effectiveness due to an addition of placebo effect. The reverse is true for the control group. Apart from the study design, the quality of the main body of the research is of course important. Nevertheless, a study with good quality does not guarantee a good external validity. External validity is the degree of generalizability of the findings to the people other than the subjects of the study concerned. The characteristics of the subjects are not necessarily similar to those of other individuals. Age, ethnicity and culture are some common variations. Hence, the findings cannot be directly applicable to other people concerned (the patients, for instance) automatically. This calls for the last "A", Apply, in the 5 "As" cycle. Clinicians should carefully exercise their judgment to determine whether they would trust the findings and hence recommend the patients to practice yoga. On top of the degree of match of the characteristics between the research subjects and the patients, other non-research factors including resources (such as staff expertise, availability of equipment and places), costs, administrators' preference and patients' choices etc are all necessary points to be considered.

To sum up, I have attempted to answer the question by briefly touching on the subjective issues (healthcare professionals' own stand points about what constitutes a profession) and objective issues (understanding and preparedness of evidence-based practice). Nevertheless, my analysis is rather superficial and there are indeed much more other perspectives. It hence calls for further discussion in both theoretical and practical levels from the points of views in medical sciences and social sciences etc.

Reference

1. Duke Program on Teaching Evidence-Based Practice (2011) Introduction and Background to EBM.

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