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Views on Health and Disease in Alternative and Conventional Medicine

A qualitative study based in focus group interviews with alternative therapists, medical doctors with background in alternative medicine and general practitioners.

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Preface

In this master thesis, the similarities and differences in views on health and disease between CAM practitioners, MDs with CAM background and GPs were explored through focus group interviews.

The thesis started out with an idea of wanting to describe the philosophical differences in views on health and disease between acupuncturists, homeopaths and general practitioners, using only qualitative methods through interviews. The original thought behind this was to give voice to the experience and understanding of practitioners, even when it would have to be through my interpretation, since it is impossible to be completely detached. Already during the first meetings with my original supervisor, this idea was expanded on. As a requirement for a master thesis, communication, red flag situations and a survey using quantitative methods needed to be included. The intended interviews with homeopaths and acupuncturists were changed to a group consisting of acupuncturist, homeopath, hands on healer and massage therapist, in order to match the groups of CAM practitioners invited to the survey.

When the information was collected, the interviews had been transcribed, themes identified and the data from the qualitative section had been analysed, it became clear that the dataset was bigger than expected, making it difficult to incorporate it all in one thesis. Also, due to a misunderstanding in the invitations to the qualitative part, resulting in a high number of CAM practitioners compared to MDs, making the analysis process difficult and partly unreliable, the project was scaled down to using only qualitative data, and giving a qualitative analysis of health and disease views from the different viewpoints.

From my earlier experience, being a homeopath and currently finishing my fifth year of medical studies, this project has made it even more clear to me that there are differences in the understanding of health and disease between CAM practitioners and MDs. I have also become even more convinced that it is important that we as MDs clearly understand the views of others, both for our own sake and for the sake of the patients. This kind of research that looks at our fundamental understanding is both important and necessary. When there are blind spots, when we are not aware of our own attitudes or the attitudes of our patients, this might

prevent us as medicinal practitioners to provide the best possible care. And because of this, this kind of research is important.

This project has had two supervisors. Trine Stub, Post Doc at Nasjonalt Forskningscenter innen Komplementær og Alternativ Medisin (NAFKAM), supervised the start of the project, through the interviews and until the transcription and themes in the material. The writing of the thesis was supervised by Nina Foss, Head of Studies, Institutt for Helse og Omsorgsfag. They both deserve thanks for all assistance, and for the information they have provided, the support they have offered and the reading they have done.

A special thanks goes to Jairon Guerrero Cuesta, Social Anthropologist, for reviewing the material with me, correcting my language as far as possible, English not being our mother tongue, and especially for discussing all the contents with me, improving it significantly, and last but not least putting up with my impatience.

My father, Dag Ellingsen, deserves a big thank you for helping me with translating the statements from Norwegian into English. I could not have done this without you.

Carin Pettersson also deserves a big thank you for reading through the material, correcting my language and for giving me good advice to improve the thesis.

The mistakes that may remain are all my own responsibility.

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Tromsø, 05.06.17,


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Table of Contents

- 1 Introduction 1
 - 1.1 Aims, ethical perspectives and definitions 1
 - 1.2 Demarcation 2
 - 1.3 Disposition 3
 - 1.4 Theoretical background of the differences in views of health and disease between CAM and conventional medicine 4
 - 1.4.1 Evidence-based versus experience-based 6
 - 1.4.2 Biomedical versus energetic 7
 - 1.4.3 Reductionist versus holistic 10
 - 1.4.4 The cultural perspective: the importance of understanding different world-views 13
- 2 Methods 15
 - 2.1 Qualitative method 15
 - 2.1.1 Focus group interviews 16
 - 2.2 Recruitment and selection 17
 - 2.3 Analysis of the data 20
- 3 Results 21
 - 3.1 CAM practitioners 22
 - 3.1.1 Energy as a fundamental part of treatment philosophy 22
 - 3.1.2 Holistic view 24
 - 3.1.3 The higher meaning of disease 25
 - 3.1.4 Summary of CAM practitioners 25
 - 3.2 MDs/CAM 25
 - 3.2.1 Energy as part of the treatment philosophy 25
 - 3.2.2 Holistic view 26
 - 3.2.3 The higher meaning of disease 26
 - 3.2.4 Health as a continuum 28
 - 3.2.5 Summary of MDs/CAM 28
 - 3.3 GPs 28
 - 3.3.1 Evidence- and experience-based practice 28
 - 3.3.2 Biomedicine as part of the treatment philosophy 30
 - 3.3.3 Holistic view 32
 - 3.3.4 Health as a continuum 32
 - 3.3.5 Summary of GPs 33

4	Discussion	34
4.1	Evidence-based versus experience-based	34
4.2	Energy versus biomedical views	35
4.3	Holistic view	36
4.4	Level of education	38
4.5	The higher meaning of disease	38
4.6	Continuum of health	39
4.7	Philosophy and cultural background	39
4.8	Strong and weak areas of the research	40
4.8.1	Reliability	41
4.8.2	Selection bias	41
4.8.3	Information bias	41
4.8.4	Validity	42
4.9	Implications and suggestions for further research	43
5	Conclusion	44
	Works cited	47
	Appendixes	50
	Attachment 1: Interview guide, first edition	50
	Attachment 2: Interview guide, revised	53
	Attachment 3: Grade of some articles	55

Abstract

In 2007, 48.7 % of the Norwegian population used Complementary and Alternative Medicine (CAM) outside the healthcare system with acupuncture, homeopathy, reflexology, massage therapy and hands on healing being the most common. Research suggests that conventional medicine's view on health and disease is reductionist, evidence-based and biomedical, while CAM's view is holistic and experience-based.

The aim of this research project is to explore how medical doctors (MDs) and practitioners of CAM view health and disease.

A qualitative study was conducted, using focus group interviews: one group consisting of different CAM practitioners (homeopath, acupuncturist, hands on healer, massage therapist), one with medical doctors with CAM background (MDs/CAM) and one with General Practitioners (GPs).

Findings from the GP group is that they work out of a biomedical view, practice from the bio-psycho-social model, practice evidence based whenever possible, and change their work practices according to the latest research. The CAM practitioners consider energy to be important, blocked energy is connected to disease, and free flowing energy means good health. They see themselves as working holistically. The MDs/CAM work with an understanding that both energy and the biomedical view are important. Another significant difference between the groups is the level of education. The GPs have a six-year university education while that of the CAM practitioners is variable, from none to several years of education. In this study, the GPs viewed themselves to be more similar to the CAM group than to other MDs in many aspects, especially they considered themselves as more holistic in their view of the patients.

For further research, it would be beneficial to interview different groups of MDs. In addition, it would be interesting to interview different CAM professions separately since they express different views on many issues on health and disease.

Keywords

- CAM
- Philosophy
- Health
- Disease
- Conventional medicine
- Medicine

Abbreviations

- CAM: Complementary and alternative medicine
- MD: Medical doctor
- GP: General practitioner
- MDs/CAM: Medical doctors with additional training in CAM

1 Introduction

1.1 Aims, ethical perspectives and definitions

The aim of this research project is to explore how medical doctors (MDs) and practitioners of Complementary and Alternative Medicine (CAM) view health and disease. A qualitative study design was chosen. Three focus group interviews, one group consisting of different CAM practitioners (homeopath, acupuncturist, hands on healer, massage therapist), one with medical doctors with CAM background (MDs/CAM) and one with general practitioners (GPs) were conducted.

My interest for the different views on health and disease dates back to when I started to study medicine in 2012. I realised that there are some important differences in the world-views of conventional medicine and homeopathy. I have a homeopath degree from Norsk Akademi for Naturmedisin (NAN), and worked as a homeopath for seven years until 2010. My background, experience, and understanding of these two disciplines gives me extensive insight into both worlds and their different views on health and disease.

As a homeopath, I had an emphasis on the holistic views of health and healing, which meant I would see every human being as a unity: physically, emotionally and mentally, everything interconnected and interdependent in a socio-cultural setting. Every symptom indicates a disturbance, but it is never the disease itself. I would look for patterns in the disease history, and did my best to connect it all, letting everything fit into one path, the path of the patient.

When I got ill in 2010, it was serious enough to need treatment, and I had to seek treatment in conventional medicine. I experienced how fragmented conventional medicine can be, working with one organ or organ system at a time; but also how effective conventional medicine is when it comes to treating symptoms and saving lives.

What I have found most encouraging when studying medicine at The Arctic University of Norway (UiT), is that conventional medicine is constantly improving. There are almost no truths that will not be questioned at one point or another, and when the answer is different than expected, the methods and treatments are changed accordingly. I also learned about the natural development of diseases, and how complex medical research is, especially when it comes to finding evidence for treatment methods.

My personal experience, influenced the questions I asked in the interviews, the information I identified, and for the themes I found in the information.

This project did not require approval from Regional Etisk Komite (REK), since it does not contain any patient information. Norsk Senter for Forskningsdata/Personvernombudet for Forskning (NSD) has been informed of this project.

In the thesis, the following definitions have been used:

- *CAM*: As defined by Wieland: “Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period” (1, p. 4)
- *Conventional medicine*: Standard medical care, also known as western medicine (2)
- *Holistic*: As defined by Kemper: “Holistic medicine refers to the care of the whole patient (e.g., body, mind, emotions, spirit, and relationships) in the context of his or her values, beliefs, culture, and community” (3).

According to Fønnebø and Launso (4), 48.7 % of the Norwegian population used CAM outside the healthcare system in 2007. This in itself makes it interesting to research views of health and among MDs and CAM practitioners.

1.2 Demarcation

The project started with a broad set of questions, using both qualitative and quantitative methods. The original set of research questions was:

1. How CAM and conventional medical doctors perceive red flag situations and communicate this to patients who want to combine conventional and CAM in health care.
2. Investigate how CAM and conventional medical doctors communicate and cooperate about mutual patients.
3. Delineate the different views of health and disease between CAM providers and conventional medical doctors.

A survey, developed by T. Stub et al., used as a pilot study for the “Cancer and Patient Safety” project by Nasjonalt Forskningscenter innen Komplementær og Alternativ Medisin

(NAFKAM), was used in this project (5), to answer questions regarding red flag situations and communication between CAM and conventional practitioners. In addition, an interview guide was developed specifically for this project. This guide included questions about the philosophical view of treatment methods and if/how this is different from CAM/conventional practitioners, how to evaluate health, how they diagnose, how they communicate and cooperate, how they do consultations, how they evaluate improvement/aggravation and how they define health and disease. They were also asked about how they perceive risk situations, so called “red flag” situations.

As these aspects have not been studied to any significant degree nationally or internationally, this is mainly unfamiliar territory and it required extensive information gathering.

The focus groups provided a lot of valuable information on many of the topics, resulting in more information than expected. When analysing the qualitative data, it became obvious that the themes spread out in many different directions. Because of the many aspects identified, it would be difficult to incorporate them all in one thesis and support this with the required scientific work in a qualitative study aimed at in-depth understanding. Due to limited time and resources available to work with the thesis, it would be difficult to analyse such extensive amounts of data material. As a result, in addition to this being my main interest of research, the focus group discussions on health and disease was selected as the data material for analysis.

The original research questions were reduced to:

Investigate similarities and differences in the views on health and disease between CAM providers, MDs with CAM background and GPs.

1.3 Disposition

To understand the analysis of the information provided in the interviews, it is important to first understand the differences between CAM and conventional medicine on health and disease given in literature and research. Firstly, I provide a short description of the differences between CAM and conventional medicine found in other studies, in addition to theoretical differences with examples from Traditional Chinese Medicine (TCM), homeopathy, healing, and massage therapy.

Secondly, I will provide a description of the methods used in this project, an overview of qualitative research with emphasis on the focus group interviews, a description of the recruitment and selection of participants, and a short description of the analysis process.

The results section contains a short description of the dynamics of the groups, and the results from each of the groups, sorted into the themes identified in the interviews:

- CAM: Energy as fundamental part of treatment philosophy, holistic view, and the higher meaning of disease
- MDs/CAM: Energy as part of the treatment philosophy, holistic view, the higher meaning of disease, and health as a continuum
- GPs: Evidence- and experience-based practice, biomedicine as part of the treatment philosophy, holistic view, and health as a continuum

In the discussion section, the identified themes as well as their theoretical background are discussed. An overview of the strengths and weaknesses of this particular research project is included here.

The appendixes include the interview guides and an evaluation of some of the articles used.

1.4 Theoretical background of the differences in views of health and disease between CAM and conventional medicine

A literature search was conducted in MedLine on February 21st 2017. Figure 1 shows the process of the literature search, including the keywords used. The search listed 2062 articles, out of which only 10 were of interest for this thesis, and among these 10 articles, only three were done as clinical studies. The remaining articles discussed health and disease from a theoretical point of view.

Additionally, searches in PubMed were conducted on “Health” [Mesh] AND “Disease” [Mesh] AND “Philosophy” [Mesh], “Medicine, Chinese Traditional” [Mesh] AND “Philosophy” [Mesh], “Hahnemann” AND “Philosophy”, and on “Hering’s law”, “Therapeutic massage” and “Healing”.

In addition to the literature found in these searches, literature I reviewed during my time as a medical student and while studying homeopathy was used.

Group A Combined with OR	Group B Combined with OR	Group C Combined with OR
<ul style="list-style-type: none"> • CAM.ti,ab,kw • Complementary medicine.ti,ab,kw • Alternative adj3 medicine.ti • Alternative therap*.ti,ab,kw • Alternative medicine.ti,ab,kw • Complementary adj3 medicine.ti • Exp complementary therapies 	<ul style="list-style-type: none"> • Exp medicine • Conventional medicine.ti,ab,kw • Western medicine.ti,ab,kw • Exp evidence based medicine 	<ul style="list-style-type: none"> • Exp philosophy • Health adj3 disease • Philosophy of care.ti,ab,kw • Worldview.ti,ab,kw • World-view.ti,ab,kw
Group A, B and C were combined with AND		

Figure 1. The process of literature search, in order to find articles concerning the philosophy and views on health and disease in CAM and conventional medicine.

Most of the articles found in the MedLine and PubMed searches were criticisms of the biomedical and reductionist views in conventional medicine. It proved difficult to find articles with a positive explanation of the background, understanding, advantages and contributions of biomedical and reductionist views in conventional medicine. This might be because both biomedical and reductionist views are common in the conventional medicine, and their fundamental and positive sides might be looked at as so obvious they are not even stated.

Several of the articles were published in magazines for alternative medicine (4, 6-15). Some of the articles from these magazines gave an impression of favouring the alternative point of view, providing an underlying assumption that the alternative treatment or philosophy is in some ways superior to the biomedical and reductionist views of conventional medicine (6, 8-10, 12-15). I find this to be a kind of oversimplification when it comes to the beneficial sides found both in CAM and in conventional medicine.

It was difficult to find articles describing the views on health and disease in conventional medicine. Research does not focus on the views of health and disease in conventional medicine in the same way as it does with CAM. These challenges made it difficult to find

balanced literature and research on views on health and disease in CAM and conventional medicine.

The different views of health and disease exist in a medical pluralism. Johannessen (16) found that both patients and practitioners hold several world-views. This means that every practitioner, either of CAM or conventional medicine, might hold more than one world-view of his/her work.

1.4.1 Evidence-based versus experience-based

Conventional medicine aims at evidence-based treatments as far as this is possible. In evidence-based medicine, the use of current best evidence for decisions about the care of the individual is used in a conscientious, explicit and judicious way (6, 17). Evangelatos and Eliadi (6) states that the most common method of obtaining the best possible evidence is through Randomized Controlled Trials (RCTs). Marcus (17) explains that the evidence-based medicine is supplemented by clinical experience and the preferences of the patient in conventional medicine.

Marcus (17) states that the main differences between CAM and conventional medicine are connected to identifying the cause of disease, treatment of disease and attitudes towards research. He found conventional medicine to be based on research, being evidence-based. The conventional medicine accepts that clinical trials are important, and is willing to change practice according to new research. According to Marcus, this is a contrast to the view held by CAM practitioners who base their practice on tradition and commonly held beliefs.

Further Marcus (17) claims that from a scientific viewpoint many alternative modalities lack evidence. This may be the main reason why many MDs do not recommend that patients seek treatment with CAM providers. On the other hand, Lüdke and Musial (18) found that, CAM practitioners claim that the methods used to investigate effect of treatment (RCT) are not suitable for CAM therapies since these therapies treat the whole being, not just the disease.

CAM is on the other hand often viewed as belief-based (17) or based upon anecdotal proves (19), and hence is more experience-based clinical practice. Among CAM practitioners and some patients it is believed that there has not been conducted enough research yet for it to be evidence based (19). Others view CAM as vitalistic based as a contrast to evidence-based (17).

1.4.2 Biomedical versus energetic

Conventional medicine is viewed as biomedical (6, 7, 19-21), Identifying the biological causes resulting in diseases and using changes in biological processes as treatment. It focuses on how tissues, cells and molecules work in the body, and how diseases influence these processes. Biomedicine is said to have a mechanical view of the body (6, 20, 21). In the biomedical world-view, there is a duality in mind-body and a duality in health and disease (20, 21). Disease is viewed as something undesired, and is fought against; mortality is seen as something that needs to be avoided almost at all cost. Tilburt (21) states that when it comes to treatment, it is important to treat and to ameliorate when ever possible. This view has its strength in producing medicines and treatments that do ameliorate and treat symptoms, often both fast and efficient.

An example of this, is how research has identified structures in cells that can be used both to classify diseases and as targets for treatment. Keating (22) found that this is the basis for the development of many medicines today, and some researchers think the future of medicine lies in identifying relevant molecules responsible for pathology and then create three dimensional molecules to fit into this structure as medicines, while others argue this to be too reductionist. An example of three dimensional structures that has proven to be important, is the surface markers of the leucocytes, which is used to classify leukaemia (22). Lately the genotype of chronic myelogenous leukaemia has been identified, and specific treatment targeting this has been found (23). Another example, connected to a common problem today, is high blood pressure, leading to increased risk of cardiovascular disease. By studying the biological systems of the body, where the RAAS (renin-angiotensin-aldosterone-system) is important, mechanisms for regulating the blood pressure has been identified (24). Medicines that influence the RAAS system, by affecting a part of it, e.g. angiotensin II blockers, will lower the blood pressure and reduce the risk of cardiovascular diseases. Examples like these are common in medicine.

In the biomedical view, there are objective facts, facts that can be measured in an objective manner with external methodology (6, 21), e.g. blood samples, x-rays, EEG, etc. In order to engage in this type of research, knowledge about cellular physiology is important, and it is in many aspects viewed as the best way to understand the body. An example of this approach is measuring blood glucoses. When the level of blood glucoses is too high, the risk of several diseases emerges, when it falls too low it becomes dangerous. By measuring the glucoses

levels and HbA1c, it is possible to look at both the current level of glucoses in the blood, and the average from the last three months. This provides a picture of the individual's condition, and it is a help in diagnoses of diabetes, when combined with c-peptide among others, this will distinguish between diabetes type I and II, something that determines the treatment (25). Another example is the commonly used CRP, an acute phase protein, which can be used to measure the body's response to antibiotics given for acute diseases. These are only two of numerous examples of how objective facts can be used in the diagnosis and evaluation of treatment.

Some CAM therapies embrace the biomedical view. This is the case when Traditional Chinese Medicine (TCM) is split into acupuncture, Tai Chi, Qi Gong, moxibustion and massage therapy, in the same way as conventional medicine is split into cardiologists, oncologists, gynaecologists etc. (20).

Marian, Widmer, Herren, Dongas and Busato (7) conducted a survey in Switzerland, researching the world-views of MDs with and without CAM background. They found a polarity in the world-views between CAM and conventional medicine. The MDs/CAM had a view with the complexity of interactive dimensions, while on the conventional side the biomedical model was paramount. The bio-psycho-social model was seen as part of the interactive, assigned to the MDs/CAM (7).

At the medical school at UiT, the bio-psycho-social model is often mentioned. This model views the patient within her/his social and psychological environment, and at the same time view the patient as a biological entity (17, 26). Barrett et.al. (19) suggests that GPs might be the MDs who have embraced holism, humanism and the bio-psycho-social model to the largest degree.

Ning (20) found that the view patients' hold might differ from that of the MDs. In North American culture, there is a belief in the body's energetic system, often expressed through the immune system. Many people believe that a strong immune system is based on having enough energy for coping with the ups and downs of daily life, and as a result, energy is an important factor in disease prevention. Ning further found that CAM differs from conventional medicine in that they explain health and disease through a vital force, bioenergy, Qi, Prana. They believe that this vital force can heal the body. In some parts of the biomedicine, this is also found, particularly connected with patient centred care and palliative

care. Psychoneuroimmunology studies the link between body and mind. Therapeutic methods like psychotherapy may also be included here (20).

Marcus (17) states that the different treatment systems in CAM are based on different views, but they all have a vitalistic view of health and disease, where disruption of energy leads to disease and a cure comes through mobilization of energy.

In TCM energy, in the form of Qi, is a basic and essential understanding. Disturbances in the distribution of Qi in the body may lead to diseases (27, 28). Xutian (28) states that Qi is not only an energy found in the body, but within everything in the universe. Qi circulates throughout the body in the meridians, and the contact to the surroundings is through the acupuncture points (29). Xutian (28) further explains that meridians are not visible to the eye, but are explained as canals or areas where the energy can flow within the body.

Hahnemann (30), the founder of homeopathy, stated that in homeopathy, disease is viewed as an unbalance in the “Dynamis”, the vital force within the person. This concept of the vital force does not only influence the view of health and disease, but also the view of how to cure and as the action of the homeopathic medication. Waisse and Bonamin (8) explained that according to this, any substance that will be able to cure, does this by influencing the vital force, and restore the body to its natural, normal function. Since the vital force is not visible in itself, the unbalance is only shown through symptoms and signs. Hahnemann (30) states, the symptoms and signs are the only guide a doctor has got in order to figure out what is the problem of the patient, and the treatment.

Energy is also important in the evaluation of healing and health in homeopathy. Oberbaum, Singer and Vithoukas (9) found that contrary to conventional medicine, which will look upon symptoms in a linear scale and look for improvements in single symptoms or sets of symptoms, homeopathy will look for more subtle changes and changes in the vital force. In a case where some symptoms decrease and others increase or new symptoms arise, there is need for a system that checks if the treatment is beneficial.

The traditional way of viewing the ameliorations and aggravations in homeopathy is often referred to as Hering’s law. As stated by Fisher (10), Hering himself never mentions this as a law, but as observations. These observations indicates that in order to be considered as an improvement, the symptoms should move:

- From above to below
- From within to without
- From more vital to less vital organs/areas
- In opposite order of appearance

(10, 11)

Benor (12) explains that healing is intentional influence that goes from one/several beings to one/several other beings, through interventions not known by physical laws or knowledge today. This is an old system of treatment, used in many cultures through the ages (29).

Healing is usually done either by hand, touching the person or the energy field of the person, or by prayer or meditation (12, 29). The healer experiences this energy field as multiple layers around and through the body. The energy fields are hierarchically organized, where the emotional, mental and spiritual fields can influence the physical body. What is going on in the physical body is an expression of what is going on in these layers of energy. Some people see these energy fields as auras. Others feel them with their hands. A healer will feel parts of the energy being blocked, and work on that. This is done by touching the blocked area, or other points, by projecting energy or withdrawal of energy (12, 29).

The western massage therapists usually work from a physical point of view, while the eastern have an energetic view. They both want to improve the circulation, either of physical entities like blood, or the circulation of energy (29). Fortune and Hymel (31) found that even when the focus of the massage therapist is on the physical, on some specific muscles, also digestion, respiration and circulation are influenced. Also the psychological and emotional levels are influenced by the massage.

1.4.3 Reductionist versus holistic

The dominant approach in western, conventional medicine is biomedical and reductionist, where a higher order phenomenon is dissected into lower, something that gives good and efficient research (19, 32, 33). The complex system of the human body is studied in its individual parts. This has given breakthroughs in medical care and diagnostics (19, 33), but according to research has also led to fragmented care, where sections of the person is treated instead of the whole, integrated human being (33).

Tilburt (21) found that a world-view where everything can be measured and counted makes the RCT research design the gold standard. A RCT is the only research method that can identify whether or not one treatment works better than another and establish its effectiveness. This is also the background for the evidence-based medicine, where one treatment is proven to be better for a group of people than another treatment, or than no treatment.

By studying the body in its individual parts, efficient medications and treatment methods have been identified, followed by accurate diagnosis. One example of this is where x-rays can show a broken bone and the type of fracture. The joint experience of the orthopaedist and radiologist will inform the treatment. This is an efficient and necessary treatment of one part of the body, which does not look at the reason for the broken bone, or the totality of the patient, but treats what is necessary in order to fix the immediate problem. This does not say that MDs do not care about the totality, but that they do what is needed in order to treat the part that needs treatment. However, if a patient for example showed signs of physical abuse, a careful inquiry would not go amiss. This case would require legal action if the patient was a child, according to Norwegian law.

Reductionist views also give strength to the evidence-based way of thinking. Barrett et.al. (13) found that CAM practitioners viewed the biomedical/reductionist method a strength when dealing with emergency situations and effectiveness, but failing to treat the whole person and dealing with chronic disease. This view is also supported by Casell (34), who states that conventional medicine is preoccupied by dissecting and seeking explanations in the molecular level, which is beneficial in order to understand the disease, but according to Casell, this kind of conventional medicine will never be able to explain the illness in one person, with the subjective experiences, fears and worries it might bring.

The reductionist view can be understood by the following:

- What we know on a fundamental level, also explains what we know on a higher level that is not so fundamental (22).
- What is on the higher level, can be decomposed into what is on the fundamental level (22).

If this is considered to be truth, the dissection into smaller parts and searches for a molecular explanation might be efficient. In conventional medicine there are numerous examples of how

diseases have been explained by this approach. One example is the sickle cell anaemia, where one amino acid in the haemoglobin is changed for another as result of a mutation in one single base of the DNA (35). This change in the DNA results in a molecule that does not work correctly. Another example is in the previous mentioned chronic myelogenous leukaemia and its treatment (23).

In holistic views, the body is seen as an energetic entity where food, environment, relationships, inheritance, culture and activities all contribute to the level of health or disease in a person (19, 33, 36). Or as seen by Heusser (37), health is both physical, living, psychic and spiritual. Or as stated by Chow, Liou and Heffron (33), in the holistic view, the whole is more than the sum of the parts. Each symptom is understood as part of the whole. There is an emphasis on healing and wellness, the whole person is viewed as a complex, dynamic system, and it is the patterns of dysfunction one looks for, not disease in parts of the body. In this view, they state, the bio-psycho-social model fits in (33).

According to Chow, Liou and Heffron (33), integrative medicine is often used as a concept for taking the best parts of CAM and conventional medicine, though without specifying what the best parts are. The difference between the conventional and integrative medicine can be illustrated by the argument of whether or not it is the germ that causes the disease or if it is the disturbed balance of the patient that allows the germ to take root. CAM looks for the inner balance and harmony, conventional medicine looks for causes of disease (33).

In TCM, the holistic view is expressed by the way all the symptoms and signs of the patient are used in understanding the situation, it is also put into the living context of the patient. As described by Kaptchuk:

“To Western medicine, understanding an illness means uncovering a distinct entity that is separate from the patient’s being; to Chinese medicine, understanding means perceiving the relationship among all the patient’s signs and symptoms in the context of his or her life.” (27, p.6)

Further, this holistic view is described as separated into two parts: Yin and Yang (14, 27, 28). Hao, Liu, Yue and Liu (38) explains that it is also expressed in how the five elements; wood, fire, earth, metal and water, are seen not only as being connected to the body, but also to nature in general.

The healing system of homeopathy is based upon the principle of similars (9, 30). This principle states that a homeopathic remedy will help for the similar symptom complex in a diseased individual, as it will produce in a healthy. Further it is important to treat the whole picture of symptoms, not only parts. This is the holistic way of thinking in homeopathy. In homeopathy signs and symptoms are regarded to be individual for each patient, and their individuality informs the treatment (15, 30).

1.4.4 The cultural perspective: the importance of understanding different world-views

The way health and disease is viewed is important, even though it might be difficult to define, since it will influence research, clinical settings, politics and everyday life (39, 40). Ning (20) found that the biomedicine reflects the cultural concepts and social values of the western societies, but is practiced differently in different countries.

Mordacci (41) found that patients often lack a good explanation from our contemporary culture when it comes to meaning and valid sense of illness; the usual answer is technical. Buetow and Kerse (42) stated that in the Ottawa Charter and Māori perspectives, health is interpreted according to peoples functioning in their environment, both physical, psychological, social and spiritual. This view might be closer to what people normally think about health and disease. Chow, Liou and Hettron (33) found that health and disease is influenced strongly by culture and religious background. When this is different between doctor and patient, it might give rise to difficulties.

All decisions in healthcare are based in implicit cultural understandings (39, 40). There are many different definitions of what culture is. One definition, presented by UNESCO that explains the contents of a culture, showing that MDs and CAM practitioners with their different value systems and beliefs might hold different cultures, is:

”Culture should be regarded as the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs” (43).

At lectures given at UiT in the autumn of 2015, professor James Allen emphasised how different cultures and the lack of understanding is an obstacle to treatment. According to

Allen, as long as the patient believes that the doctor does not understand her culture, she is less likely to follow the recommendations of the doctor, or share her symptoms with her. Also Klainmann and Benson (44) found that both the culture of the patient and of the doctor is important. It is important to ask what matters most to the patient in the experience of the illness or disease in order to overcome cultural differences, and through this alliance and understanding, it might be possible to reach to an understanding of the treatment needed with the patient (44). According to Evangelatos and Eliadi no treatment can be fully effective without taking into account patients' believes and values (6).

2 Methods

In this research project, the different views of health and disease held in CAM and conventional medicine were studied. A qualitative method, using focus group interviews were selected to explore this.

2.1 Qualitative method

A qualitative approach holds its strengths in areas where little is already known, and to understand dynamic processes which include cooperation, development and wholeness (45). It is often used to obtain information about diversity, variety, experiences, thoughts, expectations, motives, and attitudes, answering questions like "what is..", "what does ... mean", "how is ... done" (45). It can also be used in combination with a quantitative project in order to explore specific areas of research or to better understand what the numbers actually mean (45). It can also provide answers to questions one did not know one had. As in all research it is important to ask what we already know and what this study might add to that field (45).

Qualitative methods are often criticised for being subjective. The researcher is the main research instrument when it comes to qualitative methods. However, having too much distance to the material researched may result in not understanding the answers provided by the participants, while getting too close and involved might lead to problems related to reporting the participants' views. As an example: a researcher who holds a deep interest for the area of research will be able to conduct relevant and purposeful interviews, but at the same time might lose the distance and the critical views necessary to properly analyse the results. However quantitative methods are also influenced by subjectivity. The researcher chooses the field of research, the questions to ask in surveys, how to ask them, and the interpretation of material, even when it comes to the understanding of numbers is subjective (45).

In qualitative research, it is important that the reader can follow the researcher's line of thought and choices made through the research. In order to ensure this, it is important that the reader gets to know the position of the researcher, so the reader can understand the interpretations (45). It is therefore important that the researcher identifies his or her own role in the research project, and one's position and experiences of relevance. Also it is important to involve others to interpret the data together with others, and to give analysis based in

theoretical perspectives (45). This reflective process is considered to be an important part of the qualitative research method.

The results of qualitative research, as with quantitative research, will always be open for debate, and for different interpretations (46). This is partly in the nature of the qualitative findings and the development of qualitative based knowledge, and due to the researcher and theoretical perspectives being important in the analysis of the researched material (46).

Qualitative methods have many different approaches (45):

- Semi structured individual interviews.
- Observation.
- Participant observation.
- Narratives, casus and other stories.
- Study of documents.
- Metasynthesis.
- Focus group interviews.

2.1.1 Focus group interviews

A focus group interview will provide information as a result of group discussion. This distinguishes it from single interviews. The single interview is often called semi structured interviews or in-depth interviews (45). The strength of single interviews is in the close contact between the researcher and the research object, and the open-ended questions open up to reflections by the research object. The single interviews are suited for nuanced and sometimes for sensitive information. In order for this to work efficiently there is need of the researcher being capable of creating a certain level of trust between the interviewer and interview object (45).

According to Malterud, focus groups are often used to gather information about experiences, attitudes and standpoints in areas where people interact (45, p. 138). In a focus group the participants can respond to each other, change their minds, elaborate on their own ideas and on the ideas of others (47, 48) With focus groups, as with other interviews, the research questions would best be answered by using open-ended questions, where no pre judgement or options are made for the participants. In this way ideas and thoughts unknown to earlier research might emerge (47, 48).

A focus group usually consists of 5-8 participants, but the number of participants is less important than the strength of information they provide, something that is ensured by a homogenous composition (45). The homogenous composition makes it easier for the participants to elaborate on their own and others views, without conflicts and tension in the groups (45). The drawback of a homogenous group, is that it might stifle development of ideas and prevent challenging the status quo.

Usually there is both a moderator and a secretary present at the interviews. The moderator is the active one, asking questions to the group, where the secretary notes the general mood of the participants, writes statements and notes who said what in what order to make transcription easier, and serves as a second person to have heard all the information, making interpretations and analysis more solid (45).

The choice of focus group interviews for this research was selected because the research question "*Investigate similarities and differences in the views on health and disease between CAM providers, MDs with CAM background and GPs*" is a question about attitudes and standpoints, which are often displayed when people interact. This method was chosen instead of single interviews since focus was on non-sensitive information, and due to the amount of information that is available as a result of the group discussion.

2.2 Recruitment and selection

In order to create homogenous groups for the interviews, three different groups of professions were invited to participate: CAM practitioners, MDs/CAM and GPs. The group of CAM practitioners consisted of an acupuncturist, a homeopath, a hands on healer and a massage therapist. They were originally selected in order to match the groups invited to the survey that was originally a part of the research project. In the survey they were chosen because they are among the most commonly used CAM therapies in Norway (4). Among medical doctors, GPs were chosen because they are the MDs treating most diverse kinds of diseases, and in that aspect they are thought to be closest to the CAM practitioners in the patients groups they treat. The MDs/CAM were chosen because they have knowledge of both the medical and the CAM viewpoints, being a group of integrative care.

The CAM practitioners, GPs and MDs/CAM were selected to have a purposive sample (45), thought to be homogenous within the groups in order to facilitate a good communication, but

heterogeneous between groups in order to receive different view points of the research question. The recruitment of participants proved to be difficult, ending up with 4 different CAM practitioners, 3 MDs/CAM and 5 GPs, being a convenience sample (45).

An interview guide was developed, see attachment 1, focusing on questions connected with communication between CAM and MDs, views on health and disease, how they evaluate health/disease and red flag situations. This interview guide also contained a hypothetical casus, with a disease history. The thought behind this was to see how the different practitioners evaluated health, what kind of information they would need for their consultations and if they would perceive red flag situations built into the casus. The interview guide was revised during the process of the interviews, based on experiences in the focus group interview with CAM practitioners, in order to best fit the focus of the remaining interviews (45). In the first interview with CAM practitioners on June 13th 2016, I experienced that the hypothetical casus of the interview guide did not work well because it left the participants with doubts about how to answer. None out of the four had ever had any cooperation with MDs. The interview guide was reviewed, in which the casus was removed, and with less emphasis on actual cooperation, see attachment 2.

The interview with the CAM practitioners lasted about 90 minutes. The second group interviewed, and the only interview conducted in Oslo and not in Tromsø, was on June 24th 2016 with MDs/CAM. This interview lasted about 60 minutes. The third and final interview was held November 7th 2016 with GPs. For this interview I only had 30 minutes. Since, the interview was shorter than the others, it contained fewer questions about details concerning health, disease, communication and philosophy of treatment.

The CAM therapists were selected from a Google search on alternative therapies, e.g. acupuncture, reflexology, massage, healing and homeopathy, limited to the province of Troms in the north of Norway. The doctors with alternative therapeutic background were invited from lists provided by The Norwegian Association for Homeopaths (NHL) and some MDs/CAM known either to me or to my supervisor. The GPs were invited from the clinic where I had my 5th year general practice in medicine.

A lot of information in communication is provided in a non-verbal form. Also the verbal form can be misinterpreted. Because of this both I and my supervisor were present at all the interviews and a debriefing was done right after all the interviews to ensure that we had a

mutual understanding of the information that had been provided (48, 49). I had the role as the moderator in the interviews, asking the questions and making sure that all the participants had the opportunity to express their opinions. The supervisor had the role as secretary, writing down statements and the general mood of the meetings.

For background information on the participants, see table 1

Table 1: Background of the participants in the focus group interviews, regarding gender, age, profession, years of practice and speciality.

Participant no	Group	Gender	Age	Profession	Years of practise	Patients/ week	Speciality
1	CAM	F	65	Massage, reflexology	7	20	³⁾
2	CAM	M	44	Healing	4	4	Chios master, reiki master, healer and teacher NSFH, seminars
3	CAM	M	45	Acupuncture	10	30	Muscle pain, urinary tract infections, female diseases, airways
4	CAM	M	51	Homeopath	13	0 ¹⁾	³⁾
5	MD/ CAM	M	51	GP, homeopath	21	70+	General practice
6	MD/ CAM	F	61	MD, homeopath	30	10-20	Obesity, hypothyreosis, diets
7	MD/ CAM	F	50	MD, homeopath	15	Some ²⁾	³⁾
8	GP	F	30	MD, GP	5	50	GP in specialisation
9	GP	M	55	MD, GP, acupuncture	26	³⁾	GP specialist
10	GP	F	56	MD, GP	25	80	GP specialist
11	GP	M	48	MD, GP	³⁾	³⁾	³⁾
12	GP	M	40	MD, GP	14	100	GP specialist

1) Stopped practicing in 2013

2) Last 12 years mainly worked as assistant professor, but sees patients too

3) Did not provide this information

2.3 Analysis of the data

The interviews were audiotaped and later transcribed. I did the transcription, in order to get a better view of the information and identify other aspects than those already clear immediately after the interviews (45). Transcribed material will only give a partial picture of what happened during the interviews (45), since a lot of information is always in a non-verbal form.

NVivo was used as help in sorting themes from the transcribed material. During the analytic process, the raw material was revised several times. First in order to look for themes, after themes had been found, to see if other information might fit in, and in order to see if there were other themes or information hidden in the material that had not been visible on the first, second or third review. The themes were discussed with my supervisor who had been present at all the interviews, with a mutual agreement about the most important themes and the most surprising results according to our prior knowledge. This process nearly followed the Systematic Text Condensation (STC) method, being a kind of transverse analysis (45). The main structure of STC is to first get a general impression of the transcribed material, then find thematic units, then abstract the content of these unities and last to summarize the meaning of this (45).

3 Results

The group of CAM practitioners proved to be very heterogeneous, and they expressed unique individual views. They used some of the same vocabulary, but often with different meaning. This is further elaborated below. Their interaction was friendly, but they did not shy away from clear expressions of disagreement and also sometimes expressed something that can be interpreted as dislike of other participants' opinions. Their diverse backgrounds made it difficult to get further information about each participant's views. This was also the first interview, and the interview guide was not optimal. The good thing about the group being so heterogeneous was that their different explanations of concepts like energy and blocking was made explicit, something that might have remained implicit in a homogenous group.

The participants in the MD/CAM group all knew each other from before, having participated in other research groups. They were in many ways homogenous in their answers, resonated easily with each other's statements, and often agreed. They had a friendly tone, and often expressed admiration for each other's statements and elaborated on them further. Generally speaking, this group had different views on health and disease than the CAM practitioners and the GPs, and in many aspects positioning themselves somewhere between those two groups. Participant 7 of the MD/CAM group often supported the statements of the other two participants. This is not obvious from the statements given in the results, since the supporting statements have not been chosen for the thesis due to limited time and space.

The GPs work together on a daily basis and know each other well. They agreed on most views, and they would elaborate on each other's statements. The interview with the GPs was very efficient. When asked a question, they would answer, elaborate a bit further, but not go off topic. This might be the same efficiency they use in their daily practices, which are very busy. In my opinion, as a result of working with them, is that they interact well with each other, but they are always busy, so the interaction has to be efficient. As a result, the information gathered was precise, but rather superficial. It might have been better to interview the GPs one at a time, and have more time for the interviews in order to get in-depth information, but this will be speculations. Some parts of the biomedical and reductionist understanding of conventional medicine might be so implicit in the understanding of the GPs as it is not even mentioned in the interviews. As a surprise was that one of them is also trained in acupuncture, so he would technically fit into the MD/CAM group, but is treated as part of

the GP group in the analysis as he was part of the GP group interview. Participant 8 of the GP group often supported the statements of the others, but also reminded silent for some of the interview, resulting in few statements from her in the results. This might be because she was the youngest and least experienced of the GPs interviewed, but other explanations are of course possible. Participant 11 arrived late in the interview, resulting in few statements from him in the results.

Six different themes were identified, sorted by the group they were identified in:

- CAM: Energy, holistic view, and the higher meaning of disease
- MDs/CAM: Energy, holistic view, the higher meaning of disease, and health as a continuum
- GPs: Evidence and experience-based practice, biomedicine, holistic view, and health as a continuum

3.1 CAM practitioners

3.1.1 Energy as a fundamental part of treatment philosophy

Energy was an important aspect for the CAM practitioners. They distinguished between a balanced body and free flowing energy that would mean health and a blocking in the energy that would mean disease. When they elaborated on the word “blocking”, they all had different definitions. For the healer it was about spiritual and bodily energies. For the acupuncturist it was about the meridian system. For the massage therapist it was about physical changes in the body, like a scar after an operation and the effect it would have on the muscle-facia system or nerve system.

“(Health is that) the body is in balance and the energy-flow goes the way it should, only then you get to exploit it and evolve. Poor health is when either damage or sickness occurs, giving blockage in one or more ways. (...) So when I think of blockages, I think of physically, not of any imagined stoppage. It lies on the physical plane.” Participant 1, CAM/massage therapy

“You can say that these energies may be stopped if there is a physical injury or a psychological problem that gives you a physical pain. In the body, you have many chakra points, and they are likely to be linked to organs and even to emotions. In

the body, you can say that you have seven chakra points, major chakra points that is, while you have lots of small points all over the body. You can say that if these chakra points are damaged somehow, so that the energy do not pass properly through, that the flow is blocked by a damaged organ, or a broken arm, or that you think too much". Participant 2, CAM/healing

"Let us say pain, if (there is a) stop or blockage some place or other, then pain or other symptoms are created. Then, both external medicine and all acupuncture or possibly Chinese massage or other forms of treatment will focus on restoring balance and functions of the organs. And thus get energy flowing in the body, meridians, then you get better health, get rid of the symptoms." Participant 3, CAM/acupuncture

The participant, who emphasized energy the strongest among all the participants, was the healer. In his world-view and treatment system, energy is the most important part. In the view of the healer, there is a universal energy, and this energy is gathered in some way by the healer, and then channelled through the healer onto to one being healed.

"The whole universe consists of energies. And what I do is to get some energy from somewhere. Then somehow, it goes through me, making me a channel, a funnel or a mould or something like that. Then it moves down to the person I am treating. (...) When you fetch down into that energy you go down into a condition or a trance. (...) If one imagines that a certain amount of energy is delivered every day; which the body needs for restitution of itself (...) and if you use all that energy to think negative thoughts, you will enter a negative spiral whereby you may become what you call sick" Participant 2, CAM/healing

The other participants in the CAM group had a more physical view of energies, particularly the massage therapist. She emphasized how she would work on the healthy side, how the blockings in the body were physical, and how massage would work, since both the blockings and the solutions then are physical. At the same time, she would speak about signal lines in the body.

"(I) am working on the side of health and not on the side of sickness. (...) Even a scar has bindings; it cannot flow freely, causing tensions in a different place. And

it has nothing to do with extraordinary things that you cannot touch and feel. It is quite concrete. And that is the reason why massage can work.” Participant 1, CAM/massage therapy

“Where we have an energy system mainly based on food, drink and air. A dash of care and love is also necessary for one to feel that one has the right to life or is able to carry it on.” Participant 4, CAM/homeopathy

The CAM practitioners used general symptoms as an expression of the energy, both to evaluate the health situation of the patient at that moment, and to evaluate the direction of a cure. In the direction of a cure, they would sometimes get surprising results, where in their understanding the body would choose to start the healing in one part rather than in another.

“If I am to perceive the health condition of a person, I measure simple things. Which I asked my patients every time, whether they slept well, ate well, had a normal temperature and how it was with their mind, whether they had any big challenges. (...) As a homeopath, when we give a medicine, we often see that some symptoms go the wrong way in the beginning, while the general symptoms that I just mentioned often will move in the right direction. You sleep better, have better appetite and feel more rested and so on. In a way it is the general things that count.” Participant 4, CAM/homeopathy

“The energy that you get, it is often a bit self-sufficient, it goes where the body most needs it.” Participant 2, CAM/healing

3.1.2 Holistic view

The CAM practitioners spoke about uniting the physical and the psychological in their patients, and where this would have to be harmonious in order to create good health.

“It applies to both the physical and the mental. You regard the body as something that is holistic and mutually affecting.” Participant 2, CAM/healing

“Actually, we must see human being as a whole. (...) Bodily and mental is unified, has harmony between physical and mental.” Participant 3, CAM/acupuncture

3.1.3 The higher meaning of disease

The homeopath in the CAM group expressed how symptoms are produced by the body in order to bring the individual to a state of better health, and because of that the symptoms should not be removed without considering the underlying disturbance. Also the body has a kind of built in knowledge, always expressing the patient's health situation. In this sense, health becomes more than the absence of symptoms, it is development of inbuilt possibilities.

“A symptom is not necessarily a sign to be eliminated or taken away, but something to lead us to better health. And often these symptoms and signs are quite typical and specific in relation to what is the solution for a better health. (...) The body never lies, it answers honestly about your health, and what challenges you are struggling with in your life. (...) Health, however, is basically that you are somehow able to unfold your inherent possibilities and qualities, without in any way being inhibited.” Participant 4, CAM/homeopathy

3.1.4 Summary of CAM practitioners

For the CAM practitioners energy is important. When it is free flowing, it gives rise to health, when it is blocked it gives rise to disease. Within the group of CAM practitioners the words energy and blocking were used broadly: from the spiritual to the physical. They hold a holistic view of health and disease where the mental, emotional and physical parts of the body are a unity, which cannot be separated. The CAM group homeopath spoke about the higher meaning of disease. He talked about disease as an opportunity, not only as something negative, but where the disease and the symptoms could signify something good for the patient.

3.2 MDs/CAM

3.2.1 Energy as part of the treatment philosophy

MDs/CAM thought of energy as additional to the biochemical views. This aspect is from the CAM part of their background, and in their view completes the teaching of conventional medicine. A well-balanced and free flowing energy would mean health.

“I try to explain to them that we are three things. We are biochemistry, we are energy and we are structure. (...) I believe there is a universal energy governing everything on earth, even humanity and the consultations I have. (...) When I say

what is health, or good health, it is that you have balance, you have good energy, you have balance in the psyche, crying, laughing is allowed, but that you feel mentally stable. Good, deep regenerative sleep and a normal digestion”.

Participant 6, MD/CAM

All the MDs/CAM were educated as homeopaths, and would use Hering’s law in their evaluation of the healing process. This is an energetic view of how the healing process goes from deeper to more superficial levels of the body, often with secretions as part of the healing process.

“It is Hering’s law, as we have learned in homeopathy. The symptoms have moved from a deeper level to a more superficial level, and besides there is secretion.” Participant 5, MD/CAM

3.2.2 Holistic view

Also, the MDs/CAM would express a holistic view, and saw their way of working as more holistic than that of the typical conventional medicine, but they recognized that most MDs might not work like this.

“It is the holistic view. This is a big, big difference between us (e.g. other MDs and MDs/CAM). I almost feel sorry for the GPs. How are they supposed to understand the problem of the patient, when they do not know the anatomy, if we should call it anatomy, meridian-anatomy.” Participant 6, MD/CAM

“There is a clear boundary between a mechanical understanding and a holistic understanding when you look at it objectively, but when you transfer it to the individual physician there is such a difference between doctors in how they approach patients.” Participant 5, MD/CAM

3.2.3 The higher meaning of disease

One of the participants from the MDs/CAM spoke about disease as an opportunity, something the patients get in order to change their life in some way or another, and where the doctor can help in that process by helping the patient to understand the disease.

“Me, I see sickness as a possibility. It is a possibility for change. It is a call for help. Sickness is a call for help. (...) I try to help them to be in the process and

understand, help them to understand why they got cancer in that particular organ.” Participant 5, MD/ CAM

In his view, not only the disease has a kind of higher meaning or significance, also every single meeting with a patient has this meaning. This shows how the concept of meaning goes through his world-view. Life is meaningful, and both health and sickness are meaningful too.

“There is no such thing as coincidence, or that it is fate or something like that. I see that the people who come to me, that I am supposed to help, there is some purpose behind it.” Participant 5, MD/CAM

When it comes to the understanding of disease being more than just bad luck or coincidences, it is easy to think that the individual has caused the disease in one way or another. The participant emphasized that this is not the case; the individual has not done anything wrong in order to get ill, at least not consciously. On the other hand, he did view the individual responsible on a deeper level, especially because that, in his view, would help in the healing process.

“That however does not mean you have done anything wrong in order to get sick. For that can be taken to mean that it is not bad luck. That you have done something wrong and is guilty of causing your own sickness. At the same time, you are on a deeper plane responsible for your own sickness; for it is by taking responsibility that you can start a healing process.” Participant 5, MD/CAM

Also, when talking about mistakes he had done in his practice, he could see a deeper meaning in this. He would do everything in his power to avoid mistakes, but when it happened, he would go through what he described as a grief process, and on a deeper level he would feel that there is a meaning, even with the mistake.

“And you do not understand why it is slipping, it is just slipping. It is a grief reaction, a human reaction of sorrow to feel that you have done wrong. Simultaneously, on a deeper plane, this is consistent, it gives meaning.” Participant 5, MD/CAM)

3.2.4 Health as a continuum

The view of health as a continuum was particularly clear among the MDs/CAM, where one of the participants would even draw it for her patients in order to explain the movement either towards health or towards disease for them. They also expressed it in a sense where one might have a disease, but still not be sick, or even when seriously ill, can feel good in it.

“I draw them a little sketch. Say you are now at A (draws a line with A in one end and B in the other), with all the pains you now suffer, we would like to get you over to B, where you will be well, or better.” Participant 6, MD/CAM

“You could be bed-ridden, you could be physically much reduced, and still have some good condition in spite of it all, have a hope, a goal in life.” Participant 7, MD/CAM

3.2.5 Summary of MDs/CAM

The MDs/CAM viewed energy as part of the human system, besides structure and biology. Energy is an important concept, and one that they find to distinguish them from other MDs. They hold a holistic view of health and disease. One of the participants of the MDs/CAM spoke about the higher meaning of disease. He spoke about a philosophy where there are no coincidences, and at the same time there is no destiny. They viewed health and disease as a continuum, where one could be more or less healthy.

3.3 GPs

3.3.1 Evidence- and experience-based practice

In many aspects, the GPs thought their way of working was pretty close to the one of the CAM practitioners. They both see patients who are unselected, have chronic and complex problems, work with their patients over time, and take care of many aspects of their health. The great differences the GPs found to be in the level of education, where the MDs have a broad and extensive education, work evidence-based and with updated practice in accordance to new research. They viewed CAM to be much more rigid. In spite of their scientific background, they were very aware that a lot of what they do as doctors is not scientifically proven. They work in a field, which is partly evidence-based, but where a lot of their work is based on their experience

“I actually know quite a lot about alternative medicine, I do not think we, as physicians are quite representative of Norwegian doctors, I believe we think quite like many alternative-doctors about quite a lot. Many of the patients we meet in general practice are a lot like the patients who seek alternative treatment. (...) I believe we meet people with much the same breadth in understanding. I think we try to achieve this. Then it is a question of how we practice this in the busy everyday life. It is not always by the book. We do not always remember to consider the underlying factors. (...) If we compare general practitioners “skilled GPs” in relation to some hospital doctors who are more branch-specific, organ-specific in their approach, I believe the difference between them and us can be just as great as the difference between us and practitioners of alternative medicine (...) Then there is one big difference, and that concerns the knowledge base of medicine. Somehow, we lie in a knowledge base, which is constantly developing, where one is open to the truth of 5 years ago is no longer valid. There is a steady onslaught of things we did 10 years ago, that we do not do today, because the world is changing. And this I feel as much more static in alternative medicine. (...) However, in all humility, was it not BMJ (British Medical Journal) that 10 years or so ago said that about 30% of what general practitioners are about is scientifically founded, and the rest is based on experience” Participant 9, GP

“I think we have different backgrounds in education, that we have detailed training in all organ-systems and such. How things function on the biological level. And also, by the way, training in how mental illnesses can evolve, what is affected by the environment, and what is more genetic. So I think we have a slightly different educational background.” Participant 10, GP

The GPs worked both out of evidence- and experience-based knowledge. None of the CAM practitioners or MDs/CAM talked about either evidence or experience-based ways of working.

3.3.2 Biomedicine as part of the treatment philosophy

The GPs worked out of the biomedical view, but also from a psychosocial and more holistic point of view, further described in 3.3.3 *Holistic view*. They held the biological background to be one of the great differences between them and CAM practitioners.

“(It is) very biological, but actually also very psychosocial. (One) learns that a lot of non-biological factors matter when it comes to illness.” Participant 12, GP

“Some things are biological, some are upbringing and some are what happen in the surrounding environment, some things are mental and some are external, physical things. (...) I think, however, that we have different educational backgrounds, that we have detailed training in all organ-systems and such. How things function on the biological level. And also, by the way, training in how mental illnesses can evolve, what is affected by the environment, and what is more genetic. So I think we have a different educational background.” Participant 10, GP

One of the explanations for the use of biological factors was in drug interactions, another was in discovering serious diseases early and to follow them up.

”Biological things are important as regards interactions with medications.” Participant 10, GP

“There are some who take St. John’s wort. I prescribe that, it is just as good a depression medication as SSRI.” Participant 9

“Except for a lot of interactions.” Moderator

“Yes that is the scary part. If they use other medications you keep away from it.” Participant 9

“If you find haemoglobin of 6.7, in a patient who complains about a bit of abdominal pain or a little lethargy you react like this (snaps fingers) and hospitalize the patient immediately. Here we have a severe cancer or some other serious problem that may have to be operated on until proven differently. Thus we may in some, but in the minority of consultations, say that laboratory examination may be relevant. If you have the typical discovery in the abdomen with défense

and full peritonitis, you hospitalize the patient because he needs to be operated on immediately. Changes in the EKG, like, can be hard, good to have these tools for precise diagnostics where there is a biological hazard.” (...)

“How do you determine whether patients are improving or getting worse?”

Moderator

“Laboratory tests, say (a patient) has had antibiotics for 3 days for presumed pneumonia, the CRP has fallen from 40 to 30, ergo, the treatment is effective, the patient is improving. But it can also be anamnestic. The patient feels better, ergo, improvement. Probably an improvement.” Participant 12

The word energy was not used among the GPs. They found this to be one of the differences between them and CAM practitioners.

“Now I better be careful so I do not misspeak, but it must be research-based and it is up to conventional medicine to explain this, while you may use different words, like energy or, this I do not know much about, how they work, but I imagine this is the main difference.” Participant 8

When it comes to the healing process, it might be claimed that also the GPs would use expressions of energy and general symptoms in the same way as the CAM practitioners, even when they would not use those words. The GPs mainly addressed improvement and aggravation through the anamnesis, but also through the use of laboratory tests, and the way the patients would look. The GPs would sometime experience improvements in areas they did not expect. All the below statements are answers to the question: “How do you evaluate if a patient gets better or worse?”

“It is mainly the anamnesis, but it is also lab and clinical examination”

Participant 10, GP

“See it when picking them up from the waiting room”. Participant 11, GP

“Largely I think function, what they say of what they manage in relation to whether things are getting better or worse. It was also quite fascinating as regards being an acupuncturist. I also experience this in conventional medicine, (someone) is treated for migraine, then comes back and tells me the migraine is very good, and I also sleep very well. And this (insomnia) they have not

mentioned. They relate what changes they experience, again it is the sickness story, or as time goes by the wellness story. But even what they tell about what they manage.” Participant 9, GP

3.3.3 Holistic view

When it came to the GPs, they found that they had a more holistic view than some CAM practitioners. They often experienced that patients who had visited CAM practitioners, had gotten a very physical or biochemical answer to their complaints, when the GPs found that it was more mental/emotional. They found that the CAM practitioners often would look for a simple and easily understandable solution for the patient, often some kind of allergy or over sensitivity, without looking at the broader picture. The GPs thought that not only the CAM practitioners had this physical/biochemical understanding, they found this also to be the case in physiotherapists, hospital MDs and other specialists. The GPs spoke about using the bio-psycho-social model in their practices.

“As a general practitioner, I think that we to a very small degree separate psyche from soma. We think of it as very intertwined, but then we find that both (other) doctors and alternative medicine are much more separated. That this is what it is on a molecular level. If you (want to) correct it you just eat this or that and it will work out fine.” Participant 10, GP

“What would be a typical explanatory model in conventional medicine?

Moderator.

“On a cellular level maybe, physiology. Cellular biology.” Participant 8, GP

“There are different points of view. Bio-psycho-social explanatory model is a type of heading that you can use.” Participant 9, GP

3.3.4 Health as a continuum

The GPs spoke about how health and disease could be viewed as a kind of scale, and how the patient is the one to define what is healthy and not. On the other hand, the GPs are instructed to define sickness and health by the Norwegian law, for patients to get support by the healthcare system.

“We all have several symptoms that may be seen as illness. In a way, it is a scale. If you are above a certain level, you feel you are well. If you have little enough of

illness, you are on the inside. If the scale shows many symptoms of sickness, enough that it bothers you, then you are sick. There are, however, no people who are totally well or completely sick, because they are well (or sick) in other ways. If they are sick in one place, they are well at another place in the body.”

Participant 10, GP

“In what we now say, it is to a great extent the patient who decides, whether he feels well or sick, and that, of course, is his right. In this society, we have been given the role to be the ones to decide. For example relative to NAV (Norwegian social security system).” Participant 12, GP

3.3.5 Summary of GPs

The GPs did not speak about energy, but they do evaluate health looking at the patient's general wellbeing and find improvement in areas they did not expect or the patient had not told them about. As a contrast to energy, the GPs spoke about the biomedical views of conventional medicine. They saw the mental, emotional and physical parts of the body as a unity, which could not be separated. In their understanding of this, the GPs spoke about using the bio-psycho-social model. They view health and disease as a continuum, people are more or less healthy, and they might feel healthy even when they have a disease. The definition of what is ill/sick and what is healthy is mainly up to the patient but sometimes the GPs would have to define it according to Norwegian law connected to social and healthcare services.

4 Discussion

This project looks at views on health and disease among CAM practitioners, GPs and MDs/CAM. This is done through focus group interviews. First, I will discuss themes that emerged through the interviews that correspond with the literature search, starting with evidence and experience based praxis, continuing with energy and biomedical views, and going through holistic views. Second, I will highlight the three themes that did not emerge in the literature search, but which became apparent through the focus group interviews: level of education, significance of disease and the continuum of health. After a brief discussion on philosophy and culture as indicated in the literature and through the interviews, I will summarise strong and weak sides of this research project. At the end of this discussion, I will briefly present suggestions for further research.

4.1 Evidence-based versus experience-based

The GPs in this project related both to evidence-based and to experience-based ways of working. The GPs found their way of working evidence-based to be one of the main differences between them and the CAM practitioners. None of the MDs/CAM or CAM practitioners mentioned neither the terms evidence- nor experience-based during the interviews. This might be due to the themes by chance were not discussed in the groups, but it might also be a result of the lack of scientific proven treatments in CAM. When it comes to the literature, Barrett et al. (19) states that some CAM patients and practitioners referred to CAM as not being backed up by science, not yet being proven scientific or only anecdotally proven. Marcus (17) states that CAM lack scientific proven treatments.

Some of the findings from this research suggest that on a practical level the views of health and disease are much more similar among GPs and CAM practitioners than the literature describes. Most surprisingly was the view presented by the GP group, that they see themselves as closer to the CAM practitioners than to the hospital specialists when it comes to views of health and disease. They conclude this because both groups seeing unselected patients, following them over time and treating all kinds of problems. In specialist treatment, which is organised according to one organ or organ system, the MDs in Norway will see a selected sample of patients, who have already visited their GP for a referral. Barrett et al. (19) states that the GPs might be the MDs closest to CAM, by having embraced holism, humanism and the bio-psycho-social model. Since the hospital specialists often treat only one organ or

organ system, and as a result do not take the whole human into consideration, it might be that the hospital MDs work more out of the biomedical and reductionist philosophies, being the main findings of conventional medicine as expressed in the introduction (6, 7, 19-21, 32, 33). The view of the GPs held about themselves as being closer to the CAM than the hospital specialist MDs might be as illustrated in figure 2.

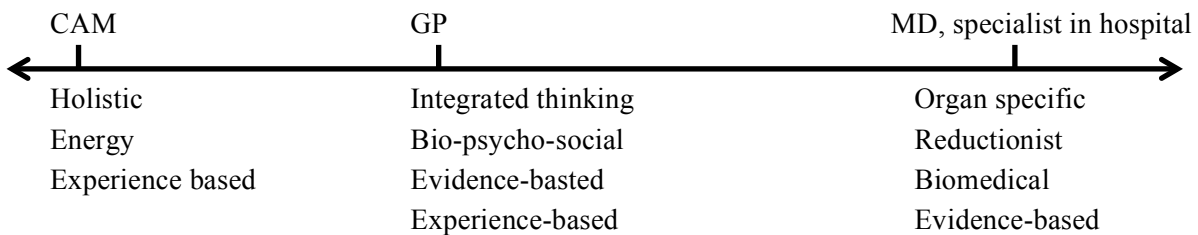


Figure 2: The distance between CAM, GPs and MDs as explained by the GPs, with some of the features seen as typical for each of the groups.

4.2 Energy versus biomedical views

All the CAM practitioners who spoke about energy agreed that a free flowing energy would mean health, while a blocked energy would mean disease. Findings of CAM as being more focused upon energy has also been done in a pervious study (19)

The CAM practitioners viewed energy in slightly different ways. The healer spoke about a universal energy that influences the body through spiritual fields, something that is also found in literature about healing (12, 29). The acupuncturist spoke about energy in the meridians, and of balancing the energy in order to create health, something that is found in literature about Qi as the energy (27, 28). In the interviews, the homeopath did not speak extensively about energy, but the theory behind homeopathy includes energy as an important aspect in the form of Dynamis (8, 30). The concepts of Qi and Dynamis are in many ways similar, both being the basic energy of the body, but it is not so explicit in its spiritual content as in the theories in healing. This corresponds to the interviews where the healer spoke more about the spiritual parts than did the rest of the participants. The massage therapist spoke about energy as being part of the body, something that also found in the western ways of thinking about massage therapy (29).

The MDs/CAM also spoke about energy. They view energy as an essential part of life. One participant expressed it as being one out of three important parts of the human body: biochemistry, structure and energy. Here the MDs/CAM bring in the biological and physical aspects in a way that the CAM practitioners did not. In this aspect, energy is only one part in a bigger whole for the MD/CAMs, while for the CAM practitioners energy is the main part. Ning (20) states that in western society energy is often mentioned; by patients who often express this through their understanding of the immune system, where it is perceived that a strong immune system needs enough energy, and energy is important in order to prevent disease. It is still unclear what this energy really is, since there is no method to measure it today. This view of energy is in line with the view of the MDs/CAM in the interviews.

The homeopath in the CAM group and the participants in the MD/CAM group all used the Hering's law in their consultations in order to evaluate the health of the patients, and as a help in order to explain the situation for patients. This is consistent with homeopathic literature (10, 11). Hering's law can be viewed as an energetic way of looking at improvement and aggravations. When it came to the GPs, their evaluation of health was not clear, they do not following a specific system, and a definition is not found in literature.

The GPs spoke about the biomedical views, something they used as part of their practices. They found biomedicine to be important in evaluation of health in order to distinguish dangerous symptoms and signs from harmless, in order to look for improvement and aggravations and as an understanding of medications and interactions. They did not mention energy, and they viewed energy as something that distinguished their way of working from that of the CAM practitioners. The way they talk about working from a biomedical view is in line with literature, where conventional medicine is viewed as biomedical (6, 7, 19-21).

4.3 Holistic view

The GPs interviewed in this project, put weight on the bio-psycho-social model and how they apply it in their daily work. This model is part of the conventional medicine in Norway, not only as seen by the GPs in this study, but also as it is taught at The Arctic University of Norway, UiT. In other studies conducted in other countries the bio-psycho-social model has been connected to the CAM view point (7).

When elaborating about the bio-psycho-social model, the GPs would also talk about how they view the patients holistically. Many researchers connect a holistic view to CAM practitioners (19, 33, 36, 37). When it comes to GPs' holistic view, the bio-psycho-social model fits in very well. The holism of this model might be a bit different from the holism spoken about in CAM. A typical way of illustrating the bio-psycho-social model is given in figure 3, where the interactions of biological, physical and social factors are creating health or disease.

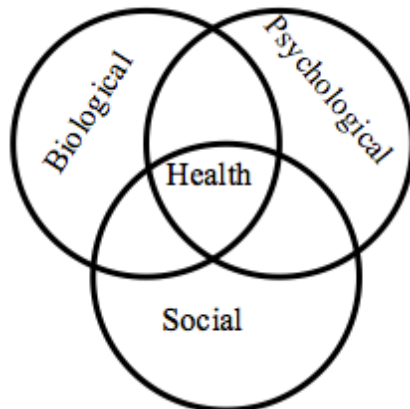


Figure 3: The Bio-Psycho-Social model, where the interaction of biological, psychological and social factors creates health or disease. Idea for illustration from Boundless.com (50)

The GPs found that many CAM practitioners, as well as other MDs and practitioners of conventional medicine to a lesser degree would think holistic and to a greater degree would use biological and physical explanations. Except for Barret et al (19) who states that GPs have embraced holism, humanism and the bio-psycho-social model, there is no literature that indicates that GPs use a holistic view point in a common practice. On the other hand, there is a lot of support for CAM being holistic (19, 33, 36). There is no mentioning in the researched literature of CAM not being holistic as experienced by the GPs in the interviews.

The MDs/CAM however, also viewed their way of working as being holistic, and the principles in conventional medicine not to be. On the other hand, they thought that the MDs often worked more holistically than the philosophies of conventional medicine should indicate. This is in line with the thoughts of the GPs.

The CAM practitioners also spoke about a holistic view, where they integrate both the psychological and physical parts of the patient in their treatment. They did not speak a lot about this, almost as if this aspect is implicit in their way of working and thinking. This would correspond well to a common underlying thought in CAM: everything is one unity. The

divisions we make in the unity, is only because that is how we perceive the world with our senses and the way we interpret it in our western society and culture (51).

This way of explaining the holistic view of CAM practitioners might be theoretical when it comes to many practitioners. It is well known from popular literature that very biological and biochemical explanations are being used among many CAM practitioners in order to explain complex problems. An example of this is all the different detox cures on the market, promising to help every kind of problem there is or all the different kinds of diets that is supposed to help every single problem one has.

4.4 Level of education

At the interviews, the GPs stressed that there are big differences in level of education between themselves and the CAM practitioners. According to Norwegian law, everyone can practice CAM, also with any formal education (52). Some CAM professional organisations demand a minimum of education in both CAM and conventional medicine, e.g. Norske Homeopaters Landsforbund (NHL) (53) and Akupunkturforeningen (54), others base their memberships more upon the experience of the practitioner, e.g. Nordic Healing Association (55). The reason for this is, according to Nordic Healing Association, that healing often is viewed as a natural gift, not something to be taught, and many healers working out of call or vocation. There are still debates on whether or not the lack of formal education in CAM is a threat to patient safety. The diversity of backgrounds in CAM is quite contrary to the uniformity of the medical schools, which teach more or less the same curriculum everywhere, a curriculum based on the evidence-based philosophy.

4.5 The higher meaning of disease

One of the MDs/CAM and the homeopath of the CAM group spoke about significance or higher meaning of disease; it is not bad luck or destiny, but all the symptoms holds a meaning for the person getting them. This is in line with the homeopathic philosophy as expressed by Waisse and Bonamin (8), where the life-force (Dynamis) gives rise to symptoms in the best way possible to tell about the disturbance of the Dynamis. The symptoms are not the disease, just the expression of it.

Mordacci (41) suggested that patients often lack explanations of the meaning and valid sense of their illness as the answers they get from their GP or other MDs are too technical. CAM

practitioners are more prone to use a language and vocabulary that are more familiar to the patient so that the person gains a greater understanding of the meaning of disease, as seen by the CAM practitioner, giving the patients a valid sense of their illness. On the other hand, I think this approach might give rise to guilt and bad feelings about one's situation, and in some cases it might also underrate the medical or biochemical cause of the disease, leading to patients not seeking the correct/most efficient treatment.

4.6 Continuum of health

The material shows that both the MDs/CAM and GPs consider their patients to be more or less ill, describing health and disease as a continuum. They also stressed that the patient is the most central part in this. The only exception is the GPs when they are required to define who are sick and not, according to the Norwegian healthcare system. The literatures studied for this thesis did not put any emphasis on patients being more or less ill, on the other hand, it did not speak about patients being either ill or healthy either. It is interesting that both the MDs/CAM and GPs put emphasis on the patients view, making the patient in the centre of the attention.

4.7 Philosophy and cultural background

The view of CAM as rigid and conventional medicine as changeable according to the newest research was clear in the interviews. This is a well-known fact that Marcus (17) has written about from a theoretical point of view. In the interviews for this thesis a practitioner, who has been working in both fields, stated how he found conventional medicine to be changeable, following the newest research, while CAM to a greater degree would use their old systems and try to make new findings fit into the system instead of changing the system.

The lack of a clearly defined philosophic basis or perspective in conventional medicine might both be a disadvantage and a great advantage in connection with praxis and to understand patients. When it comes to understanding the life-situation of patients and their view of their own situation, the lack of a clear philosophy might be a disadvantage. When it comes to the flexibility needed to constantly change according to the latest developments in research, the lack of a clearly defined and static philosophy can be an advantage. However, it might be that the philosophy of conventional medicine is not lacking, but that it is implicit in the MD's daily life and hence difficult to put into words.

One could say that the opposite is the case when it comes to CAM. The rigid and unchanging systems give an in-depth and lasting understanding of health and disease and the healing process of the patient, but it lacks the flexibility for incorporating new knowledge.

In literature, it was clear that the way health and disease is viewed is important, since it will influence research, clinical settings, politics and everyday life (39, 40). In this, culture is important. Chow, Liou and Hettrou (33) stated that health and disease is influenced strongly by culture and religious background. Ning (20) stated that the biomedicine reflects the cultural concepts and social values of the western societies. The problem comes when the patient and the health care provider, whether it is a MD or CAM practitioner do not share the cultural view of the patient, and they are not aware of the issues this is posing. Klainmann and Benson (44) states that both the culture of the patient and of the doctor is important, and to overcome cultural differences, they need to build an alliance and understanding, so it might be possible to reach an understanding with the patient about the treatment needed (44). According to Evangelatos and Eliadi (6), no treatment can be fully effective without taking into account patients' beliefs and values. Because of this cultural barrier, I find it important to understand your own culture, your prejudice and presumptions, because when you understand your own point of view, it is easier to see how it fits into that of others.

4.8 Strong and weak areas of the research

The research question, "*Investigate similarities and differences in the views on health and disease between CAM providers, MDs with CAM background and GPs*", is best answered through open-ended questions, using a qualitative method. The sample with GPs, CAM and MDs/CAM would be appropriate for answering this, at least partly. Focus groups are well suited when it comes to getting information about standpoints in areas where people interact (45), hence being the best choice for exploring the research question.

When it comes to the CAM group, this was very heterogeneous group, so a better approach might have been to invite several groups, e.g. one with homeopaths, one with acupuncturists and so on, in order to also compare their differences in views on health and disease. In the same way MDs are a broad group of partly different practitioners, so GPs might differ significantly from oncologists or urologists as an example. In this way, this project might be seen as a start, where further research is necessary to understand the differences also within CAM and within MDs.

4.8.1 Reliability

The interviews were done in focus groups, and later transcribed before the data was sorted into themes. This kind of work will always reflect upon the thought system of the researcher. In order to minimize this influence, all the interviews were done with both me and the supervisor present, and we discussed the sessions immediately after the interview. However, my background is very relevant in this study. I am formally trained as a homeopath with a degree in homeopathy from NAN, and I have worked with homeopathy for several years, before I started to study medicine. I am currently finishing my fifth out of six year medicine degree at UiT. This is both a bias in selecting the information from the interviews, and an advantage when it comes to understanding both the CAM and conventional side. Since my world-view is reflected by the world-view of both the CAM practitioners and the MDs/CAM, they might have gotten more space and understanding for their views than the GPs. On the other hand, my thesis supervisors have both been involved in this process, having different backgrounds than mine, so this will probably have been corrected for. Also, the interview with the GPs was shorter than the other two interviews, providing less information, but they were very specific in their answers. This might also contribute to their points of view being discussed less and getting less room than that of the CAM practitioners.

4.8.2 Selection bias

All the GP participants invited came from the medical practice where I had an 8 week internship. This might have had an influence on the interviews, but this is probably small. I did not select the office where I had my internship, it was assigned by the university. As for the MDs/CAM, I did not know them. The community of MDs/CAM in Norway is pretty small, something that might influence the participants when it comes to supporting research. The CAM communities are also small. Two of the practitioners were acquainted with me before the interviews, something that might have influenced their choice to participate. This is not necessarily a disadvantage when it comes to sharing information, it might as well be an advantage; since some information is better shared with someone you already know and trust.

4.8.3 Information bias

Information bias might be an issue, especially with CAM practitioners and MDs/CAM, since their numbers are small in Norway. They might censor and carefully select the information they provide if they fear that their statements will be recognised. They might also give more

positive support for CAM, than what is their real experience. This might be the case when one of the participants was eager to stress how he follows the Norwegian law at his practice.

Another information bias in this study might be a result of the background literature used. Most of the articles found in the literature searches based on the key words were critical to biomedicine and to the reductionist ways of working in conventional medicine. The reason for this might be that the good sides of biomedicine is thought to be known in a western society, and might be implicit in the writing since this is the common way of practicing medicine. Also the philosophical content of conventional medicine was difficult to come by, again, this might be due to it being implicit in our daily lives, and hence difficult to see.

4.8.4 Validity

Validity can be either internal or external. The external validity is about the extent to which the study result can be applied to a larger population, the internal is to which extent the study methods are consistent (56). The external validity will be dependent upon time and situation (45). When it comes to this project that might have been problematic. The interviews were all done in Norwegian. When translating, some of the meaning is always lost. An example of this is the word “sykdom” in Norwegian. This might be translated to both “disease” and “illness”, since the Norwegian language does not distinguish these two.

Since this is a field where little research has been done, there is no gold standard (45), but the findings are mainly according to the three previous studies. All in all the internal validity seems to be appropriate in this project.

To enhance the external validity, the supervisor and I made the interview guide jointly. I was then in my 4th year of medicine studies and the supervisor for the first part of the thesis was working on a post doc in CAM and is educated as both as a homeopath and an acupuncturist. Theory about health, disease and treatment philosophies of homeopathy, acupuncture, massage therapy, healing and conventional medicine was studied when working on the interview guide.

The interview groups had few participants, and there was only one interview per group. This might not ensure saturation, where further interviews or gathering of information will not give new information (45), so there might be themes that are not researched well enough, and that might have gotten different answers in bigger groups with other people. On the other hand,

the transmissibility is not proportional to sample sizes, the strength of the information is much more important (45). In this way, both the GPs and the MDs/CAM gave information that seemed to be of very good strength, where the participants backed each other in their statements. The CAM group was too heterogeneous to do this, using some of the same words, but with different meanings.

4.9 Implications and suggestions for further research

It would be interesting to know the different views of other groups of MDs, and to distinguish different groups of CAM practitioners, since they are a very heterogeneous group. The sample in this research is too small when it comes to CAM, and might not represent the thoughts and ideas of many practitioners.

5 Conclusion

This Master thesis' research question, *to investigate similarities and differences in the views on health and disease between CAM providers, MDs with CAM background and GPs*, has been explored through the use of literature searches and focus group interviews.

A qualitative approach was chosen in order to answer the research question, since it is a question about attitudes, where open-ended questions would best enlighten the field. Focus group interviews were chosen in order to obtain information from the group discussions and to observe group dynamics. In order to have homogenous groups, one group of CAM practitioners consisting of one homeopath, one acupuncturist, one hands on healer and one massage therapist, one group of MDs/CAM and one group of GPs were interviewed, one interview per group.

The CAM practitioners viewed energy as fundamental in their understanding of health and disease. Free flowing energy would mean health, while a blocked energy meant disease. The participants had different opinions about the energy, from the spiritual understanding of the healer to the physical understanding of the massage therapist. They looked upon health and disease in a holistic way, where the physical and psychological is seen as a unity. The homeopath found disease as having a kind of significance or higher meaning for the person being ill, something that might help the person in some way.

Also the MDs/CAM found energy to be important in their views of health and disease, something that they thought distinguished them from other MDs. Additional to the energetic view, they had a biological and functional view. They worked out of a holistic view, and they found this to be an important division between them and other MDs. At the same time they thought that MDs might work more holistically than the biomedical understanding of conventional medicine indicates. They viewed health and disease as a continuum, where one could be more or less healthy or more or less ill. One of the participants viewed disease as having a kind of significance or higher meaning, where disease has a function for the patient.

The GPs worked out of a biomedical view, where they at the same time worked holistic, taking both the biological/physical, emotional, mental and social parts of the life of the patient into consideration, something they summoned up in the bio-psycho-social model. The biological model was important to them when it came to the understanding and detection of

serious pathology. The holistic view with the bio-psycho-social model was a part of their understanding that they found to be closer to the CAM practitioners than to other MDs. They also worked out of an evidence-based practice where evidence is available, as well as experience-based where there is no conclusive evidence. They viewed health and disease as a continuum, where one could be more or less ill, and where the level of health was mainly dictated by the experience of the patient.

There are some differences between the groups. The greatest difference is probably in the level of education. MDs have a high level of education. Some CAM practitioners also have extensive education, while some do not have any formal education in their field, but perhaps a great call or vocation.

Both the CAM practitioners and MDs/CAM used energy as part of their understanding. The GPs did not mention this concept, and would instead enhance the biological view of health and disease. This corresponds to findings in the background literature, viewing CAM as energetic and conventional medicine as biomedical (6, 7, 17, 19-21).

In this study, only the GPs spoke about using evidence based practice. They also admitted that their practise is partly experience-based. The CAM practitioners and MDs/CAM did not speak about either evidence or experience-based, this might be due to them not being comfortable with this terminology not or for the MDs/CAM that they were too obvious to mention. Some literature states that CAM might only be anecdotally proven (19), and that it lacks scientific proof (17).

One of the participants in the CAM group and one in the MDs/CAM presented views on illness and disease as having a kind of significance or higher meaning. This is a concept supported in homeopathic literature (8). None of the other participants mentioned this concept.

There were also similarities between the groups. All groups view the patients in a holistic way, where they view the psyche and soma as interconnected. Even though they all do this, they might attach different meanings to what holistic and interconnected views really mean. The GPs found that they would work in a more holistic way than would many CAM practitioners, other MDs and practitioners of conventional medicine, who would rather give physical explanations to what for GPs was complex cases involving both psyche, soma and

the environment of the patient. In the literature studied for this thesis, only one study was found to support the notion that GPs work in a holistic way (19).

The most surprising outcome of this study, was that the GPs interviewed viewed themselves as being closer to the CAM than to the hospital specialist MDs in many aspects. This was because both groups work with complex cases, see unselected patients as opposite to the hospital specialist who in Norway will see patients referred from a GP, and follow them over time. This also was due to the holistic view of the GPs. In most of the literature, conventional medicine has been described as reductionist (19, 32, 33). For the GPs interviewed in this project, the reductionist view was not obvious, but might have been implicit.

Culture is also an important factor when it comes to health and disease. According to literature, it is fundamental for our attitudes and actions, and it underlines how we treat patients (39, 40). When the culture of the patient and of the health provider (e.g. MD, CAM practitioner) is not the same, the patient will often find it difficult both to give information and to trust the advice given. In order to overcome this, it is important for the health provider to know her own culture and to understand it, so she can easily see the differences to the culture of the patient, and identify where the two do not match.

The CAM group was very heterogeneous, so interviewing them as one group presented challenges. For further research, it would be better to divide them into groups in accordance to their professions, e.g. one group of homeopath, one group of acupuncturists and so on.

For further research, it would also be beneficial to interview other groups of MDs, in order to gain a better understanding of the different views of health and disease, and the differences that might be between different groups of MDs.

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List of Tables

Table 1: Background of the participants in the focus group interviews, regarding gender, age, profession, years of practice and speciality.....	19
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List of Figures

Figure 1. The process of literature search, in order to find articles concerning the philosophy and views on health and disease in CAM and conventional medicine.	5
Figure 2: The distance between CAM, GPs and MDs as explained by the GPs, with some of the features seen as typical for each of the groups.....	35
Figure 3: The Bio-Psycho-Social model, where the interaction of biological, psychological and social factors creates health or disease. Idea for illustration from Boundless.com (50).....	37

Appendixes

Attachment 1: Interview guide, first edition

Åpne med presentasjonsrunde slik at alle de tilstedeværende kan bli kjent med hverandres bakgrunn med hensyn til navn, tittel, hvor lenge de har jobbet, hvor de jobber, om de gjør noe annet enn praksisen innenfor det gitte terapiområdet (for eksempel forskning, undervisning, andre terapiformer).

Deretter gå inn på definisjoner:

- Kommuniserer du noen gang med alternative behandlere/leger/helsepersonell om felles pasienter?
 - Hvordan foregår denne kommunikasjonen?
- Hva vanskeliggjør samarbeidet/kommunikasjonen slik det er nå?
- Hvordan ønsker du at et samarbeid mellom alternative behandlere og helsepersonell skal foregå?
- Hvilke opplysninger fører du normalt sett i journalen?
 - Hvilke opplysninger er viktige å ha med i journalen med tanke på samarbeid?

Dersom spørsmålene er ikke besvart under kasusdelen:

- Hvordan vil dere definere helse?
 - Hva er god helse?
 - Hva er dårlig helse?
 - Finnes det noen øvre grense for god helse, og hva er i så fall denne?
 - Finnes det noen nedre grense for god helse, og hva er i så fall denne?
 - Hva skal til for at dere oppfatter at en person har god helse?
- Hvordan vil dere definere sykdom?
 - Finnes det noe skille mellom at en person er syk og har en sykdom? Forklar
 - Hva skal til for at dere oppfatter en person som syk?
 - Hva skal til for at dere oppfatter at en person har en sykdom?
- Hva er forskjellen på sykdom og syke mennesker?
 - Hva bør legen/behaviorer fokusere mest på, og hvorfor?
- Er det noe skille mellom hverdagsplager og sykdom, og hva er i så fall dette?

- Hva er en hverdagsplage, hva er en sykdom, og hvem avgjør hva som er en sykdom?
- Hvordan avgjør du om pasienten din er blitt bedre eller verre på oppfølginger? Her er det ønskelig med konkrete eksempler.
 - Hvem avgjør hva som er bedring og forverring?
- Hvilke faresignaler vil du typisk være på utkikk etter hos en tilsynelatende frisk person? Hvordan oppfatter du disse signalene, og hvordan går du videre med dem?

Ola er 42 år gammel. Han er gift, har ett barn på 14 år fra et tidligere ekteskap. Det er ingen kjente arvelige sykdommer i familien. Han reagerer noe på bjørkepollen, men har ellers ingen allergier eller reaksjoner på legemidler. Bortsett fra allergien har han stort sett vært frisk gjennom hele livet, med unntak av normale akutte episoder med forkjølelser og infeksjoner. Ole jobber som snekker. Før jobbet han med selve snekringen. I dag driver han for det meste med administrasjon av firmaet sitt som har 10 ansatte, og gjør det godt.

I dag kommer Ola til konsultasjon fordi han har fått vondt i ryggen. Smertene er litt ubestemmelige i kvalitet, relativt konstante, sitter lumbalt. Han kan ikke avgjøre om det er noe som verken lindrer eller forverrer. Han har brukt Ibux litt til og fra den siste måneden, men egentlig ikke hatt noen særlig effekt av det.

I forhold til ryggplagene og jobben sin bruker han flere ganger ordet ”håpløst”. Han virker også noe aggressiv uten at han velger å gå nærmere inn på det selv.

Du tar en skikkelig, grundig anamnese. Det kommer bl.a. fram at Oles nye kone virkelig ønsker seg barn, og de har forsøkt iherdig i over ett år nå uten at det har kommet noe. Situasjonen begynner å slite på forholdet dem i mellom. Kona er 35 år gammel og har ingen barn fra tidligere. Du observerer at Ole ser ut til ikke å ville snakke om dette, og heller ikke generelt om hvordan han har det. Du spør også direkte om hans søvnmønster. Da kommer det fram at han sover godt, men ofte må opp og tisse på natta, noe som forstyrrer ham i søvnen, ettersom det i tillegg til å være mange toalettbesøk, også tar lang tid.

To uker senere kommer Ole tilbake. Nå sliter han med at det svir når han må tisse, og han har smerter i ryggen. Disse smertene er litt annerledes enn de han beskrev sist. De sitter litt høyere opp, og kjennes innimellom ut som knivstikk i ryggen. Det hele har bare pågått siden dagen i forveien, først med sviende vannlating, senere med ryggsmertene. Han kjenner seg også skikkelig dårlig, nesten litt influensafølelse i kroppen.

Det viser seg at Ole har en UVI som behandles effektivt. To uker etter er han tilbake igjen. Ryggen er fortsatt vond, omtrent som ved den første konsultasjonen. Men denne gangen er det litt vanskeligere å få ut av ham hva som egentlig er problemet. Etter mye nøling og inngående spørsmål forklarer han at han føler seg aggressiv og finner ikke lenger glede i det han tidligere fant glede i.

Spørsmål som vil bli stilt underveis i kasuset:

- Hvordan vurderer du helsetilstanden her?
- Hva er sykdomstegn?
- Hva er friskhetstegn?
- Hva mer har du behov for av informasjon her, og hvordan vil dere gå videre?
- Vil du gjøre noen undersøkelser?
- Hva vil en tentativ diagnose og behandling være?
- Er det noen forskjell på dette og pasientens lidelse?
- Vil du sette opp flere konsultasjoner etter denne? I så fall hvorfor/hvorfor ikke?
- Hvordan vil du avgjøre om pasienten er blitt bedre eller verre neste gang du ser ham?
- Ser du noen røde flagg/faresignaler i denne historien?
- Hvilken utvikling forventer du å se ved riktig/feil behandling?
- Får de nye opplysningene deg til å revurdere diagnostisk tankegang og røde flagg?
- Hvordan vil du kommunisere en konsultasjon som dette overfor en alternativ behandler/helsearbeider?
- Hvordan vurderer du utviklingen fra sist, sykere, friskere, ingen sammenheng, annet.

Attachment 2: Interview guide, revised

Introduksjon.

- Min bakgrunn, hensikten med studien, tidsavgrensning, lydopptak, gå når ønsker det. Skrive under. Dere får noen spørsmål. Fint om responderer på hverandres utsagn.
- Bakgrunn til veileder og hennes rolle.
- Bakgrunn deltakerne: hvor jobber, hvor lenge, annen type bakgrunn.

Helse og sykdom

- Hvilket verdisyn, verdensbilde eller filosofi bygger din behandlingsform på?
- Hvordan evaluerer du helsetilstanden? Hvilke symptomer/tegn bruker du?
- Hvordan stiller du en diagnose? Medisinsk eller naturmedisinsk
- Hvordan vil du beskrive den naturmedisinske/medisinske diagnosen for en lege/alternativbehandler?
- Hva spør du pasienten om og hva undersøker du ved første gangs møte?
- Hva spør du om på en oppfølging? Hva undersøker du?
- Hvordan evaluerer du om pasienten har blitt bedre eller verre? Hva ser etter for å vite om går den rette veien? Hvilke mål bruker du? Konkrete eksempler ønskes.
- Hva gjør du om det går rett vei? Hva gjør du om det går gal vei?
- Hvordan oppfatter du at ditt syn på helse/sykdom (behandlingsfilosofi) skiller seg fra alternativmedisinens/konvensjonell medisins? Hva er likt og hva er forskjellig?
- Tror du dette kan være problematisk for pasientene? I så fall, på hvilken måte?
- Tror du dette kan være problematisk for kommunikasjon med helsepersonell? På hvilken måte?
- Samarbeider du noen gang med lege/alternativ behandler? På hvilken måte?
- Hvilke opplysninger fører du i journalen? Hvilke opplysninger er viktige å ha med i journalen med tanke på samarbeid?
- Hva er god helse?
- Hva er dårlig helse?
- Hva er sykdom?

Røde flagg

- Hva forstår du med røde flagg situasjoner?
- Hvilke symptomer/tegn får deg til å tenke på røde flagg?

- Ved akutt sykt barn, hvilke faresignaler ser du etter? Hva vil du spørre om og hva vil du undersøke? Hva gjør du videre?
- En godt voksen pasient, lite syk fra tidligere, nylig fått rygg smerter. Hvilke faresignaler vil du være på utkikk etter? Hva vil du spørre om og hva vil du undersøke? Hva gjør du videre?
- Hvordan snakker du med pasientene dine om røde flagg/faresignaler?
- Har røde flagg/faresignaler noen innvirkning på hvordan du kommuniserer med pasienten om bruk av alternativ medisin/konvensjonell medisin?
- Hva tenker du rundt etikk og forsvarlighet ved kombinasjon av alternativ medisin og konvensjonell medisin?

Attachment 3: Grade of some articles

Reference: Barrett, B., et al., <i>Themes of holism, empowerment, access, and legitimacy define complementary, alternative, and integrative medicine in relation to conventional biomedicine.</i> Journal of Alternative & Complementary Medicine, 2003. 9(6): p. 937-47. (13)			GRADE Level C Recommendation IV
Aims 1: What is CAM? What CAM therapies do you use/practice? Why? How are goals accomplished? How are CAM and conventional similar or different? 2: How are CAM and conventional similar or different? Can they be reconciled/integrated? What are barriers? How can they be overcome?	Material and method Data from two interviews based qualitative studies: 1: In person interviews. Semi structured instrument with open-ended questions of 20 CAM practitioners and 17 users/clients of CAM . 2: In person interviews. Semi structured instrument with open-ended questions of 32 CAM practitioners Telephone listings were used for selection of participants in both studies. Both the analysis were done as multidisciplinary review of taped-and-transcribed interviews .	Results <i>Conventional medicine is</i> More reductionist More controlling More deductive More generalizable More scientific Less time with patient <i>CAM is</i> More holistic More empowering More inductive More individualistic More intuitive More time with client Barriers for Integration: From conventional medicine: Arrogance Belief of ineffectiveness of CAM Competition Costs and cost effectiveness Distrust Fear of liability Ignorance Momentum (habits and tradition) Lack of availability From CAM: Lack of communication Lack of evidence of effectiveness Lack of legal recognition Lack of training Philosophical differences Political pressures Prejudice Profit motive Territorialism	Discussion/comment The statement of the aims was not too clear, but implicit. The methods, material and method is well described, and done in a way likely to provide the information necessary. The background of the researcher is not discussed. Not discussed ethical issues.
Conclusion			
Country USA			
Year of data gathering 1999-2001			

Reference: Fortune, L.D. and G.M. Hymel, <i>Creating integrative work: a qualitative study of how massage therapists work with existing clients</i> . J Bodyw Mov Ther, 2015. 19(1): p. 25-34. (31)			GRADE
			Level C
			Recommendation III
Aims To gain foundational knowledge about clinical reasoning and applied knowledge, this study examined how 10 MTs conducted an entire session with established clients. Results support translational research design and inform educators.	Material and method Ethnomethodology and phenomenology informed the qualitative design. Videotaping actual sessions and interviewing the participants immediately afterward while viewing the videos collected data. Computer-aided analysis identified data patterns for thematic interpretation.	Results The MTs shared tacit knowledge that directed their work: a) maintaining a primarily biomechanical focus, b) prerequisite safe touch, c) multitasking not allowed, d) MTs assume physical risk, and e) the work affects multiple bodily systems. The MTs sensed effectiveness experientially by adopting common tactics: a) visualizing the manual engagement points, b) assuming the client controlled the physiological release, and c) educating the client. Within these commonalities, they operationalized their work in complex and singular ways, with the particular client relationship critical to structuring the session and evaluating the outcome.	Discussion/comment In the methods the position of the main researcher being a massage therapist is valued. The sample was a convenient sample. The video was watched by researcher, therapist and patient, and followed by an interview. There is no specific discussion of ethics.
Conclusion MTs viewed their work primarily as a biomechanical intervention, but understood therapeutic massage as serving multiple functions. Process-oriented clinical reasoning mirrored models found in psychotherapy and was informed by experience, intuition, and training, which resulted in an intentionally holistic approach.			
Country USA			
Year of data gathering 2010-2011			

Reference: Marian, F., et al., <i>Physicians' philosophy of care: a comparison of complementary and conventional medicine</i> . <i>Forschende Komplementärmedizin</i> (2006), 2006. 13(2): p. 70-7. (7)			GRADE
			Level C
			Recommendation III
Aims Explore the philosophy of care (convictions and values, priorities in medical activity, motivation for CAM, criteria for the practice of CAM, limits of the used methods) of conventional and CAM general practitioners (GPs) and to determine differences between both groups.	Material and method This study was a cross-sectional survey of a representative sample of 623 GPs who provide complementary or conventional primary care. A mailed questionnaire with open-ended questions focusing on the philosophy of care was used for data collection. An appropriate methodology using a combination of quantitative and qualitative approaches was developed.	Results Significant differences between both groups include philosophy of care (holistic versus positivistic approaches), motivation for CAM (intrinsic versus extrinsic) and priorities in medical activity. Both groups seem to be aware of limitations of the therapeutic methods used. The study reveals that conventional physicians are also using complementary medicine.	Discussion/comment Unclear how the GPs were recruited, all of them or only a sample. Written, open-ended questions, might be a bit limiting for the philosophy of care. Used 175 answers to find categories, tested them on 10 questionnaires. 32 % returned questionnaire. Done in Switzerland, pretty similar culture and population to Norway, but with different history and health care system, might not be possible to transfer results. Probably first research done on philosophy/world-view concerning treatment. Unclear who did the analysis and the influence of their background on the results.
Conclusion			
Country Switzerland			
Year of data gathering 2002			

Reference: Barrett B, et al., <i>Bridging the Gap Between Conventional and Alternative Medicine</i> . J of Fam Pract, 2000. 49(3): p. 234-239. (19)			GRADE
			Level C
			Recommendation III
Aims Investigate the knowledge, attitudes, and practices of patients and providers of complementary and alternative therapies	Material and method Qualitative study with semi structured in- depth interviews focused on the knowledge, attitudes, and behaviours of a random sample of 17 patients who had used both CAM and conventional therapies during the past year. Participants were recruited using telephone listings. Twenty alternative practitioners were selected to represent the major modalities. The topics discussed included healing philosophy, choices of therapeutic methods, and ideas concerning concurrent use of differing therapeutic modalities. An 8-member multidisciplinary team analysed the transcripts individually and in group meetings	Results Four major themes emerged from the interview data: (1) holism, (2) empowerment, (3) access, and (4) legitimization. Both patients and providers distinguished between the socially legitimized and widely accessible but disempowering and mechanistic attributes of conventional medicine and the holistic and empowering but relatively less accessible and less legitimate nature of alternative healing. There was a strong call for integrating the best aspects of both.	Discussion/comment Inclusion process described, and with high standard, through telephone listings. The backgrounds of the researchers are not described, so the biases are difficult to identify. Description of the analysis process contains several steps and multiple people involved in order to best find the valid results. Ethical issues are not mentioned in the article. Difficult to tell how the data analysis was done and by whom.
Conclusion The patients and providers interviewed for the study suggested that the apparent strengths of CAM, especially holism and empowerment, could be used to help improve the quality of conventional health care. The authors suggest that some ideas and methods from CAM should be investigated and, if found deserving, either adopted or adapted by the official medical system. They feel that this type of integrative effort requires regulation as well as recognition.			
Country USA			
Year of data gathering 1999			

<p>Reference: Fønnebø, V. and L. Launso, <i>High Use of Complementary and Alternative Medicine Inside and Outside of the Government-Funded Health Care System in Norway</i>. Journal of alternative and complementary medicine, 2009. 15(10): p. 1061-1066. (4)</p>			<p>GRADE</p> <p>Level C</p> <p>Recommendation III</p>
<p>Aims The objective of this study was to describe the Norwegian population's use of complementary and alternative medicine (CAM) inside as well as outside of the health care system in Norway over the previous 12 months.</p>	<p>Material and method A survey based on telephone interviews has been conducted. The interviewees were sampled from the 97% of Norwegians aged 15 years or older living in private households with a landline telephone or a cell phone. In total, 9035 individuals were called in order to include 1007 individuals in the sample.</p>	<p>Results “Over the previous 12 months,” 48.7% of the respondents had received CAM by CAM practitioners outside of or by health care personnel inside the health care system. Approximately 18% had received CAM by providers four or more times “over the previous 12 months.”</p>	<p>Discussion/comment A well described study, with a well selected population. Doubtful of the transferability to other countries and in time.</p>
<p>Conclusion The high use of CAM provided by CAM practitioners outside of as well as by health care providers inside the health care system indicates that users do not see themselves as belonging to one or the other system; they have already combined both systems when designing their own care.</p>	<p>The main outcome measure was the proportion receiving CAM given by a CAM practitioner over the previous 12 months</p>		
<p>Country Norway</p>			
<p>Year of data gathering 2007</p>			