GPs attitudes on complementary and alternative medicine (CAM) and its role within the German healthcare system - a focus group study

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Background: There has been a marked increase in the use of complementary and alternative medicine (CAM) in recent years worldwide. In Germany, apart from 'Heilpraktiker' (= state-licensed, non-medical CAM practitioners), general practitioners (GPs) provide CAM in their practices. The aim of this study was to explore the attitudes of GPs on CAM and the value they ascribe CAM within the German healthcare system.

Methods: Using a qualitative methodological approach 3 focus groups with a purposive sample of 17 GPs were conducted. According to pre-defined questions the following key themes were discussed: role of CAM within the German healthcare system, quality & CAM, education & CAM, research & CAM. The discussions were transcribed verbatim and analysed using qualitative content analysis.

Results: The majority of the participating GPs had integrated one ore more CAM methods in their every-day practice. The analysis of the main category 'role of CAM within the German healthcare system' resulted in 5 subcategories: integration of CAM, CAM in the Statutory Health Insurance, modernisation of the Statutory Health Insurance Act and 'Heilpraktiker'. By most of the GPs CAM was highly valued as complemental approach in their daily practice, in particular for patients difficult to treat or not satisfied with regular healthcare. Regarding quality there were two broad groups of GPs: those who thought patients would benefit from standardizing CAM and those who feared that quality control would interfere with the individual CAM approach. Main issues regarding research / education were the need for the development of alternative research strategies and the criticism of existing CAM education.

Conclusions: The majority of the participating GPs regarded integration of CAM within primary care as reasonable completion in their every-day practice. Public-oriented demarcation to 'Heilpraktiker' is seen as an important challenge. Application of CAM methods according to existing evidence and quality assessment seem to be reasonable approaches from the GPs´ perspective. In addition to an increased research funding a better

remuneration of the factor ‘time’ by the Statutory Health Insurance is regarded as main prerequisite to enable a general access to ‘Integrative medicine’ in Germany. *(350 words)*

Background

In Germany, the overall percentage of individuals with experience in Complementary and Alternative Medicine (CAM) increased from 52% in 1970 to 73% in 2002 [1]. A recently published national representative sample shows that herbal medicine, exercise therapy and hydrotherapy are the most frequently used CAM methods [2]. Besides these so-called classic naturopathic methods homeopathy, manual therapy and acupuncture are commonly used CAM therapies in Germany [2].

The extent to which CAM is practiced by physicians or non-medical therapists differs considerably among countries. In Germany, medical doctors can obtain a variety of additional qualifications relating to specific CAM methods (e.g. chiropractic, homeopathy) or to classic naturopathic medicine in general (naturopathy) regulated by the regional chamber of physicians. In 2005 the German federal medical chamber documented 46.000 qualifications referring to the area of CAM. Among those qualifications chiropractic and naturopathy were the most prevalent ones [3] (Table 1). Recently, acupuncture was introduced as 'new' CAM qualification (former 'acupuncture-certificate') accredited by the local medical chambers. Although exact data are missing it is estimated that about 20.000 to 30.000 physicians are practising acupuncture in Germany at the moment. Furthermore, many physicians are providing CAM in their daily practice without having any CAM qualification or certificate [4].

Only a small part of CAM is covered by the statutory health insurance (SHI), namely physiotherapy, chiropractic, classic naturopathy (incl. phytotherapy) and homeopathy to a very small extent, and, newly, acupuncture in patients with knee pain and lumbar pain. However, for reimbursement by SHI the therapist must hold the corresponding CAM-qualification. All remaining CAM methods are not covered by SHI but have to be paid by the patients themselves as so-called 'IHS' (=**I**ndividual **H**ealthcare **S**ervices; in German '**I**ndividuelle **Ge**sundheits-**L**eistungen' = IGeL) or may be paid by private health insurances.

Historically, the SHI Modernization Act in 2004 (=GMG 2004) was a step backwards for CAM. Thus, with the beginning of January 2004 almost all non-prescription drugs were excluded from being reimbursed by the SHI [5]. Therefore, since 2004 all homeopathics as well as phytotherapeutics (with the exception of mistletoe, St. John´s wort, psyllium and ginkgo) were no longer reimbursable drugs. Furthermore, for the first time patients had to pay a consultation fee of 10 € per quarter to see their doctor.

Apart from physicians there are non-medical, state-licensed practitioners in Germany, so-called 'Heilpraktiker'. Official recognition was brought to the 'Heilpraktiker' profession by the 'Heilpraktiker'-law in 1935. A 'Heilpraktiker' has to pass an exam on basic medical knowledge and skills at a local public health office to obtain a state license. However, 'Heilpraktiker' are not obliged to undertake medical training. 'Heilpraktiker' only practice in the ambulatory sector and their services are not covered by the SHI but there are many private health insurances paying for 'Heilpraktiker' services, especially additional insurances (in Germany so-called "Zusatzversicherungen"). Different from physicians 'Heilpraktiker' must not strictly comply with fee schedules and they are allowed to promote their services in public [6]. Any CAM method can be performed by a 'Heilpraktiker' as long as it is consistent with the 'Heilpraktiker'-law ('avert a danger to the health of the people') [7]. In general, 'Heilpraktiker' provide a great variety of CAM methods. Since they also may perform injections, for instance of homeopathic remedies, and other invasive procedures, complications are predictable [8]. Within the last ten years the number of 'Heilpraktiker' increased from 9.000 in the year 1993 to nearly 20.000 today. So, with around 60.000 general practitioners (GPs) the ratio of 'Heilpraktiker' versus GPs is thought to be 1:3 at present [3]. The majority of 'Heilpraktiker' (>90%) are well organized in 6 professional associations [9].

Altogether, CAM still is a highly critical issue among German doctors and, consistently, a matter of controversial debate in journal articles or public discussions [10,11]. What are the experiences of German GPs integrating CAM in their practice? Which role do GPs attribute to

CAM within the German healthcare system? Is there a general opinion among GPs in terms of financing CAM by the SHI system versus self-paying? What do GPs think of 'Heilpraktiker' and how do they assess their role within the German healthcare system?

Up to now, these questions are barely explored in scientific studies and, therefore, were the purpose of the presented project. CAM definition - for the purpose of this paper - included all diagnosis and treatment methods complementing 'conventional medicine' such as classical naturopathy (hydrotherapy, phytotherapy, kinesiotherapy, dietetics, physical and regulative therapy), acupuncture, chiropractic, homeopathy, anthroposophic medicine and neural therapy but also less well-known and used methods such as bioresonance therapy and autohemotherapy.

Methods

We chose a qualitative approach consisting of focus groups because little is known about perspectives and rationales of GPs regarding CAM in Germany. Focus groups are an established qualitative research method to determine information from particular groups as e.g. professional groups [12]. Unlike single person interviews focus groups are able to explore disagreements as well as defining consensus and to work with group interaction processes to uncover hidden attitudes. 5 to 8 participants are considered as optimal size for focus groups [13].

Discussions were supervised by a moderator of the author team (SJ / BM). At the beginning of each focus group there was a short introduction given by the moderator and a presentation about the recent situation of CAM in Germany to bring all participants on the same standard of knowledge. In the course of each focus group central questions were presented by the moderator to introduce key themes. The moderator ensured that each aspect of these questions was explained sufficiently, so that no questions or misunderstandings remained.

The questions focused on the following key themes:

- Role of CAM within the German healthcare system
- Quality & CAM
- Education & CAM
- Research & CAM

During discussions the moderator paid attention that contributions to the discussions were distributed more or less evenly among participants, i.e. that the moderator might have asked some of the participants directly for his/her opinion.

Participants

GPs were recruited through a congress of the Department of General Practice and Health Services Research at the University Clinic of Heidelberg taking place the 8th of October [14]. Furthermore, GPs from the professional background of the authors were invited to take part in the discussions.

Working in practice as a GP, self-employed or employed, and interest in the issue of CAM were inclusion criteria for participation in the focus groups. Participants must not necessarily practice CAM. In contrast, by the initiators of the project it was intended also to include GPs with rather critical opinions towards CAM: on the one hand to picture the general opinion as realistic as possible and, on the other hand, to give the discussions a controversial note to uncover possibly hidden attitudes.

Data analysis

The interviews were recorded digitally and transcribed literally. Each GP was labelled with a number. GP1- GP 7 were particpants of focus group 1, GP 8- GP12 were participants of focus

group 2 and GP 13 –GP 17 were participants of focus group 3. Trancripts were analysed according to qualitative content analysis of Mayring [15]. Deductive categories were applicated based on the key themes and central questions presented in the focus group respectively. Inductive categories were developed from the text by two researchers (SJ, BM). ATLAS.ti software was used for coding and text searching [16]. At regular research team meetings codes were merged within ATLAS.ti. In an iterative process with continuous discussion among the researchers the categorial system for each key theme was modified. Network views were developed within ATLAS.ti. The quotations cited here were translated by SJ from German into English.

Results

17 GPs were recruited for participation in the focus groups. 12 GPs were recruited among congress participants whereas 5 GPs were recruited from the professional background of the authors. 3 of the GPs had academic links to the Department of General Practice and Health Services Research, Heidelberg University in addition to working in practice. Table 2 shows the main characteristics of the participating GPs.

Each focus group lasted about three hours. The content analysis of the focus group transcripts resulted in a categorical system with 4 main categories (key themes) and several subcategories displayed in table 3. Subcategories were further categorised and network views were developed displayed exemplarily in Fig 1 and Fig 2 for the subcategory ‘Heilpraktiker’.

Role of CAM within the German healthcare system

<u>Integration of CAM</u>

Most GPs reported that they have integrated one or more CAM methods in their daily practice. GPs described their 'integrated' every-day practice as continuum of possible medical approaches floating between 'strict conventional methods' and 'strict natural methods'.

‚I usually say conventional medicine looks from the front and CAM looks from behind and- in case you are able to do acupuncture- you look around. And then you choose what you think is the best for the patient. That´s the way, I think.' (GP 7)

From the perspective of most GPs, the patient him-/herself serves as main criterion for a more 'natural' versus 'conventional' approach. Important patient characteristics to be considered are the individual constitution, type of complaints as well as experiences and expectancies of each patient.

Altogether, most GPs regarded integration of CAM as chance to install a medicine with lower level of side effects and a more preventive approach with activated patients resulting in a higher permanent benefit for patients on the long run.

CAM & SHI

In all discussions GPs criticized that there is no sufficient payment for the time listening and talking to patients. GPs hypothesized that, since time with and for the patient is the basis for many CAM methods, better remuneration of the factor 'time' by SHI would enforce CAM.

In this context GPs felt little happy about the recent regulations concerning SHI remuneration for acupuncture consisting in 20-25 € per acupuncture session. GPs complained that this amount not at all covers the time needed for a comprehensive Chinese diagnosis and/or potential details emerging in the course of treatment. Therefore, some GPs refuse practising acupuncture under these conditions.

Extended inclusion of CAM within the catalogue of benefits of the SHI was controversially discussed among the GPs. Some regarded evidence-based medicine as suitable tool to decide

which CAM method -as well as conventional method - should be covered by SHI. As it was suggested that generating evidence in CAM is connected with several difficulties such as research funding and barriers at the universities an often asked question was: 'So, what to do in the meantime?'

'In case one would try to clarify SHI-covered medicine, it would be necessary to separate much waste: useless meniscus surgeries and intracardiac catheters in heaps performed without sufficient diagnosis ..... However, nobody would join it. That´s the problem. But there would be enough money.' (GP 5)

Furthermore, GPs criticized the lack of linkage among existing CAM-offers covered by SHI. In fact, 'back care courses' or 'yoga courses' provided by public gyms are covered by SHI. However, patients often make use of those courses unbeknown to their doctors. The majority of GPs considered that, to optimize benefit for patients, those courses should be integrated in a comprehensive therapeutic concept. In this regard, a key role for CAM practising GPs is seen to link and integrate existing possibilities.

'So, when I look at this brochure of [name of a public gym], I see back care courses, courses for dietetic treatment - who pays? Statutory health insurance....then I think....[a colleague interrupted: outsourced so to speak]...yes, well 'past'-sourced upon my regulative therapy concept.' (GP 13)

Some GPs postulated that an increased use of CAM would decrease overall costs in healthcare system. This was explained with lower direct costs (fewer and cheaper drugs) and lower indirect costs resulting from increased patient activation and patient empowerment in consequence of a good compliance regarding CAM.

<u>SHI Modernization Act (GMG 2004)</u>

Loss of patients in practice (up to 30%) was repeatedly mentioned by GPs providing CAM as negative consequences of the GMG 2004. Suggested reasons were the ceased reimbursement

of phytotherapeutic and homeopathic drugs and the newly introduced consultation fee. The consultation fee as reason for loss of patients seems to play a role, particularly, in practices where the doctor serves as 'CAM-deluxe-doctor' visited in addition to the 'normal' GP. On the other hand those 'CAM-deluxe-doctors' participating in the focus groups had the impression that - with the GMG 2004 - there had been a selection of very 'CAM-convinced' patients presenting with higher treatment expectations. This was seen as optimal prerequisite for CAM treatment and, therefore, as positive consequence of the GMG 2004.

Furthermore, GPs observed that, with introduction of the GMG 2004, some patients with acute symptoms presented with delay. GPs reported that those patients are more impatient having a higher ‚treatment pressure' when arriving at the practice. This would make a CAM approach more difficult. On the other side, serious symptoms may be identified (too) late or diseases may be protracted. Further negative consequences of the GMG 2004 were seen in the development that poor patients stopped taking phytotherapeutic drugs and, therefore, CAM has become a matter of money. However, several GPs reported that patients continued treatment with 'phytos' after a short break paying them out of their own pocket. .

'There are some patients saying: 'No, that is too expensive for me', for example with these ginkgo preparations ('My pension is not enough'), but most patients were saying: that was helping me so far, I would like to continue with this. Some patients are asking more detailed: Are you sure that this is really necessary?' (GP 8)

Some GPs reported that, with the introduction of the GMG 2004, they separate more strictly between medical services covered by SHI and any further medical services. Apparently, patients seem to accept this approach. Moreover, it was suggested by the GPs that the GMG 2004 had the paradoxical side effect that patients now pay more willingly for individual healthcare services (IHS) because they have realized that SHI does not pay for CAM and, therefore, also the doctor does not get anything paid for the time, he/she spends for CAM.

'Increasingly, we offer individual healthcare services. In the past we have injected this …just without taking money. Since 2004 we take 5 € per injection and I must say this is accepted by patients more and more. The problem, I think, is more on my side as a doctor. For example, we have a homeopathic colleague....and when we cover his practice, patients come with their homeopathics and ask already when registering: 'What do I have to pay?' This is completely normal.' (GP 10)

A few GPs mentioned a more relaxed consultation as positive consequence arising from the GMG 2004. On the one hand, this is explained by the fact that phytotherapeutics and homeopathics no longer burden the GP´s sectoral budget for drugs. So, decision of therapy ('natural' versus 'no therapy') lies more with the patient.

'And that is why I am more relaxed now. In case a patient wants to have something 'natural', then he/she has to pay for it. Certainly, I give advices but I am no longer stressed by patients saying: He prescribes this but not that one…and so on. This is beneficial.' (GP 2)

Individual Healthcare Services (IHS)

The issue 'CAM provided as IHS' was discussed controversially. Most of the participating GPs clearly see the risk that patients might be exploited by doctors offering absurd, unproven, possibly harmful methods. This situation even gets more drastic by expanding the spectrum of indications on the basis of dubious diagnoses with the aid of technical equipment such as kirlian photograpy. However, this risk is also seen for IHS in conventional medicine and, therefore, describes an overall problem of out-patient healthcare in Germany.

'It starts with absurd equipments for a few thousand Euros: ozone-therapy, colon-hydrotherapy or bioresonance-therapy. At the same time an amortisation schedule sets a plan how many patients per quartile have to be diagnosed or treated, that the equipment turns out to be profitable.' (GP 5)

A negative consequence of IHS was seen in the upcoming commercial role of the GP which might endanger a trustful doctor-patient relationship. Most GPs stated that they are not willing to accept this role.

'...and when I say that CAM should have more importance in our healthcare system- beyond IHS – then, because I do not want to be a businessman putting my vitamins and dietary supplements on the desk and opening a branch on the name of my wife.' (GP 13)

There was an accordance among the GPs upon the communication style regarding IHS: all services should be made transparent for all patients. Furthermore, IHS should only be performed after a thorough and honest discussion with the patient in advance. Most GPs were of the opinion that for offering a certain CAM method one´s belief in the efficacy of this method is an essential precondition.

In case the decision for CAM is made on demand or in agreement with the patient some GPs see an advantage in IHS. It is suggested that the conscious decision for a therapy has a positive impact on patients´ expectancy and valuation towards the therapy which may increase the overall benefit of the treatment. Besides, some GPs argued that payment of IHS would ‚cross-subsidise' increased expenditure of time in connection with an overall-CAM approach.

'A chance of IHS may be, that, yes, the valuation of something you have paid for is different from something you get for free. And this, maybe, is assessed or realized different by patients…' (GP 16)

<u>'Heilpraktiker'</u>

Opinions towards 'Heilpraktiker' differed widely among participating GPs. Main positive and negative arguments of the discussions are presented in fig 1 and fig 2.

Most GPs worried that the education of 'Heilpraktiker' may not fully enable them to identify certain symptoms and diseases or to assess the urgency in certain medical conditions.

Furthermore, GPs criticized that 'Heilpraktiker' tend to provide patients with simple, one-dimensional explications for their symptoms. This leads to the development of simplified and, partly, wrong medical theories.

'Sometimes you hear remarks of patients about correlations and therapies in conventional medicine: thyroid hormones weaken the thyroid gland. Those wrong or simplified medical theories and absurd ideas circulate among the total population' (GP 5)

Another negative aspect from the GPs point of view might be that 'Heilpraktiker' abet a pathologization process of banal medical complaints providing simplified, often premature explanations. On the one hand those explanations often stick on the patients as irreversible diagnoses. On the other hand - some GPs supposed - a therapeutic demand is created in this way leading in extreme cases (e.g. in patients with unfavourable or fatal prognosis) to addictions and financial exploitation of a patient.

'So, I think, pilgrimage is a good word for this. I have a patient, who drives hundreds of kilometres to a 'Heilpraktiker' just putting stones on her belly. She goes there once in a quarter and pays 800.- €. She says she would need that.' (GP 8)

Another critisicm expressed by some GPs is the fact that 'Heilpraktiker' usually avoid giving patients responsibility for her/his condition but blame an 'enemy from outside' such as intestinal mycosis which is a typical 'Heilpraktiker'- diagnosis for lots of complaints.

'Giving patients a co-responsibility for their situation… patients do not like this. And the 'Heilpraktiker' says: There is an enemy in your body - we will fight this enemy. This relieves. Not you have to do anything. You only have to let it done.' (GP 11)

Several positive arguments face those critical remarks. 'Heilpraktiker' spend more time with patients. 'Heilpraktiker' seem to be more on 'folks side' and represent, therefore, a kind of self-help or lay-help. Possibly, patients consulting 'Heilpraktiker' are looking for help on an 'eye-to-eye level' and, - some GPs suggest – might feel better off with 'Heilpraktiker' than with doctors on an emotional level. The consequence might be a good compliance.

'But the general idea is not so bad to educate a kind of lay-help for banal complaints. This could save the professional system work.' (GP 5)

Most GPs supposed that the popularity of 'Heilpraktiker' is tightly linked in patients´ low level of trust in regular healthcare. GPs presume that some 'Heilpraktiker' take advantage thereof and try to generate a special 'esoteric' aura to attract people.

In Germany, still many patients can not differentiate between GPs practising CAM and 'Heilpraktiker'. Therefore, GPs regarded a public-oriented demarcation from 'Heilpraktiker' as important. In this regard, some GPs criticised a missing solidarity among CAM practising doctors including a missing organisation representing this group of doctors in the public.

'Often I hear that from my patients: Are you a 'Heilpraktiker' ? Either the image of CAM-practising physicians is so bad or the healthcare system is so intransparent to our patients. There is still a lot to be done to sharpen our profile.' (GP 14)

In summary, 'Heilpraktiker' are partly seen as competitors and partly as co-workers filling the gap of humanity, time and empathy patients often complaining about within the contemporary medical system .

Quality & CAM

Definition and application of quality standards in the field of CAM was a controversial issue among the GPs. There were two broad groups of GPs: those who thought that patients benefit from standardizing CAM and those who feared that quality control would have negative effects for patients affecting the more subjective, emotional aspects of the therapeutic/ healing process. Nevertheless, both groups considered the definition of quality criteria to some degree useful to limit an uncontrolled growth of the 'medical grey area'. In particular for CAM methods covered by the SHI quality control was considered important by GPs.

'I guess, seriousness and limitation of this 'creating-his-own-market-mentality' can only be obtained by evaluating CAM, standardizing CAM and implementing CAM in medical training and eduction on a level as high as possible.' (GP 8)

Through all focus groups there was a lively discussion to what extent an individual approach on the basis of a patient´s bio-psycho-social context, opinions and expectancies can be represented by pre-defined quality criteria. The more sceptic group of GPs worried that, in particular, CAM methods involving a complex intervention would lose a part of their therapeutic efficacy by standardization. Also the factor 'individuality', marking the core element of many CAM methods, was seen in danger.

'It will be possible for certain methods. But for methods where doctor-patient relationship, expectancies, time and so on play a major role - as for example in psychosomatic medicine - it becomes more and more difficult.' (GP 9)

Patients' subjective benefit of a therapeutical approach was assessed as essential quality criterion by the GPs. Therefore, adequate communication before, during and after completion of a therapeutic (CAM)-procedure is important.

'First, there must be a definition of the aspired result. What do I expect? What does the patient expect? What does he need? What do I think does he need' (GP 3)

'But this means also quality: trying to feel what patients expect. When I am feeling that somebody is not ready at all for a certain method then I will certainly not force him. I will look for another vehicle.'(GP 8)

Furthermore, most GPs regard the factor 'time' as one of the most important quality indicators for a successfull CAM therapy. Some GPs mentioned that it would be important to incorporate physician-factors within quality assessment of CAM because effects of many CAM methods seem to be 'therapist-dependent'. However, since this rather concerns 'soft skills' (e.g. ability of empathy, ability to communicate) than 'technical skills' this was seen problematic by most GPs. Another problematic but important indicator was seen in the

physician-factor ‘authenticity’. Some GPs supposed that patients straight away feel whether the doctor him-/ herself is not convinced of a certain therapy. Thus, ‘authenticity’ of the therapist was meant to have a substantial impact..

Furthermore, the ‚nihil nocere-principle’ was mentioned as a basic principle of quality, in particular, when administering substances to a patient such as phytotherapy or Chinese drugs. In the view of the GPs only proven preparations should be implemented. Altogether, GPs seemed to be sceptical about the issue ‘quality’. Some GPs worried that quality criteria could be used to apply pressure for cost saving reasons.

Education & CAM

There were only a few comments on the role of CAM at universities. Most of the GPs considered that CAM should be integrated in undergraduated education. For post-graduated education, GPs considered a collateral continued medical education in conventional and CAM topics as being important to obtain and maintain a broad medical perspective.

Altogether, GPs seemed to be little happy with the quality of CAM education courses. Predominantly, the courses were rated as too expensive and poor regarding content and presentation. Some GPs reported that some courses resemble pure marketing events with referees often showing self-importance and overstatement concerning THEIR method.

‘Anyway, this referent was so arrogant…HIS method cures everything: myocardial infarction, asthma etc.... Such a performance is not acceptable.’ (GP 8)

Altogether, from the GPs point of view quality of CAM education must be improved. Desirable formats would be courses or quality circles including the presentation of independent, well prepared evidence-based information.

Research & CAM

Concerning the issue ‘research’ GPs differentiated between CAM methods with a rather individual approach (homeopathy, TCM) and others (phytotherapy, autohemotherapy).

For the latter GPs estimated an evidence-based research approach as possible and reasonable. Particularly, research in phytotherapy was demanded by GPs since -from their point of view- patient demand for phytotherapeutics is huge.

In contrast, regarding methods with an individual approach the majority of GPs doubted that current research methodology will lead to ‘evidence’. To evaluate those methods, development and adoption of alternative research strategies was demanded. Those alternative strategies should incorporate patient-centred outcome measures on an individual level to consider the individual approach. Furthermore, studies comparing ‚conventional routine care’ versus ‚complementary routine care’ were suggested by the GPs. Meanwhile, for most of the GPs application of those CAM methods in practice without a robust base on current evidence seemed justifiable. Nevertheless, GPs confirmed that study results influence them regarding choice and exertion of certain CAM methods.

‚Even though not all publications are 100% close to reality, I feel more comfortable with my individual therapeutic decisions when I know that there are at least a few positive studies.’ (GP 1)

Discussion

In the present article attitudes of GPs on the role of CAM within the German healthcare system were explored. Furthermore, perspectives on the issues ‘quality’, ‘education’ and ‘research’ in connection with CAM were investigated. To some extent, the discussions on these topis were controversial. This may originate from the heterogenity of the participating doctors. Indeed, all were GPs, but the spectrum ranged from the ‚typical country doctor’ to the ‘CAM-deluxe doctor’ in a city area. The majority of the participating GPs stated to use

one or more CAM methods in every-day practice (beyond dietetics, regulative therapy and physical therapy).

One key issue of the discussions was the lacking consideration of ‘time’ – both in terms of valuation and in terms of money – as an important diagnostic and therapeutic factor. GPs supposed that the basis for most CAM methods as well as for good primary care is a diagnostic/therapeutic approach considering the bio-psycho-social context of a patient. Studies have shown that sufficient time in the consultation as well as the feeling to be valued as an individual by the doctor and the impression that the doctor understood 'the bigger picture' were aspects closely linked with patients’ perceptions of good consultation quality [17]. Furthermore, there is evidence that the empathy of practitioners, as perceived by patients, has a direct impact on patient enablement and health outcome [18,19]. Consistently, GPs in our focus groups criticized that those aspects are not adequately considered in the German healthcare system. Therefore, changing remuneration enhancing the factor ‘time’ was seen as key factor to improve the situation in Germany and, beyond this, an essential precondition for applying CAM in practice.

A further important aspect in this connection is the dissatisfaction of Germans with their healthcare system [20]. In a study comparing three European countries people in Germany show less trust in healthcare, while people in England and Wales have the highest trust levels [21]. As an explanation for this low level of trust in Germany again, amongst others, the deficite of ‘time’ was hold responsible by the GPs. Studies revealing a longer relationship with the physician, doctor's communication skills and doctor-patient interaction as determinants of trust underline this hypothesis [22, 23]. A lack of trust may cause patients to look for help on the ‚grey area’ of the health market. Thus, the great demand for ‘Heilpraktiker’ as non-medical practitioners in Germany was attributed by GPs to patients´ low level of trust in regular healthcare. Since, in particular chronically ill patients show low

levels of trust and their number may further increase in future, health policy makers should, therefore, be alert to the quality of non-regular healthcare providers such as 'Heilpraktiker'.

As a basic principle, the majority of GPs require that only health services provided by physicians, not by 'Heilpraktiker', may be reimbursed by health insurances (also private ones). Furthermore, education and licensing, but also issues such as fees and advertizing promoting 'Heilpraktiker' compared to physicians should be reconsidered and re-organized. It is supposed that a change in remuneration enhancing the factor 'time' would improve doctor-patient interaction and, thereby, would improve trust in regular healthcare. This might indirectly be followed by a decreased demand for non-regular healthcare such as 'Heilpraktiker'.

Public-oriented demarcation from the ‚grey area' of the health market and its dubious, non-evidence-based methods of diagnosing and therapies was regarded as challenge for the future. In this regard, developing solidarity among CAM-practising on a national and international level was considered as important issue for the next time. Therefore, networking involving universities as well as professional associations was suggested. A start has been made with networks such as the FORUM (Forum of Academic CAM research Groups) comprising colleagues from Germany, Switzerland and Austria [24]. Furthermore, cross-national initiatives for inclusion of CAM into the 7th EU Research Framework Programme and the following common research proposals attest to an improved networking on an European level [25].

Changes on the basis of the SHI Modernization Act were moderate from the perspective of those GPs practising CAM. Some reported temporary decreases in consultations and increased prescriptions of antibiotics. These subjective impressions of the GPs are confirmed by survey data: immediately after introduction of the consultation fee in January 2004 the number of consultations decreased by 8% to rise again above baseline values in the late 2005 [26]. At the beginning of the year 2004 increased prescriptions for antibiotics and antitussives

- possibly instead of phytotherapeutics - were observed in a study evaluating patients with acute cough [27]. Altogether, SHI Modernization Act seemed not to have left behind a strong influence on 'CAM care'. However, the impact for research, e.g. in the area of phytomedicine was substantial. Due to decreasing turnovers of phytotherapeutic drugs pharmaceutical companies producing phytotherapeutics invested less – at least temporarily in 2004 and 2005.

Another key theme was the impact of IHS providing CAM in pratice. Most GPs vehemently rejected a role as businessman / businesswoman for IHS. They were very critical of colleagues offering dubious methods and charging a lot of money. However, CAM is only a small part of this 'second health market' of IHS. In particular, in the diagnostic field IHS explosively increased (e.g. fitness check-ups, tonometry) whereas in the therapeutic field - including CAM- IHS only moderately increased [28]. In connection with IHS, GPs regarded as positive that patients specifically search and pay for CAM might have higher expectancies on the effect of a therapeutic method. Indeed, there is evidence that high patient expectancies may result in better outcomes [29,30]

Repeatedly within the focus group discussions the opinion was advanced that the overall costs of the healthcare system could be reduced by integration of CAM. Until now, this hypothesis could not be explicitely confirmed by studies [31, 32]. However, the study of Busato et al provided evidence of another structure of costs in CAM-physicians indicating a more patient-centred care [32]. Thus, CAM-physicans were more expensive regarding consultations whereas expenditures for drugs were less compared to Non-CAM-physicians. Another longterm observational study showed a modest reduction of sick leave in chronically ill patients receiving a multimodal CAM therapy [33].

Regarding quality assessment two main issues were discussed: the need of defining quality and the concern about losing the key components of CAM while doing so. As comprehensive quality criteria for CAM GPs mentioned physician-factors such as authenticity, ability for empathy etc. Indeed, there is plenty of evidence that physician-factors, in particular ‚weak'

factors rather than ‚technical' skills, have a significant impact on the outcome of a therapy [34,35,36]. Abilities required to achieve well-performed CAM possibly may be enhanced by attending for example Balint groups.

However, GPs raised the question how to represent those 'weak' physician factors within quality assessment. Studying literature one can find approaches such as the 'Consultation and Relational Empathy' (CARE) measure [37] or the 'Medical Interview Satisfaction Scale' (MISS-29) measure [38] developed to assess patient satisfaction with individual doctor-patient consultations. Both measures were developed for general practice.

The discussions on 'CAM & research' reflected the incongruity – at least suspected by the majority of the participating GPs - between the individual approach of CAM and the application of modern research methodology represented by the RCT-design. However, evidence-based medicine is not a closed system, but may be developed and adapted to 'real life'. So, alternative study designs more appropriate for CAM may be developed and integrated in the hierarchy of the evidence-based medicine approach. Those alternative study designs should take into account the concept of the different CAM procedures and incorporate personal experiences of the therapists and the patients. First steps are already done by CAM researchers [39].

The presented work uses a qualitative methodology aiming at collecting opinions and generating hypotheses for following projects. Due to the qualitative approach the sample of GPs was neither representative nor homogeneous. Thus, quantitative conclusions can not be drawn. However, it was taken care to ensure an appropriate mix of GPs practising different CAM-methods in each focus group. Furthermore, it was looked for at least one GP not practising CAM in each focus group. As it is the nature of qualitative research, the analysis of the texts may be influenced by the evaluators both involved in the issue of CAM (SJ, BM). By means of continuing discussions with all authors we have tried to minimize those influences. Since we had the impression to reach saturation in the analysis of the key themes after 3 focus

groups we stopped recruiting GPs. There is always a risk when translating complex concepts such as a qualitative study. However, we have made great efforts to find congruent terms during the translation process. Due to the differences in healthcare systems in Germany and other countries we have tried to explain all relevant facts in detail [40]. Nevertheless, in the present article there might remain some ambiguities caused by differences in healthcare systems.

Conclusion

The majority of the participating GPs considered integration of CAM within primary care as reasonable completion. From the perspective of GPs a better remuneration of the factor 'time' - both in terms of valuation and in terms of money - is the main prerequisite for realizing 'Integrative medicine' in Germany. CAM should be implemented on the basis of evidence considering patient's individual demands, values and social-economic background as well as the expertise of the individual doctor. The continous 'echo' by the patients may be regarded as valuable guideline within the therapeutic process. Reimbursement by SHI has to be balanced well-considered between existing evidence and patients' demand. However, a comprehensive funding is a precondition to generate evidence and to further evaluate cultural, social, economic and political aspects of CAM. In future studies, general issues such as the quality of doctor-patient-relationships or activation of patients in doctors applying CAM compared to Non-CAM-physicians should be assessed beyond 'specific efficacy'.

Competing interests

The authors declare that they have no competing interests

Authors' contributions

SJ and BM conceived the study, conducted and analysed the focus groups. SJ drafted the manuscript. AM, TR and JS were involved in the study design and made contributions to the manuscript. All authors read and approved the final manuscript.

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Tab 1: Qualifications in the field of CAM in the years 1993 and 2005
(Source: National Association of Social Health Insurance-accredited Physicians)

Type of qualification	**Doctors with qualification (n)** **1993**	**Doctors with qualification (n)** **2005**
Naturopathy	4.573	14.088
Homeopathy	1.905	5.901
Chiropractic/Spinal Manipulation	5.355	16.934
Physical therapy	1.991	5.981
Balneology and medical climatology	1.560	2.916

Tab. 2 Characteristics of participating GPs

Gender:	f: 9 m: 8
Years of work in practice	7,6 years (min 0,5 J.; max. 15 J)
Structure of practice:	single practice: 7 group practice: 8 Practice-sharing: 2
Location of practice:	city: 12 rural: 5
Qualifications of GPs:	naturopathy:14 chiropractic:4 homeopathy: 5 balneology: 1 (acupuncture-certificate: 4)

Tab. 3 Categorial system with main and subcategories; frequeny of occurrence in brackets

Main categories	Subcategories
Role of CAM within healthcare system (212)	• CAM in SHI (52) • Integration of CAM (29) • Modernisation law (GMG 2004) (28) • Individual healthcare services (44) • 'Heilpraktiker' (50)
Quality & CAM (58)	• Difficulties quality control (6) • Quality criteria (26) • Standards / guidelines (7) • Quality control as instrument for rationalisation (4)
Education & CAM (22)	• quality (9) • costs (3) • university (3)
Research & CAM(22)	• individual appraoch of CAM (12) • research methodology (10) • relevance for practice (2)

Fig 1 Negative arguments with regard to Heilpraktiker (HP) raised by GPs (ATLAS.ti network view)

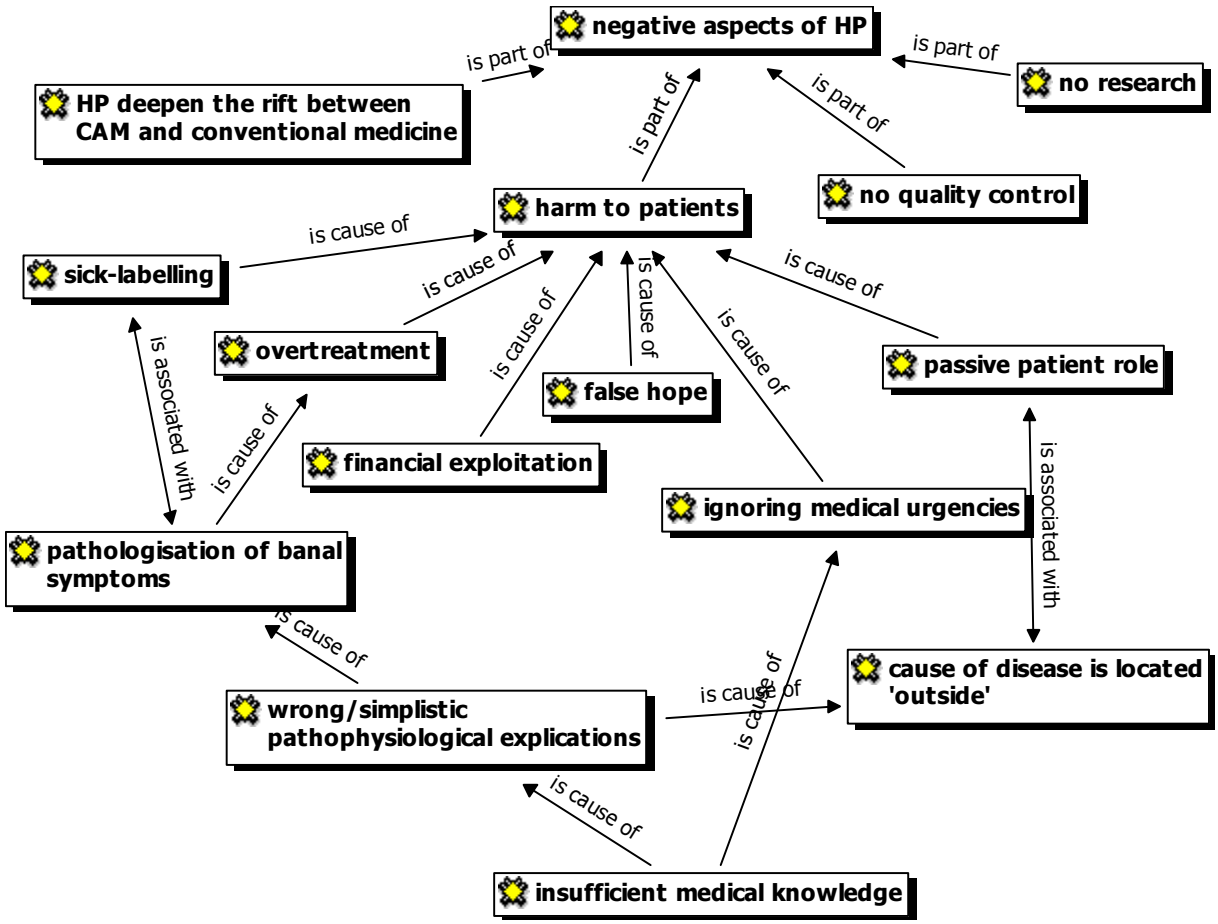

Figure 1

Fig. 2 Positive arguments with regard to Heilpraktiker (HP) raised by GPs (ATLAS.ti network view)

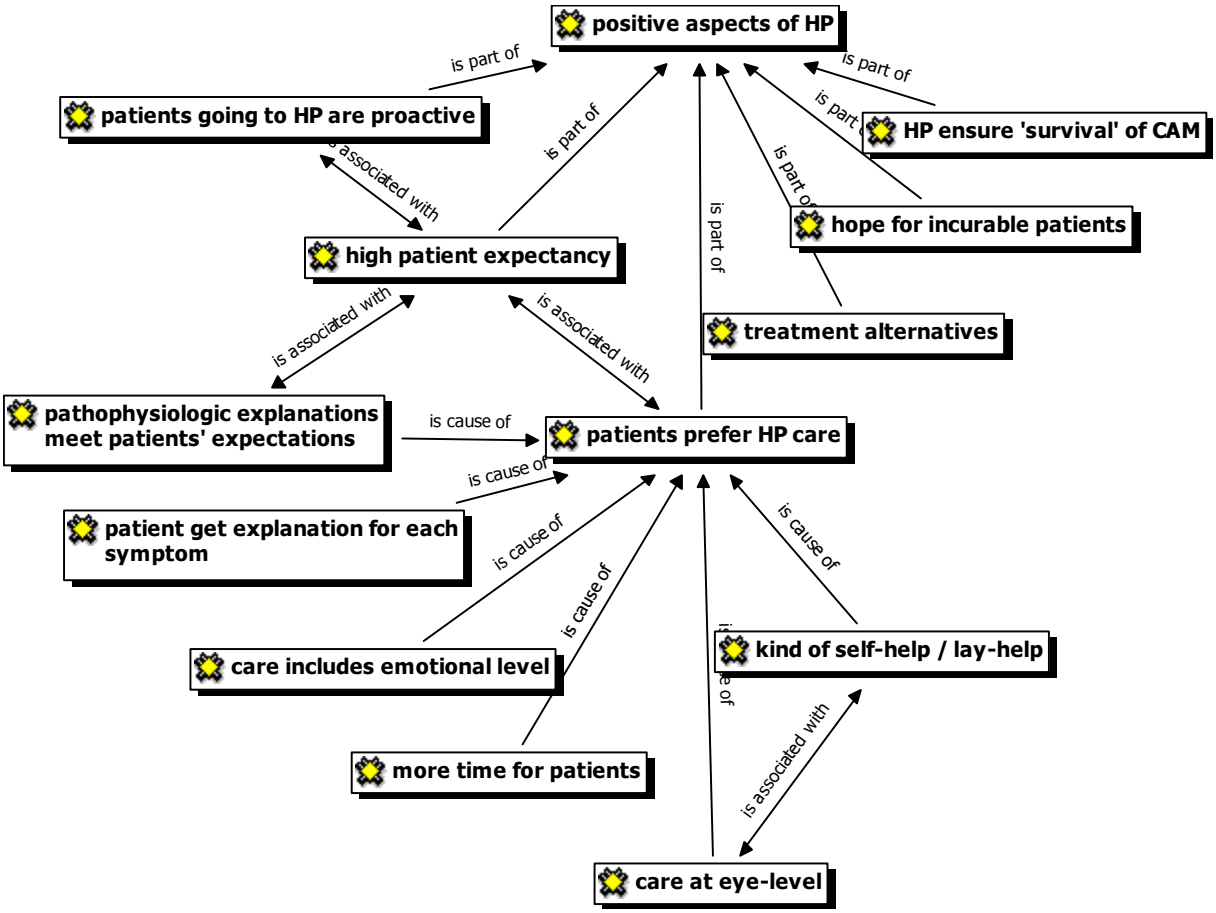

Figure 2