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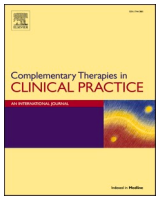

"There is a way to work together": A qualitative study on complementary medicine therapists' perceptions of their role in the Swiss healthcare system

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ABSTRACT

Background and purpose: Complementary medicine has been undergoing a process of regulation and professionalization in many countries where the biomedical model is dominant. However, little is known about therapists' opinions regarding these changes. The aim of the study was thus to explore therapists' views on the regulation of their practice and on collaboration between CM and biomedicine.
Materials and methods: We conducted this qualitative descriptive study by means of focus groups consisting of non-physician acupuncturists, naturopaths, and osteopaths in two cantons of Switzerland. A qualitative content analysis was carried out on the verbatim transcripts of the focus groups.
Results: Four main themes were identified: contributions to the healthcare system, collaboration with biomedicine, pathways to recognition, and integrative medicine. Therapists defined their role in the healthcare system in comparison to biomedicine, allowing them to highlight how they could complement it. They also noted an improved relationship with biomedicine, while highlighting the remaining barriers to optimal collaboration. Different ways were mentioned to achieve a higher level of recognition: better educating and informing physicians about CM, structured training of therapists that is federally recognized, state regulation, and development of scientific research on CM. Finally, although unfamiliar with the concept, therapists defined integrative medicine as horizontal collaboration between CM and biomedicine.
Conclusion: Despite the differences between the three CM practiced by the therapists, they produced fairly similar discourse regarding aspirations and concerns in the face of integration. This discourse should be considered in order to facilitate the integration of CM in the Swiss healthcare system.

1. Introduction

Complementary medicine (CM) is commonly used alongside conventional biomedical care in countries where the biomedical model is dominant [1–3]. CM is a broad umbrella term that comprises "a broad set of healthcare practices that are not part of that country's own tradition or conventional medicine and are not fully integrated into the dominant healthcare system" [4]. What is considered CM is therefore dependent on the cultural and health system in which the therapies are embedded overall; the boundaries between CM and biomedicine are thus fluid and ever moving [5].

In the last decades, some CM have been integrated into the conventional healthcare system to an extent that varies among countries [6]. The term "integrative medicine" (IM) is increasingly used in medical settings to describe this combination of CM and biomedicine for patient care. However, what IM really entails is under debate among both health professionals and researchers [5,7–9]. Different models, either practical or theoretical, of how to implement IM have been described [7,10,11]. Wiese et al. [12] have proposed a classification into three main conceptual models, based on the degree of autonomy of CM therapists within biomedical settings, namely, incorporation, integration, and pluralization. The pluralization model has been described as being the most likely to allow true integration [10], as it is based on patient preferences and on the different approaches functioning autonomously. In any case, studies have underlined the existing gaps between theoretical IM models and actual practice [11,13]. Criticisms of IM mainly focus on the neglect of the existing power relations between various health professions, as, in practice, CM therapists often remain

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subordinate to, or even marginalized by, biomedicine providers [13,14].

The increased popularity of CM and development of IM has been accompanied by a process of legitimation, regulation, and professionalization of certain CM in many countries [15–21]. Studies on this process often report mixed feelings on the part of therapists, divided between a desire for greater state recognition, legitimacy, enhanced patient protection, and fear of loss of autonomy, subordination to biomedicine, or excessive standardization of practice [10,14–17,22]. These fears echo the critiques of IM.

To date, few recent qualitative studies have focused on therapists' opinions regarding the integration of their practice into the conventional healthcare system [10,18,22–25]. The findings of those studies that have investigated opinions about the extent to which CM therapies should be integrated with biomedicine and the modalities of that integration vary among therapists and across the diverse therapies investigated. Views on integration may also depend on the social, clinical, and regulatory contexts within which CM therapists practice, as well as on their personal situation.

Switzerland constitutes an interesting setting to explore the integration of CM into the mainstream healthcare system, as well as the challenges faced by CM therapists regarding this integration and its regulation. First, CM is popular among the Swiss population. The 2017 Swiss Health Survey showed that 29 % of participants aged 15 years or more had used CM at least once in the past 12 months [3]. Second, some CM are covered by basic health insurance as long as they are performed by a physician trained in one of the following: traditional Chinese medicine (TCM), anthroposophic medicine, homeopathy, or herbal medicine. Other CM treatments, or treatments performed by non-physician therapists, are covered by private supplemental insurances. Third, although CM is commonly used by the population, only three CM therapies are regulated at a federal level: osteopathy, therapeutic massage, and art therapy. Other CM are either regulated at a cantonal level or not at all. As an example, acupuncturists are recognized as healthcare professionals only in some cantons, whereas naturopaths are not recognized as health professionals in any canton. Finally, regarding training, a curriculum in osteopathy was developed at the Master's level in 2014, and, in 2015, a federally recognized diploma was created, leading to the title of naturopath and delivering a diploma in one of four categories: Ayurveda, TCM, homeopathy, or traditional European naturopathy. However, at the time of the data collection (2016–2017), obtaining one of these diplomas was not a prerequisite to be allowed to practice naturopathy or acupuncture, or being reimbursed by supplemental health insurances. That was still not the case at the time of publication in most cantons. CM in Switzerland may thus be considered to be in a position of "mainstream marginality," a term proposed by Cant (13) to designate the ambiguous position of CM within a specific healthcare system. Indeed, at the time of the study, CM was very popular, mostly unregulated, and partly reimbursed by health insurance, and it had recently benefitted from federally recognized diplomas.

Given the particular positioning of CM in Switzerland, as well as the context-dependent challenges and opportunities that therapists are confronted with in the face of the increasing integration and regulation of their practice as reported in the scientific literature, our overall aim in this study was to explore how non-physician CM therapists position themselves within the Swiss healthcare system. More precisely, we aimed to collect therapists' views on the regulation of their practice and on collaboration with biomedicine. The study focused on three of the most popular disciplines in Switzerland [3]: European naturopathy, acupuncture, and osteopathy.

2. Materials and methods

2.1. Study design

We conducted this qualitative descriptive study [26] by using focus groups (FGs) consisting of non-physician acupuncturists, naturopaths, and osteopaths in the French-speaking part of Switzerland. The study was limited to non-physician CM therapists, as they are less integrated in the conventional medical system. FGs were chosen because this method allows participants to exchange and share perspectives about a common issue and create data through discussion and debate [27].

2.2. Setting and participants

CM therapists' opinions about their situation within the healthcare system might be influenced by specific cantonal regulations regarding their practice (Switzerland has 26 cantons, each with their own rules). Therefore, we decided to recruit participants from the two cantons that are the most different in terms of regulations: Vaud and Geneva. In the canton Vaud, there is no specific state regulation for CM practice or its surveillance. In Geneva, all CM therapists must be registered with the health department and accounted for with proper training.

To be included in the study, therapists had to meet the following inclusion criteria: 1) be registered in the canton of Vaud or Geneva; 2) speak French; 3) have osteopathy, European naturopathy, or acupuncture as their main professional practice; 4) not be trained as a biomedicine physician; and 5) practice at least 1 day per week.

2.3. Data collection

An interview guide was developed based on discussions with the research team, tested with three preliminary individual interviews conducted with a representative of each therapy, and adapted accordingly. The same interview guide was used to conduct all the FGs (see Appendix A. Interview guide).

The recruitment of therapists was conducted using a convenience sampling technique. Recruitment of therapists took place through the two main private registers that offer CM accreditation: Empirical Medicine Register (RME) and Swiss Foundation for Complementary Medicine (ASCA). Accreditations provide recognition of therapists and allow their patients to be reimbursed by supplemental private health insurance plans. These registers sent an e-mail on our behalf to all registered non-physician acupuncture, naturopathy, and osteopathy therapists of the cantons of Vaud and Geneva. An information letter explaining the purpose of the study and the functioning of the FGs was attached. A reminder to participate was sent through the same channel after two weeks. Therapists interested in participating in the study then contacted the research team by using the given contact information. A date suitable for the majority of interested therapists was set for each FG.

The sampling strategy used to organize the FGs took canton of practice, type of therapy, and age (over or under 45 years) into account. Age was taken into consideration because there may be differences between younger and older generations of therapists in terms of desire to collaborate with biomedicine or to be more strongly regulated. The 45-year-old cut-off was chosen because it corresponds to the mean age of the therapists practicing in these cantons, as a previous study found [28]. Data saturation was assessed by JD (first author, senior qualitative researcher in complementary medicine and primary care) during the data collection process and was attained after conducting 7 FGs. In this study, data saturation, in the sense of "informational redundancy" [29], was defined as the point where no new information was heard from the participants to the focus groups, and opinions and experiences shared tended to be redundant with opinions and experiences shared in previous FGs.

The FGs took place between December 2016 and February 2017 in a meeting room at the Center for Primary Care and Public Health (Unisanté) in the canton of Vaud and at the University of Geneva in the canton of Geneva. The FGs were moderated by JD, who animated and managed the discussion. Another member of the research team was also present to help with the organization, take note of the speaking turns and manage the recorder. This other member was alternatively a primary care physician (PYR), a MD student, and an osteopath. They were

all trained by JD to co-animate the FGs. The investigators had no prior knowledge of the participants.

Before the beginning of the FGs, both co-animators presented themselves, JD recalled the study objectives and explained the functioning of the FGs. All participants gave their oral consent to participate. All FGs were audio recorded. They lasted between 93 and 125 min. Recordings were transcribed verbatim by a research assistant and verified by JD. Any information that could identify a participant was removed from the transcripts.

The Cantonal Commission for the Ethics of Human Research (CER-VD) waived the need for ethics approval for this study given the scope and nature of the study, and as no health-related data were collected (Reference Req-2016-00535). However, all procedures performed in this study were in accordance with the Swiss Federal Act on Research involving Human Beings [30] and with the 1964 Helsinki Declaration [31] and its later amendments or comparable ethical standards.

2.4. Data analysis

A qualitative content analysis [26] was conducted on the FGs transcripts with the assistance of the qualitative data analysis software MAXQDA (v.2018.2). As stated by Sandelowski (26), this type of analysis "is especially amenable to obtaining straight and largely unadorned (i.e., minimally theorized or otherwise transformed or spun) answers to questions of special relevance to practitioners and policy makers".

After carefully reading all transcripts to familiarize with the data, one author (JD) coded the first transcript in parallel with CA, a senior qualitative researcher in public health. They then compared and discussed their coding to ensure consistency and agreement over the coding method. Due to the descriptive nature of the study, the approach to coding was semantic [32], meaning that codes generated were intended to reflect the explicit meaning of the data, contrarily to other more interpretative approaches. After that, JD developed a codebook that was later applied to all transcripts. As the analysis went on, the codebook was adapted iteratively as new codes were identified in the data. Memos were written by JD to describe each code and insure consistency in coding. She also regularly revised the different portions of transcripts assigned to each code to verify homogeneity of coding. The codes were then compared, and similar codes merged and classified into larger themes and subthemes. Analysis was both deductive and inductive: although the main themes were derived from the interview guide, attention was also paid to new aspects revealed by the FGs that were not present in the guide. Finally, all the transcripts were reviewed to identify the relations between different themes within each interview and across interviews. Atypical positions and conflicts were also documented. Several meetings were held with the co-authors (PYR and CA) to discuss the codes and interpretation of the data. These meetings allowed to confirm or challenge certain aspects of the analysis until a consensus was reached. The analysis focused on identifying common perspectives among the three group of therapists, while trying to also give voice to the specific visions present within each therapy.

Our data are based on quotation from participants. The first author translated the quotations that are used in the manuscript from French to English. An additional reading was then carried out by a native English speaker to make sure the idiomatic meaning of phrases of the FG participants was preserved. Brackets in the quotations indicate omission of utterances to create cohesive sentences. We used the Consolidated criteria for Reporting Qualitative research (COREQ) checklist to report our study [33].

3. Results

We conducted eight FGs with a total of 45 participants: three FGs in Geneva, one with each group of therapists (with no distinction of age); five FGs in Vaud, one with naturopaths (with no distinction of age), two with acupuncturists (one with participants over 45 years and one with participants under 45 years); and two with osteopaths (one with participants over 45 years and one with participants under 45 years). Thirty-one participants were women (69 %). Four main themes were identified: contributions to the healthcare system, collaboration with biomedicine, pathways to recognition, and IM.

3.1. Contributions to the healthcare system

Therapists mostly defined their role within the healthcare system in comparison to biomedicine. This allowed them to underline the gaps that they considered to be present in biomedicine and that CM could fulfill. In turn, this led them to describe their overall contribution to the system and their complementarity to biomedicine.

3.1.1. Comparison with biomedicine

When comparing their own therapies to those of biomedicine, one of the main observations of the therapists was that they brought different approaches to and visions of health and illness. Therapists considered that they brought a more "*human*" and "*poetical*" vision and used a different language to explain mechanisms of health and illness. Acupuncturists and naturopaths, in particular, insisted on their approach and reasoning being different from that of biomedicine:

> "*The epistemology is not the same, (…) does not proceed in the same way. So, the theory of science of Western medicine is not the theory of science of Chinese medicine. In fact, you can put words to it in a more or less complex way, but they don't proceed in the same way.*" (Acupuncturist, Vaud, over 45)

According to the therapists in all three professions, these different visions translated into a much more holistic approach to treating patients:

> "*We take care of the individual, of life. That is to say that we are not dealing with a syndrome, we are dealing with a person with his past, his present."* (Acupuncturist, Vaud, over 45)

Acupuncturists and naturopaths insisted that they focus less on the symptoms than on what could cause them, contrary to biomedicine providers, who, according to them, are mostly focused on treating symptoms:

> "*I always think of the onion, you see, it's the holistic vision. That is to say that, indeed, you have a symptom, your leg hurts, well you're going to give a cream, there you go, your leg doesn't hurt anymore. But the problem comes from elsewhere. So, it's the onion, one layer, two layers, three layers, it's the naturopath's job to go to the center to find the problem.*" (Naturopath, Geneva)

Emphasis was put on considering the whole person, including emotional, psychological, environmental, and life course aspects. Although some therapists acknowledged that this could also be the case for biomedicine, they pointed out that physicians were often prevented from doing so due to lack of time. Indeed, therapists stressed that their consultations lasted longer, making it possible for them to spend more time with their patients to give them a listening ear:

> "*And they need answers, they need explanations, they need to be listened to, they need the confidence that they don't always seem to find in their doctor, who is ultimately timed. We are, in my opinion, less timed.*" (Naturopath, Geneva)

In addition to a more holistic approach, the use of touch was also considered, mostly by osteopaths and naturopaths, as an important feature that has somehow decreased in biomedicine:

> "*We observe, we palpate the patient from head to toe, so we touch as well. So, it's clear that in terms of physical contact [with the patient], there is a great intimacy. More often than in a medical consultation.*" (Osteopath, Geneva)

3.1.2. Complementarity with biomedicine

Highlighting their differences with biomedicine led the therapists to discuss how they could also intervene alongside biomedicine and how all the different approaches were complementary. Some therapists considered that they were taking a space left vacant by medicine:

> "*I think it would be so desirable to have a closer link with physicians, because in the end we don't take their job. We take a part that they don't take, that they don't take anymore (…). So, I think that we really have our place along with allopathic medicine.*" (Naturopath, Geneva)

In the same vein, therapists underlined that they may also intervene whenever biomedicine reaches its limits:

> "*I have a number of doctors who send me patients because they can't find anything. (…) And that's where there is a real complementarity, (…) we don't intervene on the same factors and the same problems.*" (Osteopath, Vaud, over 45)

Many therapists also underlined how they can complement conventional treatments, in particular in chronic conditions, or alleviate symptoms associated with treatments:

> "*I have quite a few heavy pathologies such as cancers and so on, so obviously I'm never going to say that naturopathy is going to cure these cases, but on the other hand, what a benefit it is as a complement, precisely for very heavy treatments.*" (Naturopath, Vaud)

In addition, according mainly to the acupuncturists, CM may also be a useful alternative to the use of medication in some cases:

> "*It is a medicine [acupuncture] that does not require to take drugs and that has a lot of effect on it [insomnia, depression and migraine].*" (Acupuncturist, Vaud, under 45)

While pointing out the shortcomings of biomedicine, some therapists also stressed its usefulness in general and for orienting their own treatments based on the medical diagnosis or the various tests already performed on the patient:

> "*You have to have a reference to the doctor (…). If someone comes in with a migraine, I am unable to know if there is a brain tumor underneath or not. So I am very happy when the patient has seen his doctor, an MRI has been done and, ok there is no tumor, I can do my Chinese medicine treatment.*" (Acupuncturist, Geneva)

3.2. Collaborating with biomedicine

Given this complementarity and their contributions to the healthcare system, the majority of therapists wished to have more collaboration with biomedicine practitioners. However, although most therapists noted a certain openness to CM on the part of biomedicine, as well as an improvement in exchanges, barriers to effective collaboration were also highlighted.

3.2.1. Increased open-mindedness

Therapists noticed an increased open-mindedness toward their disciplines on the part of biomedicine and an evolution in time of their recognition:

> "*We can see that there is a greater interest on the part of practitioners in biomedicine, where there is no possibility of intervention, such as in pregnancy or in areas where medicine has limitations in relation to either serious conditions or chronic problems where there are many non-responders.*" (Acupuncturist, Vaud, under 45)

Many therapists in our sample did have some form of collaboration with physicians or other health professionals, osteopaths and acupuncturists in particular. However, opinions were divided as to the extent of this collaboration, as some therapists collaborated regularly, whereas others considered that this was more often the exception than the rule:

> "*The doctor said 'she needs acupuncture sessions.' He was a rheumatologist, and he really played the game of collaboration well (…). But it's rare, for the moment.*" (Acupuncturist, Geneva)

The main benefit of increased collaboration identified by therapists was improved patient care. As stated by one of the participants, this would give the patient "*a sense of consistency that both want him to be okay and both are doing what they can to make it right. He would no longer feel like a child of divorced parents, each one saying 'I'm the one who's right,' each one taking a little bit of interest.*" (Naturopath, Vaud)

Therapists gave several reasons to explain this positive evolution, such as better training of young physicians regarding CM, but the main one was patients' influence. Indeed, many therapists reported that seeing patients get better without changing their basic medical treatment made physicians interested in the other treatments that their patients were using:

> "*But the network is often done by word of mouth, by acquaintances. Because one day you treated a patient who went to such and such a doctor, he was very happy, he told his doctor about it, that's how the link was made.*" (Osteopath, Geneva)

The theme of creating a professional network often came up in discussions as a premise for good collaboration, as well as being able to recognize personal limits and therefore the need to refer patients to other healthcare professionals:

> "*But at some point, we have to feel "Well, that's out of our hands". (…) There comes a point when I see that some things are not my area of expertise anymore, I stop there, the diagnosis is wrong, go to someone else. You have to know how to do that, too. That's why the network is important, and transparency is important.*" (Naturopath, Vaud)

3.2.2. Barriers to effective collaboration

The main identified obstacle to collaboration was biomedicine's lack of knowledge about CM and its field of action:

> "*The medical world often imagines something rather irrational, magical or … They don't know exactly how we work.*" (Osteopath, Vaud, over 45)

This led physicians to suggest that their patients turn to CM only as a last resort, which in turn delays a potentially effective treatment:

> "*Ideally, we would like to be consulted a little more quickly because I have many patients who are sent to me, I would say, as a last resort (…). And I would say that it is almost too late (…). And these are people that I would have liked to have seen in the first year of their pain.*" (Osteopath, Vaud, over 45)

Along with the lack of knowledge comes a certain level of mistrust on the part of biomedicine toward CM, according to the therapists. As one acupuncturist stated, while discussing midwives trained in acupuncture who practice in hospitals:

> "*At [hospital name], in the maternity ward, for a period of time, it was forbidden, because the head doctor had decided that it was like astrology.*" (Acupuncturist, Vaud, over 45)

Some therapists also understood mistrust as a way for physicians to protect their patients:

> "*In fact, it's often a kind of fear for the patient, but we have to make them feel confident that we are well-trained therapists. I often hear the fear that the patient is advised to abandon medical care, and this is not, at least not in my desire, but I think it is not in the general desire or wish. We still want him to have appropriate care.*" (Acupuncturist, Vaud, under 45)

3.3. Pathways to recognition

According to therapists in all groups, recognition is paramount to develop collaboration. As one naturopath underlined:

> "*As long as we don't have, quote on quote, state recognition, we won't be able to cross these barriers, because as long as we are not accepted as a profession as such, well, there will always be these bubbles that remain a little bit separate. It will be complicated to build bridges*." (Naturopath, Geneva)

Four main possibilities were mentioned to progress toward this recognition: federal diplomas, education and information for physicians, legal regulations, and research. The first possibility was recognition of their practice through a Master's degree or federal diplomas. The main advantage reported was the gain of a form of legitimacy in the eyes of society in general and of medicine in particular:

> "*For us to have a voice, for us to be recognized, nothing beats a federal diploma*." (Acupuncturist, Vaud, over 45)

The federal diploma was also seen as a means to standardize and structure training. Acupuncturists and naturopaths emphasized the multiplicity of training courses available in Switzerland, as well as their variable quality. Diplomas would therefore constitute a way to formalize the professional profile of those expected to practice as therapists in these disciplines:

> "*If there is no supervision, if there is no regulation, anyone can open a school (…). And then there are so many different approaches that in the end, yeah, it can go in all directions, so I think it's good to professionalize the training in any case. And then to have, I would say a minimum threshold of capacity*." (Naturopath, Geneva)

In turn, therapists stated that this would also constitute better protection for the patients, who so far have no proper means to determine the trustworthiness of a therapist. However, these diplomas have also been the object of criticism and raised some concerns. The first criticism was related to their usefulness in everyday practice, particularly regarding reimbursement by insurance companies and the possibility of practicing in a hospital environment. Therapists also mentioned the fear that the diplomas would overstandardize their practice, as many traditions coexist:

> "*It has effects that are also negative effects where we put everyone in the same mold and it prevents things, perhaps a creativity. You could say that*." (Acupuncturist, Vaud, over 45)

A second path to recognition involved better educating and informing physicians about CM. This subtheme is linked to the observation, mentioned earlier, that physicians know little about CM and its scope of action. Enhanced communication was thus considered a key aspect by most therapists in all three groups:

> "*So, I think that our place in the health system, to come back to the question, is very important, but for us to take it solidly, we need to inform the medical world much more about what we do, about our limits, about … We need to communicate much better about our skills*." (Osteopath, Vaud, over 45)

Although there was little discussion about what form communication should take, therapists in all groups emphasized the need for a common language in order to be understood by biomedicine:

> "*Clearly, naturopathic thinking and medical thinking are not the same thing (…). However, as soon as we look for a dialogue, as soon as we look for a collaboration, we must have a common language, and we must be able to speak the same language.*" (Naturopath, Vaud)

This ability to speak the same language required, on the one hand, the ability to understand medical language and, on the other hand, the need to adapt one's own language to be understood by biomedicine:

> "*It is this difference in language that is complicated. And that's where we also have to make the effort perhaps, when we talk to doctors, not to speak our language, Yin Yang, hot, cold, but to try to medicalize our story so that they understand it too.*" (Acupuncturist, Geneva)

Another key aspect in increasing physicians' knowledge about CM was through education, whether pre- or postgraduate. Indeed, many therapists have criticized the lack of hours devoted to the study of CM during physician training:

> "*And I believe that 1h30 are given [in the medical curriculum] to the great TCM. I find it a little bit indigent regarding a medicine that is immense, that is very old, that is very effective. So, it should start there, i.e., the doctor should know what he is talking about.*" (Acupuncturist, Vaud, over 45)

A third possibility for promoting therapists' recognition relied on tighter state regulation of their practice. As osteopaths are already legally recognized as health professions at a federal level in Switzerland, therapists did not address this topic much. However, some of them underlined that state recognition was not sufficient to change attitudes toward osteopathy:

> "*In theory it's ok, at the level of statutes, laws, but it is clear that the practice takes time to be better considered, it is necessary to change cultures, customs, habits. It's a colossal task to change the healthcare system.*" (Osteopath, Vaud, under 45)

Acupuncturists, on their part, often criticized the absence of legal regulation:

> "*It's an important profession, we're dealing with health, so we need to be regulated. If I cut hair … that's something else. We have a responsibility, let this responsibility also be equal to the recognition that the state can give us.*" (Acupuncturist, Vaud, over 45)

They also pointed out that the lack of regulations or strict state control of the practices implied that, in many cantons, almost anyone can set up a practice. As one participant underlined, state regulation would be beneficial on several levels:

> "*The first thing would be that it would give good visibility, it would allow us to exist as a real profession in the healthcare field (…). Secondly, we would become partners with an authority that is a little more recognized by all the people involved in the healthcare field (…). So if you give a more precise framework to Chinese medicine therapists, doctors are not supposed to neglect it either, not to know what Chinese medicine is.*" (Acupuncturist, Vaud, over 45)

However, some therapists also underlined a potential loss of liberty induced by tighter state regulations:

> "*Personally, I think that in our daily practice we have a lot of freedom. I think that there should perhaps be more regulation for the patient, more to the advantage of the patient than to the advantage of the therapist.*" (Acupuncturist, Vaud, under 45)

Naturopaths, for their part, did not discuss state regulation or being recognized as health professionals much. They did not call for stronger state regulation, outside the federal diploma, and feared a loss of autonomy:

> "*The risk is that the control is too tight and that we lose … What makes the quality of naturopathy, is precisely to be able to be very broad (…). And we can do that because we don't have too rigid a framework, for the moment in any case.*" (Naturopath, Geneva)

Finally, scientific research, a topic mostly discussed by acupuncturists and osteopaths, was also seen as a means to be better recognized by biomedicine:

> "*It's true that a frequent criticism in the field of complementary medicine is the evocation of anecdotal evidence, on isolated cases, like we all have*

(…). But today in pain treatment, in oncology, there are some diseases that have produced enough research volume to go beyond the interest and perhaps the fear of biomedicine (…)." (Acupuncturist, Vaud, under 45)

However, therapists also emphasized the inadequacy of certain research methodologies of biomedicine in relation to the philosophy or view of disease mechanisms inherent to their therapies. They also pointed out that not everything in biomedicine is evidence-based and that empiricism should also be valued:

"*We could perhaps try to enforce empiricism, i.e., if we work on this many patients and have this many results, we don't need to do a double-blind randomized study. And empiricism is what preceded all science.*" (Osteopath, Vaud, over 45)

3.4. Integrative medicine

The term "integrative medicine" was almost never spontaneously used by the therapists during the FGs, and always in relation to collaboration with biomedicine, until it was mentioned by the interviewer. When the interviewer asked what IM meant to them, several therapists admitted to having never heard of the term or being unfamiliar with it.

Nonetheless, several definitions or interpretations of the term were given by the therapists. The most common understanding of the term was a collaboration between CM and biomedicine, as one participant summarized:

"*It's a kind of collaboration where the dialogue is open. Where doctors can call the naturopath if they have questions and naturopaths can call the doctors. And that's pretty much what it is now, if anyone wants to do it, they can, it's free.*" (Naturopath, Vaud)

Aspects of enhanced communication between all actors, as well as patient-centeredness, were also raised. For most therapists, collaboration should ideally be non-hierarchical, with leadership attributed to a specific actor according to his or her expertise and the case at hand:

"*And it's very interesting, because in fact it also defines that the center is mobile and that sometimes, we osteopaths, we are in complementary medicine and sometimes it's biomedicine that is complementary to us. (…) It can be many people who can be the main actor (…).*" (Osteopath, Vaud, under 45)

Several therapists, mostly osteopaths, stressed the importance of not integrating only a few aspects of their practice into conventional care, but integrating their disciplines as a whole:

"*It's true that we have to integrate with our own concept, not just certain manipulations, certain things. That we integrate official medicine with our philosophy, our concept and our way of seeing the human being and everything.*" (Osteopath, Vaud, over 45)

This statement echoed the fear that biomedicine would appropriate CM approaches under the guise of IM:

"*And that's the challenge of cooperation, because it's a question of do we fit into the system, do we get swallowed up?*" (Naturopath, Geneva)

Finally, a second definition of IM was also brought up by some naturopaths and acupuncturists. This definition was related to the concept of holism:

"*Integrative medicine integrates the whole body. At least that's how I understand it. It's integrating the problematics of the person who is in front of you. So, it leads to think (…) about the acupuncture points that we are going to use on this person, but it's also about his rhythm of life, his emotions, his diet, does this person eat enough of this, too much of that.*" (Acupuncturist, Vaud, under 45)

4. Discussion

This study provided insight into how CM therapists viewed their relation to the Swiss healthcare system in general and to biomedicine in particular. Therapists provided a variety of perspectives on how to affirm their status and strengthen their ties to biomedicine, while at the same time expressing a few concerns about becoming more integrated into the system.

The FGs showed that even though the three therapies studied come from very different traditions, the therapists produced fairly similar discourse when describing their place within the Swiss healthcare system. Especially emphasized were a vision of health and illness that is different from that of biomedicine, a more holistic approach to patient care, and longer consultation times. The claim for holism and the existence of competing worldviews is common in discourse about most CM therapies, especially in European and North American countries where biomedicine is the dominant medical system [15,22,34,35]. This claim is often pronounced as a critique toward the biomedical approach, which is considered too reductionist [23,35].

In addition, therapists in our study mobilized discourse that emphasized other perceived shortcomings of biomedicine, which allowed them to suggest the usefulness of CM in general, as well as the way in which CM could complement conventional care. This kind of discourse is often harnessed by therapists to legitimize CM and to delineate the boundaries of their own disciplines in order to distinguish them from others in a professionalization process [15,23,34–36]. Some of these discourses reflect stereotypical assumptions on the part of the participating therapists regarding biomedicine. In particular, the holistic approach is not absent from conventional care as a number of medical specialties (such as palliative care, general medicine, etc.), as well other healthcare professions (nurses, etc.), do claim to have a holistic approach to the patients' care [37–39]. Therapists in our study operate under different constraints than healthcare professionals that are fully integrated in the healthcare system. In particular, they are less subjected to restrictions in terms of consultation length. As having a holistic approach to patient's care requires time, this claim for holism and more time spent with the patients may be jeopardized if therapists had to work under the same conditions as other healthcare professions. However, it is important to note that because the introductory question to the FGs asked the therapists to define the contributions of CM to the Swiss healthcare system, which is dominated by the biomedical paradigm, it is unsurprising that they tried to answer by situating themselves in comparison to it as a strategy to legitimize their practice and show their added value.

Collaboration with biomedicine was deemed desirable by a majority of therapists in all groups, and many already had more or less close collaboration links with conventional healthcare practitioners. Although ill-defined by our participants, collaboration seemed to mostly imply enhanced communication between providers of care around specific patient cases. Many therapists felt that the lack of collaboration was due to lack of knowledge on the part of physicians regarding the scope of CM practice and mistrust of the ability of CM therapists to treat patients properly.

Nevertheless, therapists, for the most part, acknowledged a positive evolution in the open-mindedness of biomedicine toward CM. This change has been noted by others [13,36] and highlights a shift over the last 20 years from the total exclusion of CM to a growing awareness of and interest in the various CM by the medical world. In Switzerland, this open-mindedness is also reflected in the creation since the years 2000 of private IM clinics (bringing together therapists and other health professionals) and in the development of IM services in various hospital departments. These developments may be seen as a sign that these therapies have already gained some form of legitimacy, even in the absence of strong state regulation [6,23].

This acknowledgement led therapists in all groups to advocate the recognition of their work as a necessary step toward improving

collaboration with medicine, or toward stronger integration within the healthcare system. Whereas the discourse on the contribution to the healthcare system and collaboration with biomedicine was quite similar among our participants, the importance attached to the various means of recognition differed between groups of therapists and within groups. Education of and improved communication with physicians regarding CM was considered by all groups as being a central element. Lack of interprofessional communication has often been identified as a major barrier to collaboration between CM providers and biomedicine practitioners [16,23,40]. Regarding physicians' education, the teaching of CM has developed in recent years in the Swiss medical curriculum and CM is explicitly mentioned in the Profiles, a set of competency and outcome-based learning objectives for medical students and faculties of all Switzerland [41]. The objective of these teachings is not to cover every CM but to provide future physicians the tools and knowledge to best inform their patients and learn to communicate on the subject.

Another step towards recognition that was considered important in all three groups was standardized and state-sanctioned training. However, state regulation was mainly advocated by acupuncturists and development of research by acupuncturists and osteopaths. In general, therapists' positioning toward regulation was consistent with the results of a recent systematic review on the subject, both in terms of perceived benefits (greater legitimacy, acceptance, and recognition) and disadvantages (concerns about standardization of practice and distancing from philosophical tradition, as well as subordination to biomedicine) [16].

Furthermore, the development of research to assess the effectiveness of CM is a frequently mentioned element to facilitate the integration of CM into conventional care [14,16,42]. The number of scientific publications on CM has grown steadily in the past years [43], thus providing evidence of effectiveness for various CM in certain indications, such as symptom management in cancer care [44]. However, debates remain, both within and across therapies, as to what counts as evidence, and whether biomedical research standards and methodologies are the best suited to study therapies that have different philosophical approaches to health and healing [10,14,17,25,42], as was also the case among our participants. Differences in the importance given by each group of therapists to these different means of recognition may reflect the varying levels of their integration in the Swiss healthcare system.

Independent of their level of recognition, our results show that these three disciplines seem to be in a process of greater alignment with the dominant biomedical model, notably in terms of training and research standards. This development may be seen as a paradox, as we observed a concomitant effort to differentiate CM from biomedicine on the part of the therapists, but it mostly reflects the processes at work to secure professional identity while trying to gain legitimacy inside a wider system, through professionalization and by using the rhetoric and models of biomedicine [13,14,16,45]. According to Cant (13), CM "is 'judged' in terms of scientific criteria, placing biomedical rules of thought as the basis of arbitration, legislation and definition."

Most participants were unfamiliar with the term "integrative medicine." However, when prompted to define it, most declared that it should consist of a non-hierarchical collaboration between the different healthcare providers, based on patient preferences. Not being subordinated to biomedicine was a common preoccupation of the therapists in our study. This conception of IM corresponds to the pluralization model of IM, as described by Wiese et al. [12]. This model is often considered the best way to preserve the different paradigms of care and to account for patient preferences, although it is unlikely to become the predominant model in the mainstream healthcare system [10,11,24]. A preference for this model was notably visible in a recent study conducted among Chinese medicine practitioners in the United States, who view it as a way to prevent the dilution of their practice when combined with biomedicine [10].

The main strength of this study is that it was the first to examine therapists' opinions regarding their integration in the Swiss healthcare system and collaboration with biomedicine. In addition, the richness of our data and choice of a descriptive design allowed for a broad and detailed understanding of participant's perceptions of their role within the Swiss healthcare system and on their opinions towards regulation. Our findings align with similar studies conducted in countries where the biomedical model is dominant and underline common challenges and opportunities regarding their integration into the healthcare system. Moreover, the inclusion of therapists who practice three different types of CM allowed us to describe the similarities and differences in therapists' discourse, both within and between therapies. Nonetheless, this study has several limitations. First, we initially intended to conduct two FGs per therapy in each canton organized by age, which would have resulted in 12 FGs. However, the number of naturopaths willing to participate allowed us to conduct only one FG in each canton (with no distinction of age). The same problem occurred for acupuncturists and osteopaths in the canton of Geneva, leading to only one FG for each group in this canton (with no distinction of age). However, as no major differences were observed in terms of participant's age in the canton of Vaud, and as data saturation was reached, we contend that this did not affect our results. Another limitation derives from the fact that we included therapists who practiced only in French-speaking cantons. We reasoned that therapists' opinions were more likely to be influenced by specific cantonal regulations or level of recognition than by the language in the area in which they practice. Finally, the data presented in this manuscript were collected in 2016–2017, but their analysis could not be completed earlier than 2023, which could lead to consider that they may be outdated. However, since the data were collected, there has been no change in the regulation of therapists in the two cantons where the study was carried out. This suggests that the opinions we outline in this manuscript are still relevant for describing the situation of non-physician therapists in Switzerland. Even the more so, it would be interesting to carry out a new study to investigate whether the introduction of federal diplomas has changed therapists' perceptions of their integration into the healthcare system.

5. Conclusion

Despite the differences between the three CM practiced by the therapists, they produced fairly similar discourse in terms of aspirations and concerns regarding their position within the Swiss healthcare system. Their discourse is one element among others that should be considered in order to facilitate the integration of CM. Improving collaboration with biomedicine to enhance patient's care was particularly put forward. However, how it should be developed remains to be further explored and should consider the perspectives of other stakeholders, such as patients and conventional healthcare professionals. Regardless of the preferred model for IM, this study also points to the importance of properly defining what IM entails when attempting to develop this concept in a specific healthcare system.

CRediT authorship contribution statement

Julie Dubois: Writing – review & editing, Writing – original draft, Validation, Project administration, Methodology, Investigation, Formal analysis, Conceptualization. **Pierre-Yves Rodondi:** Writing – review & editing, Validation, Supervision, Project administration, Methodology, Conceptualization. **Christina Akre:** Writing – review & editing, Validation, Supervision, Methodology, Formal analysis, Conceptualization.

Availability of data and materials

Raw qualitative datasets analysed during the current study are not publicly available since consent for sharing data was not granted by participants; deidentified data may be available in French from the corresponding author on reasonable request.

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Competing interests

The authors declare that they have no competing interests.

List of abbreviations

CM	complementary medicine
FG	focus group
IM	integrative medicine
TCM	traditional Chinese medicine

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ctcp.2024.101919.

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