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# Offer and use of complementary and alternative medicine in hospitals of the French-speaking part of Switzerland

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## Summary

BACKGROUND: In 2004, complementary and alternative medicine (CAM) was offered by physicians in one-third of Swiss hospitals. Since then, CAM health policy has changed considerably. This study aimed to describe the present supply and use of CAM in hospitals in the French-speaking part of Switzerland, and to explore qualitatively the characteristics of this offer.

METHODS: Between June 2011 and March 2012, a short questionnaire was sent to the medical directors of hospitals (n = 46), asking them whether CAM was offered, where and by whom. Then, a semi-directive interview was conducted with ten CAM therapists.

RESULTS: Among 37 responses (return rate 80%), 19 medical directors indicated that their hospital offered at least one CAM and 18 reported that they did not. Acupuncture was the most frequently available CAM, followed by manual therapies, osteopathy and aromatherapy. The disciplines that offered CAM most frequently were rehabilitation, gynaecology and obstetrics, palliative care, psychiatry, and anaesthetics. In eight out of ten interviews, it appeared that the procedures for introducing a CAM in the hospital were not tightly supervised by the hospital and were mainly based on the goodwill of the therapists, rather than clinical/scientific evidence.

CONCLUSION: The number of hospitals offering CAM in the French-speaking part of Switzerland seemed to have risen since 2004. The selection of a CAM to be offered in a hospital should be based on the same procedure of evaluation and validation as conventional therapy, and if the safety and efficiency of the CAM is evidence-based, it should receive the same resources as a conventional therapy.

***Key words:*** *complementary and alternative medicine; hospital; use; epidemiology: Switzerland*

## Introduction

Around 50% of the Swiss population report that they prefer hospitals that offer complementary and alternative medicine (CAM), and the majority of the population would like CAM therapies to be refunded by healthcare insurance [1]. This conclusion, derived from a study mandated by the Swiss government in 2004, has become even more important since the vote of May 2009 on complementary medicines. It is all the more relevant because from the 1st of January 2012 Swiss people can choose the hospital where they are to be treated.

Although publications in the CAM field increased from 500 in 1990 to almost 2000 in 2011 (search on Medline with the key word "Complementary and Alternative Medicine"), studies on the implementation and supply of CAM in hospitals are still rare. In Switzerland, a study conducted in 2004 described for the first time the supply of CAM in Swiss hospitals: 33% of hospitals managers reported one or more medical doctors using CAM in their institution [2]. The most frequently used CAM was acupuncture. A direct consequence of the 2009 vote was the decision of the Swiss government to integrate five branches of CAM (traditional Chinese medicine, homeopathy, neural therapy, herbal medicine and anthroposophical medicine) into the compulsory healthcare insurance from 2012 and 2013, for a test period of 6 years. The question as to whether this has encouraged hospitals to increase the number and diversity of CAM offered remains open.

For the present study, the definition of CAM from the National Center for Complementary and Alternative Medicine (NCCAM), a branch of the US National Institutes of Health in Washington, was used: "CAM is defined as a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine" [3]. This definition includes more than the five CAM fields refunded by Swiss healthcare insurance, such as hypnosis or art-therapy, which have been integrated for decades in some specialised fields of medicine.

The objectives of this study were to describe the offer and use of CAM in hospitals in the French-speaking part of Switzerland, to observe their evolution since 2004, and to qualitatively explore the characteristics of this offer within a subset of CAM practitioners.

## Methodology

Ethics approval was given on the 10th of June 2011 by the cantonal ethics commission of the Canton Vaud.

As no public list of the private and public hospitals in the French-speaking part of Switzerland exists, 46 hospitals were identified using the list of hospitals obtained from the Federal Office for Statistics [4]. This document contains a table indicating the number of hospitals in each canton of Switzerland, classified either as general healthcare hospitals or specialised clinics. An exhaustive list was then created through the Internet, using the website http://www.annuairemedecin.ch.

This cross-sectional study had two phases. In the first phase, which started in June 2011 and ended in December 2012, and aimed to get a global picture of the CAM offered, a questionnaire was sent to the medical directors of hospitals of the French-speaking part of Switzerland (n = 46). The second phase, starting in September 2011 and ending in March 2012, involved semi-directive interviews with ten CAM therapists working in the hospitals.

The questionnaire was sent by post to the medical directors of hospitals in the French-speaking part of Switzerland. If there was no response, this was followed by three telephone reminders.

This very short, one-page questionnaire began with the following question: “Does your hospital offer complementary and alternative medicine?”The term “complementary and alternative medicine” was explicitly defined on the questionnaire in accordance with the definition given by the NCCAM. When the answer was positive, the responder was asked to specify in which specialised discipline (department, division or unit) it was offered and what the professional profile of those practicing CAM was (medical therapist or nonmedical therapist). Moreover, directors were asked to provide the name and telephone number of the CAM therapists (with their consent), with the information that the therapists might be contacted for a semi-directive interview.

In order to assess changes over the previous eight years, we obtained from the Swiss Public Health Federal Office the database of a Swiss study performed in 2004 [2] (data for the French-speaking part of Switzerland). Based on the analysis of this database, 43% of hospitals of the French-speaking part of Switzerland indicated that they offered at least one CAM in 2004.

Ten of the therapists identified by the medical directors in the first phase were chosen in order to represent well the different fields of CAM and the different hospitals in the French-speaking part of Switzerland. For timing reasons, four interviewees were already chosen before study phase I ended. No contacted therapist refused the interview. Interviews were face-to-face in six cases and by phone in four, and lasted between 30 and 45 minutes. All interviews were conducted by P.C.

The following items were part of the semi-directive interview: the professional education of the responding therapists and their training in CAM; the process of introducing CAM in the hospital and the reasons for such implementation; the indications and contraindications for the use of CAM; its perceived benefits and risks; the number of patients seen per month, the duration of each session and an evaluation of the mean number of sessions per patient; the type of information provided to the patients on the nature of, and access to CAM; an estimate of the proportion of patients accepting or refusing the therapy and the perceived factors influencing their decision; the presence of any scientific research that addresses the offered CAM in the hospital; and finally how these treatments were financed.

## Results

The questionnaire was sent by post to 46 hospitals. The return rate was 80% (37/46 hospitals). Among the 37 who answered, 19 medical directors indicated that their hospital offered at least one CAM and 18 indicated that they did not offer any. The return rate from private hospitals was significantly lower than from the public hospitals: 25 of 27 public hospitals and 12 of 19 private hospitals responded to the questionnaire. CAM seemed to be offered more frequently in public hospitals than in private hospitals: 15 of 25 public hospitals out offered at least one CAM, while in the private sector, only 4 of 12 hospitals made this offer. Among the 19 hospitals offering CAM, most of them (n = 12) provided between two and five different types of CAM. These CAMs were provided in nine hospitals by both medical and nonmedical therapists, in eight hospitals by nonmedical therapists only and in two hospitals by medical therapists only. The medical fields which offered CAM and the range of CAM therapies available are summarised in table 1.

Each of the ten responding therapists had been trained in medicine or other healthcare professions (nurse, midwife or physician; table 2). Moreover, eight of the ten therapists had a formal training in CAM that is recognised in Switzerland, either post-graduate complementary training from the Swiss Physician Federation or a diploma recognised by organisations such as ASCA (the Swiss Foundation for Complementary and Alternative Medicine). This education was complemented by some supervision for eight out of ten practitioners. The nurses and midwives practicing CAM without a formal diploma followed specific directives given by formally educated therapists. This was the case for one person practicing homeopathy in a division of obstetrics and another practicing aromatherapy in a division of orthopaedics.

CAMs were introduced between 2000 and 2008 in 50% of the hospitals and after 2008 in the other half. CAM introduction was in all cases the result of interest by an employee. Sometimes it was also a response to repeated requests by patients. No therapist said that the introduction of CAM was based on scientific data. In one case only, the introduction was accompanied by the creation of a working group by the head of the Department (gynaecology-obstetrics, introduction of osteopathy). Moreover, no hospital expected to research into CAM.

All practitioners clearly described indications. For some therapies, directives were established. In aromatherapy, for example, a combination of specific essential oils to be used against nausea after an operation was specified. In one obstetrics department, the use of traditional Chinese medicine, e.g. acupressure and electrical stimulation to reduce the pregnancy-related nausea and vomiting, was clearly corroborated with scientific evidence [5].

Contraindications were mentioned by eight of the ten therapists. For instance, in an oncology department, acupuncture was contraindicated for patients with leukopenia. Two therapists, in aromatherapy and in homeopathy, both in a gynaecology-obstetrics department, said that there were aware of no contraindication.

Benefits and risks were also clearly described. Well-being and relaxation of the patient were often mentioned as benefits of therapies such as reflexology, aromatherapy, manual therapies and sophrology. In a surgical department, the benefits of aromatherapy the day before an operation were improved well-being of the patient, as indicated by reduced medication, especially hypnotics, and improved relationships with the nurses. An example of risk was a case of hypoglycaemia in a rehabilitation clinic, which was possibly linked to reflexology therapy for diabetic patients 24 to 48 hours previously.

Nevertheless, a therapist in reflexology admitted that the indications, contraindications, benefits and risks in CAM therapies still needed to be explored, adding that research in CAM should be encouraged.

Information on access to CAM was most frequently given systematically to all patients (seven therapists of the ten). However, in some cases, if patients were benefiting from CAM therapies, it was not mentioned in the medical files. One therapist said that it was perhaps for legal reasons. Thus, the only way for the patient's general practitioner to know about the occurrence of such treatment was if the patient mentioned it.

When CAM therapy was offered, more than three-quarters of the patients accepted it. This level of acceptance was most often attributed to a wish for an alternative to usual medication and the expected benefit of physical contact during manual therapies. The refusals were based mostly on a lack of trust in the therapists and in manual therapies in general, or refusal of physical contact. The factors that seemed to impact the patients' answers were the relationship with the therapist and the way the CAM was presented.

The number of patients who received CAM therapy varied considerably from one hospital to another: from one to three reflexology patients a week in a rehabilitation division to 20 osteopathy patients a week in an obstetrics division. The number of sessions per patient ranged from one single session to three sessions according to eight of the ten therapists. Only one responding therapist devoted 100% of his working time to practicing CAM. Most worked on request or, sometimes, during fixed working periods dedicated to practising CAM.

Finally, among nine out of the ten therapists, the financial cost was either covered by healthcare insurance or paid by the hospital. In one case, the patient needed to have a private complementary healthcare insurance for the costs to be refunded.

## Discussion

In this study, half of the hospitals within the French-speaking part of Switzerland indicated that they offered at least one CAM therapy. Among 19 hospitals offering CAM, most of them (n = 12) offered between two and five different types of CAM, and in 9 hospitals out of 19 CAM was provided by both physicians and other healthcare professionals. Furthermore, CAM seemed to be more frequently used in public hospitals than in private hospitals. This phenomenon has not previously been described in the literature. Reflexology, manual therapies and aromatherapies were usually practised by nurses. A possible explanation may be that some nursing schools provide lectures or formal training in various CAMs. Rehabilitation, palliative care, gynaecology and obstetrics, psychiatry, and anaesthetics were the disciplines most often reported to offer CAM. This may be a result of the interdisciplinary approaches used in some of these disciplines (e.g., rehabilitation). Fur-

**Table 1:** Medical departments offering CAM (hospitals and clinics in the French-speaking part of Switzerland).

| **Departments offering CAM** | | **CAM type** | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **No.** | **Medical field** | **Ac** | **MT** | **Rx** | **Os** | **Ar** | **So** | **MH** | **AM** | **AMT** | **Se*** | **Ho** | **N/BF** | **NS** |
| 5 | Rehabilitation | x | x | x | | | x | | | x | x | | | |
| 4 | Palliative care | x | x | x | | x | x | | | x | | | x | |
| 4 | Gynaecology – obstetrics | x | | | x | x | | | | | | x | | |
| 4 | Psychiatry | x | | | | | | x | x | | | | | |
| 4 | Anaesthesiology | | | | | | | x | | | | | | x |
| 2 | Orthopaedic surgery | | | | | x | | | | | | x | | |
| 2 | Oncology | x | | | | | | | | x | | | | |
| 2 | Internal medicine | x | | | | | | | | | x | | x | x |
| 2 | Not specified | | | | x | | x | | | | | | | |
| 2 | Paediatrics | | | | | | | | | | x | | | x |
| 1 | Rheumatology | | x | | | | | | | | | | | |
| 1 | Geriatrics | | x | | | | | | | | | | | |
| 1 | Intensive care | | | | | | | x | | | | | | |

Abbreviations. Ac = acupuncture; MT = manual therapies; Rx = reflexology; Os = osteopathy; Ar = aromatherapy; So = sophrology; MH = medical hypnosis; AM = awareness methods: AMT = art or music therapy; Se = secret*; Ho = homeopathy; N/BF = naturopathy / Bach flower; NS = not specified

* Healers who play a part in folk medicine, claim they can alleviate the pain due to burns by "talking the fire out" of burns, reduce massive haemorrhages or heal warts, eczema or sprain thanks to a secret incantation: "the power" [12]. They work mostly by phone and do not demand any compensation.

thermore, there is evidence of the benefit of some CAMs in these disciplines, such as acupuncture in postchemotherapy nausea [6]. It is noticeable that in all disciplines except psychiatry, somatic pain was a major issue.

In comparison with the results of the study in 2004 [2], the percentage of hospitals which offer CAM seems to have increased: 51% in this study and 43% in 2004 (both within the French-speaking part of Switzerland). Acupuncture was in 2004, and still seems to be, the most frequently used CAM. A therapist suggested reasons for this success: the fact that these techniques have been used for thousands of years; the good organization of the ASA (Association des sociétés médicales suisses d'acupuncture et de médicine traditionnelle chinoise); the amount and quality of evidence on the effectiveness of acupuncture in some indications [6].

A few studies about the use of CAM in hospitals have been performed outside Switzerland. Among the most recent, a Norwegian and Danish study [7] showed that 50% of the hospitals in Norway and one-third in Denmark offered at least one CAM. In most hospitals, this was acupuncture. Therefore, we observed some similarities between the French-speaking part of Switzerland and these Scandinavian countries. Additionally, the American Hospitals Association reported the use of CAM in American hospitals and stressed the increase in such use from 7.7% in 1999 to 37.7% in 2008 [8]. In Israel, among 24 public hospitals, 10 offered different CAM methods in 2002 [9].

The most striking point revealed by the interviews concerned the terms of implementing CAM in the hospitals. In most cases, the introduction of CAM was motivated by the interest of an employee, who obtained the agreement of the director to practice CAM at the hospital. In some instances, the nonmedical therapists reported that the support of a physician encouraged the medical directors to take CAM seriously, and thus made its introduction easier. Interestingly, a qualitative Canadian study [10] also stressed this challenge and concluded that it is necessary to change the strategy for introducing of CAM in hospitals. Moreover, the time devoted to the practice CAM was often "hidden" in the normal working time of nurses, midwifes or physicians, as if the hospitals preferred not to show it openly. In other words, most hospital did not seem to have developed formal policies on how to introduce, supervise and evaluate such practices.

One exception to this *modus vivendi* must be mentioned. In a department of obstetrics and gynaecology, osteopathy was subjected to the same procedure of validation as any conventional medicine newly adopted in the department. Moreover, the therapy was monitored and its perceived results were measured. This procedure led to better sustainability, because the CAM did not depend on a single therapist but was openly institutionalised. This strategy meant more financial and human resources were available, and the transparency and the formalisation of the process created better acceptance of the therapy and better collaboration within the staff.

Some biases of this study deserve comment. In the first phase, the questionnaire was sent to the medical directors of 46 hospitals. In four cantons, public hospitals are grouped and organised in one single institution. The questionnaire was thus sent to the medical director of an institution representing several regional hospitals. The weight of the answer from a big hospital was consequently similar to the weight of a small independent institution. Moreover, a decision was made to send the questionnaire to the medical director of each institution, although the Swiss study from 2004 [2] showed that they were only partially aware of the activities of physicians involved in CAM and were poorly aware of CAM practiced by nonmedical therapists. The rates provided in this study are hence probably underestimates, particularly as far as nonmedical therapists' are concerned. Some CAM offered seemed not to have been reported by the head of several institutions (probably more often in large multicentre hospitals than in smaller institutions), because of the ignorance of the medical head with regard to CAM. For example, the website of a hospital indicated that aromatherapy was offered to the oncological patients, but the medical director of this hospital did not mention it in the questionnaire. Finally, the qualitative part of the study, like all qualitative research, is subject to various biases such as nonrepresentativeness of CAM therapists, recall problems, and over- or underestimation of some phenomena.

## Conclusion

Our results have several important implications. First, it seems that the number of hospitals offering CAM – in the French-speaking part of Switzerland at least – is increasing. In the present political climate there is no reason why it should not rise further, as observed in other western countries. The policies governing the introduction of CAM in the hospitals surveyed seem, with one exception, to be poor if not nonexistent. The offer is mainly based on the goodwill of the therapists, rather than clinical and scientific evidence. It is extremely disturbing that, apparently, the

**Table 2:** CAM, medical specialty and profession of the responding therapists.

| CAM | Medical specialty | Occupation |
|---|---|---|
| Acupuncture | Gynaecology and obstetrics | Physician |
| Acupuncture | Gynaecology and obstetrics | Midwife |
| Acupuncture | Rehabilitation | Nurse |
| Acupuncture | Psycho-oncology | Physician |
| Aromatherapy | Orthopaedic surgery | Physician |
| Homeopathy | Gynaecology and obstetrics | Nurse |
| Osteopathy | Gynaecology and obstetrics | Midwife |
| Reflexology | Rehabilitation | Nurse |
| Reflexology and aromatherapy | Palliative care | Nurse |
| Sophrology and manual therapies | Palliative care | Nurse |

files of patients who received CAM therapy do not mention these interventions. The introduction of every new healthcare approach, be it conventional or complementary and alternative, should follow an identical evaluation and validation procedure. Hospitals should also ensure that they are able to provide sufficient resources to make it possible to monitor the outcome. This is easy to justify, because the amount of factual and scientific knowledge about CAM [11] has increased greatly over the past one or two decades. This effort should be maintained and encouraged, particularly in academic settings, in order to allow for better evaluation of CAM use, quality of care, costs/benefits and health outcomes in the hospital. The question of how CAM should ideally be introduced into a hospital remains. If the process for implementing a CAM is the same as for conventional medicine, it could lead to less risk of the interruption of this therapy when the therapist leaves the hospital. In other words, the implementation of a CAM modality in a hospital should not be *ad personam* but rather institutionalised, in the same way as any newly implemented treatment. This remains true for all stages of the evaluation: choice of therapy, pilot introduction, monitoring of undesired effects, costs and outcomes including benefits in terms of health, wellbeing and quality of life. A follow-up study to interview the patients on their perception of, and satisfaction level with, the use of CAM would be interesting and could be considered for future work.

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