

ORIGINAL PAPER

General practitioners and classical homeopaths treatment models for asthma and allergy

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Complementary and alternative treatment (CAT) is increasingly popular with patients and health-care providers. In the western societies an increasing number of patients with asthma and allergy combine conventional and CAT. But health-care providers knowledge about the different treatment models applied within the conventional health care system and alternative treatment is generally poor. 'Treatment model' includes understanding of disease, diagnostic approach, treatment methods and expected effects of treatment. Different treatment models represent different social constructions of understanding. We present a conceptualization of general practitioners' (GPs) and classic homeopaths' (CHs) perceptions of their treatment models in patients with asthma and allergy. This is a first phase of a research project conducted in Denmark to study prerequisites for bridge building between conventional and alternative therapists.

The research questions were: How do the GPs and the CHs describe their treatment models for asthma and allergy? What are the differences and similarities between the treatment models? Is there a logical connection between the components of the GPs and CHs treatment models?

Six GPs and 11 CHs participated in semi-structured interviews. The main difference is in the GPs and CHs descriptions of the purpose of treatment. Similarities are found in the perception of a successful treatment. Both the GPs and the CHs experience treatment effects to be dependent on contextual conditions. Differences and similarities between treatment models are discussed in relation to potential bridge building between conventional and alternative health care. *Homeopathy* (2005) 94, 17–25.

Keywords: disease understanding; diagnostic approaches; treatment model; expected effects

Introduction

Complementary and alternative treatment (CAT) is increasingly popular among patients and health providers. In western societies an increasing number of patients combine conventional and CAT.^{1–13} But health-care providers and the patients knowledge about the different 'treatment models' applied in the

conventional health-care system and in the field of alternative treatment are very limited. The concept 'treatment model' includes the following components: therapists understanding of disease, the diagnostic approaches the therapist uses, the therapists choice of treatment methods and the therapist's expectation of treatment effects. A treatment model constitutes a rationale for the therapist's way of dealing with diseases. We assume that the therapists insight into and understanding of different treatment models is an essential prerequisite for advising patients and co-operation among therapists applying different treatment models.

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Received 19 May 2004; revised 2 August 2004; accepted 2 November 2004

The purpose of this article is to present a conceptualization of general practitioners' (GPs) and classic homeopaths' (CHs) perception of the components of their treatment models in patients with asthma and allergy. This was conducted as a first phase of a research project conducted in Denmark to study the prerequisites for bridge building between conventional and alternative therapists. Bridge building is an institutionalized endeavour to organize integrative care characterized by a co-operation between therapists working with different treatment models and by a patient centred approach.

On the basis of a report describing the components of the therapists' treatment models a therapist researcher seminar was conducted to give the therapists an opportunity to meet and discuss differences and similarities between their treatment models. We have not yet found any institutional setting in Denmark for this exchange of experience to be realized in clinical practice.

We chose to limit the project to asthma and allergy, because asthma and allergy are widespread disorders in the population in Denmark as in other western countries.¹⁴⁻¹⁷ GP treatment is the most frequently used form of treatment by Danish patients with these conditions.¹⁸ But patients with asthma and allergy also often use homeopathy.¹⁹⁻²² In Denmark CHs are defined as alternative therapists and are not included in the public health-care sector. Homeopathic treatment is not subsidized by the public sector.

The core research questions were operationalized in relation to the four components of a treatment model (Figure 1):

1. How do GPs and CHs describe their treatment models related to patients with asthma and allergy? What are the differences and similarities between the GPs and CHs treatment models?
2. To what extent does a logical connection exist among the components of the GPs and CHs treatment models?

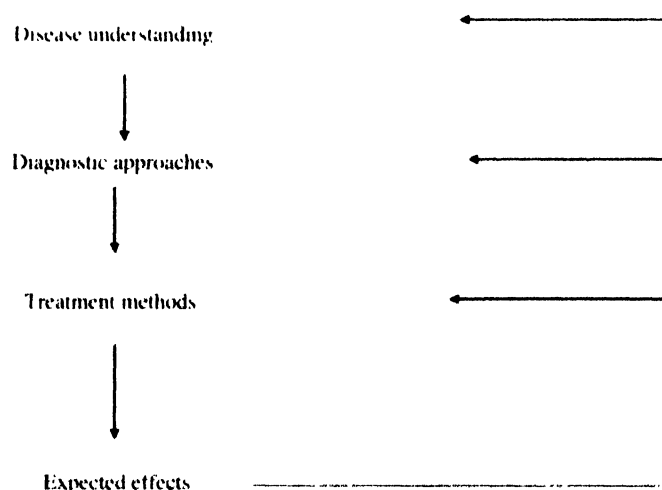


Figure 1. The components in a treatment model.

Materials and method

Recruitment of GPs and CHs

In 2000, 140 GPs in Denmark were contacted by letter and asked if they wished to participate in a project focusing on GPs and CHs treatment of asthma and allergy including qualitative interviews on their treatment models, patient evaluation of their treatments and yearly seminar where the GPs, the CHs and the researchers should participate. Six GPs wanted to participate. Reasons given for non-participation was too little time and a feeling that it could be too transgress to participate in a project with CHs.

CHs were recruited through the Danish School of Classic Homeopathy, the only school in Denmark educating CHs. Eleven CHs fulfilling the following criteria were selected: classic homeopathic education; more than 2 years clinical experience; experience treating people suffering from asthma and allergy.

The GP's age range was from late 40s to late 50s; three men and three women, working in solo practice and health centres with two to three doctors. The CH's age range was from late 30s to 64; five men and six women, working in solo practice and in clinics with two other CHs; one has a clinic with a kinesiologist. Most of the CHs have, in addition, vocational training in conventional health education as a doctor, nurse, dental technician, and relaxation teacher or other training as a chemist, acupuncturist, reflexologist, stewardess, clerk, stockbroker.

Methods

Semi-structured interviews were conducted by one of the researchers, a psychologist (CG), supervised by the senior researcher in planning the interview guide and conducting the interviews and discussing the tape-recorded interviews. The interview guide focused on the following themes: understanding of asthma and allergy, diagnostic approaches used, choice of treatment methods, expectations of effects related to their treatment and reflections on the connection between the different components in their treatment.

Qualitative interviews were used because the research questions focused on the practitioner's description and understanding of their treatment models, incorporating their experience and reflections.²³⁻²⁶ All interviews were taped and transcribed verbatim. The transcribed interviews were sent to the interviewees, they were asked to correct any misunderstandings or incorrect sentences. Then a meaning condensation and a thematic and person-based analysis of the transcribed interviews was conducted by one of the researchers, controlled and discussed with two other researchers working on the project.^{25,27-29} The procedure for the data analysis was organized according to the themes in the interview guide to reflect the components of the treatment model (Figure 1).

Theoretical considerations

We assumed that the practitioners' understandings of disease have consequences for their choice of diagnostic approaches, which in turn delimits the range of treatment efforts and effects that they aim to achieve. We assumed that there was a logical connection between the disease understandings and the expected effects of treatments. Understood in this way, the effects that therapists look for are determined by their disease understandings. More concretely, this means that if a therapist understands asthma and allergy as a situational disease,³⁰ he will define the effects of treatment in a different way from a therapist who understands asthma and allergy as a biochemical problem. In this way, understandings of disease can yield causal reasoning that legitimizes and, at the same time, delimits the focus to specific outcome expectation. A given treatment model is not in itself adequate or inadequate but is defined as adequate or inadequate through social practice and institutional power structures. The treatment models are embodied within discourses that delimit and allow for different scopes of action for therapists.

What we get when we look into therapists' treatment models is, of course, the therapists' perceptions. The treatment models described are constructed in the context of interactions between the therapist and researcher. All therapists knew before the interview that their description of their treatment model would be disseminated in a joint report to other therapists in the research project.

Results

How do the GPs and the CHs describe their treatment models related to patients with asthma and allergy? What are the differences and similarities between the components of the GPs and CHs treatment models?

Figure 2 summarizes the essential characteristics of the treatment models of the GPs and the CHs within the four components.

Understandings of asthma and allergy

The GPs stated that they were trained to understand asthma and allergy as independent entities in terms of physiological reactions and conditions. Asthma is understood as a constriction in the airways caused by swollen mucous membranes, muscle contraction or adverse drug reactions. This can be due to substances secreted by pathogens or pollutants. It may also be a direct allergic reaction. Allergy is understood as a hypersensitivity to something external, some people have an inborn tendency to react more strongly to certain allergens than others.

Based on experience, however, the GPs developed a more multifactorial explanation of asthma and allergy. Several of the GPs had begun to ponder whether the

focus on the symptoms should be replaced by a focus on something underlying. One GP said that she personally has given up thinking in terms of causal connections. This GP cannot see the claimed connections and, therefore, thinks more pragmatically and operationally: how does it appear, and what can be done? Another GP said that, with time and experience, his understanding of asthma and allergy has changed. The disease is withdrawn into the background and the person has come more forward.

The CHs work from an assumption that symptoms interact with each other and reflect underlying imbalances, which must be viewed in connection with innate predisposition, the strength of the vital force and the patient's life conditions. One CH put it as follows:

'The person's susceptibility is individual. It can be asthma, it can be allergy or something completely different. But it is not a problem to be susceptible to, for example, asthma or allergy, as long as you have a vitality that is strong enough to defend you against it. But if the vital force is weakened after, for example, a shock, a loss, traumas or other things, then it is no longer in a condition to overcome influences that can provoke, for example, asthmatic or allergic reactions, and then the problems start. Therefore, it is very important to bring out what it was precisely that provoked the illness, because it is here the individual picture begins to emerge.'

CHs understand asthma, breathing difficulty and cough as the organism's attempt, with the resources that are available, to do something about a disturbed vital force. Allergy is also seen as an expression of an organism in imbalance, of something underlying, and it is this 'underlying thing' that the CHs focused on.

According to the CHs, an innate predisposition is necessary precondition for the development of asthma and allergy. If this is not present, one will not react with asthma and allergy. Asthma and allergy is, like any other disease, dependent on the individual's susceptibility, combined with a weakened vital force. The vital force can be weakened by vaccinations, by physical factors (such as polluted environment or poor diet) psychological factors (such as repressed or unaddressed feelings). At some point the organism reacts at its weakest point, its area of susceptibility. In connection with the area of susceptibility, some CHs use the concept of miasmatic predisposition. One CH compared this with the GPs genetic view. The miasmatic expression of 'psora', 'sycosis' and 'syphilis' will be seen when the vitality weakens and symptoms begin to arise.

Differences and similarities between the GPs and the CHs understanding of asthma and allergy

While GPs understand asthma and allergy as independent entities in reference to physiological

	GPs	CHs
Understanding of asthma and allergy	Physiological understanding of asthma and allergy supplemented by a multifactorial explanation and openness towards "something underlying"	Asthma and allergy are seen as symptoms of an underlying imbalance, a disturbed vital force and miasmatic predisposition.
Diagnostic approaches	Disease history with focus on disease, measurements, test and therapeutic trials of drugs with the purpose of determining the disease.	Interview, the person's report about him/herself, his/her conduct and conditions of life, observation, with the purpose of determining the homeopathic medicine.
Treatment methods used	Drugs given against the disease/symptoms (or avoidance of drugs), interviews and preventive advice concerning behavioural changes	Interviews and a single homeopathic medicine The medicine is prescribed for the person and not against the symptom/disease
Expected effects	Physical annoyances disappear, improved function, better quality of life, life prolongation. Cure is not expected Drugs often make patients dependent. It becomes harder to keep the symptoms away the longer the patient has been on treatment Adverse reactions quite common	Indirect initiation of self curative processes monitored according to 'curative laws' The last symptoms to arrive are expected to disappear first, old symptoms can reappear in a course of treatment etc Adverse reactions are not expected but reactions such as 'aggravations' where symptoms flare up and subsequently disappear may occur

Figure 2. General practitioners' and classic homeopaths' treatment models.

reactions and conditions, CHs understand asthma and allergy as symptoms of something underlying. However, the GPs developed, on the basis of their clinical experience, a more multifactorial explanation of asthma and allergy.

Diagnostic approaches

GPs state that treatment for people with asthma begins with the disease history. The person is asked when it began, what situations it occurs in, how it feels, and how the person reacts to it. They are asked what helps and what worsens it, what diseases the person has had previously, what type of work the person does, and whether he/she smokes. It is also clarified whether there are any similar conditions in the family. Next, the heart, lungs and blood pressure are examined. Lung function is measured before and after airways-expand-

ing medication. However, asthma is also diagnosed by testing certain types of medicine—the effect of a medicine might help to determine the diagnosis. It is entirely not necessary that a diagnosis made before treatment is initiated. It can be said that working hypotheses or assumptions can be disproved or confirmed by the effect of medicine. Allergy can be diagnosed by tests, for example, a prick test for common allergens, or a blood test. The GPs with more clinical experience become less diagnosis-oriented and more patient-oriented.

It is misleading to call the CHs' method of revealing the patient's problem a diagnosis, the identification of a disease. A more suitable term would be a 'problem-uncovering'. The CH starts with a 2-h interview, at the same time, observing the person. The interview and observation have the purpose of getting a general picture of the person's physical, emotional and mental

condition, and on the basis of this to find the homeopathic medicine that corresponds to this symptom-picture. The person is encouraged to discuss what is particular and individual, and about what is experienced as limiting to their self-realization.

It is not the asthma or allergy that determines which homeopathic medicine is chosen, but the person's overall symptom or reaction pattern. The purpose of the interview is to identify the homeopathic medicine and not the disease. It can be said that every person constitutionally is one or another remedy. As one CH said:

'For a homeopath the diagnosis is the remedy the person needs. It is the way we as practitioners use diagnosis. In other words, that my diagnosis is, that Bertil is *Lycopodium*. His diagnosis is *Lycopodium*. It could be that he comes in and says, you have to help me with my asthma, but his diagnosis, in the homeopathic sense, is *Lycopodium*.'

For a CH a symptom is anything that is freedom-depriving. An objective, demonstrable disease is not attributed importance unless the person experiences it as freedom-depriving. The CH cannot use the conventional diagnosis as the starting point in his choice of homeopathic medicine, as the diagnosis merely decides what the patient has in common with other patients with the same diagnosis. As a CH described it, the conventional diagnosis tells about part of a person, and since CHs treat *whole* people, the treatment cannot be determined on this basis. However, in practice, the conventional diagnosis is used. By knowing the diagnosis the CH delimits what is general about the person's reactions and what is unique. The general is excluded and the unique retained, since it is the person's unique reactions that the CHs will use to determine the homeopathic medicine.

Differences and similarities between the GPs and the CHs diagnostic approaches

While GPs base the diagnosis on the patient's disease history, technical measures and tests or response to a medicine, CHs look for the patient's unique reactions, basing the choice of homeopathic medicine on the individual patient's characteristics, the patient's own account, and the CH's observations.

While GPs do not have experience with the CHs' diagnostic approaches, the CHs do have experience of conventional diagnosis to delimit what is common and what is unique in a particular case. The common is excluded, the unique retained in connection with the choice of the homeopathic medicine. This is opposite to the GPs, where the common is decisive for the choice of drugs. The CHs also employ the conventional diagnosis to exclude life-threatening illness. By knowing the conventional diagnosis and treatment, the CH can distinguish between symptoms due to the medicine and reactions that express the person's constitution. It

is the experience of CHs that different people with the same diagnosis may require different homeopathic medicines.

Treatment

Both GPs and CHs understand their treatment as individualized. The GPs in this project chose not to work in hospitals to get away from the standardized treatment they experienced as dominating hospital treatment. The GPs indicate that more individualized treatment requires more experience than standardized treatment. For the CHs a constitutional treatment is always individual.

Both the GPs and the CHs prescribe medicine but based on different treatment principles and of completely different type. For the GPs the purpose of medical treatment is to neutralize or curb the symptoms directly. A GP expressed it in this way:

'The medicine is designed to be destructive (breaking down) in its nature and not constructive (building up). Here, the GP must supplement medical treatment with suggested behavioural changes. The treatment with medicine is aimed exclusively towards the symptom.'

CHs distinguish between acute and constitutional conditions. But in both cases the homeopathic medicine is given to initiate a curative process indirectly and aimed at the person, not the symptoms. In an acute case the medicine is given to strengthen the person's ability to fight the condition, in a constitutional to rectify an imbalance. The purpose of the homeopathic treatment is to strengthen the person to be able to cope with the disease, the medicine mobilizes intrinsic physical, psychological and mental resources. Importance is also attributed to the interview here, but it is not looked at as a sufficient factor for the initiation of recovery. It is essential for the CHs that the person is helped to understand the connection between lifestyle and health, and to observe himself. The CHs said that people with hay fever ideally should be treated outside the pollen season so that they have at least 6 months, when they are not burdened by allergens, to strengthen the organism.

Differences and similarities between the GPs and the CHs in their choice of treatment

GPs and the CHs agree on helping the patient in her personal situation and on taking as a starting point the patient's wishes and goals for the treatment. While the CHs focus on finding the right homeopathic medicine, the GPs search "outside of" medicine in an attempt to find other options to help the patient.

Expected effects of treatment

The GPs took the view that medical treatment makes people more capable of functioning and can be life prolonging and life-enhancing, but it often makes

people dependent on medicine. The GPs' experience is that they can treat symptoms so that physical inconveniences to a great extent disappear. But medical treatment cannot cure the disease. An essential aspect is that the patient feels better—a subjective improvement has occurred. Objective improvement is not sufficient to say whether or not the treatment has worked. Likewise in allergy the medicine can curb some troublesome symptoms and make it possible for the person to function normally. When the GP prescribes it is because he believes that it can protect the lung tissue in the long term.

The CHs understand treatment effects in terms of 'curative laws'. Treatment is monitored on this basis. On the basis of 'Hering's Law' it is assumed that if during treatment the symptoms move from inside and outward, from a more vital organ to a less vital organ (for example, from the lungs to the skin, from the mental and psychological level to the physical level), if the symptoms move from above and downward (from head to legs), or if they move backwards in the disease history, it is an indication that a curative process has started and that the correct homeopathic medicine has been chosen.

The optimal course of effects is for the symptoms to simply melt away. As a CH put it:

'... when one gets the right homeopathic remedy, it is an enormous dynamic influence, it activates the vital force, then it begins to oscillate and clear up and blossom.'

The CHs experience is that, in order to set a curative process into motion, it is important that the person begins homeopathic treatment before he has been in conventional medical, symptom-oriented treatment. It is possible to treat people who are in conventional medical treatment, but it often takes longer. The person's reactions and symptoms are blurred, and this makes the choice of homeopathic medicine more difficult.

Adverse reactions

Medicines often cause adverse reactions. As a GP expressed it:

'If it has an effect, it also produces an adverse reaction.'

Adverse reactions are defined as unwanted effects of the medicine. They can be classified as adverse reactions that are due to the medicine's effect, such as asthma drugs causing palpitations. The adverse reaction is, so to speak, built into the drug and, therefore, expected. There are also adverse reactions that cannot be said to be a part of the medicine's effect, but nevertheless result from it. Experienced and anticipated adverse reactions are important to GPs. Patients seek information on the Internet and elsewhere, and GPs are aware that a symptom can be an adverse reaction or a 'real' symptom:

'If people come in with no matter what symptom, then I always ask, are you taking any medicine? Because there are in fact no limits for the adverse reactions something can have.'

The GPs understand adverse reactions broadly:

'I am against all inhaled steroids—both environmental and ecologic, in the world we now live in. (...) It is the easy solution for (us) doctors, (...) you have not got behind the reason for the asthma..'

What counts as 'tolerable' or acceptable adverse reactions, according to the GPs, must be understood on the basis of the patient's self-concept and attitude toward life. The GPs stated that taking medicine might make some patients worse than they were. GPs do not always know how the medicine will work. As one GP said, it can be hard to anticipate how the chosen medicine interacts with others:

'If there is anything I think is very hard as a doctor, it is if people are taking five, six or seven things to anticipate what will happen when they take the extra type of medicine. It is almost incalculable. I know what is said about the one preparation, but I cannot anticipate what happens when they blend all the pills together.'

According to the CHs we interviewed, there are no adverse reactions to homeopathic medicines, if the patient gets the right homeopathic medicine and in the right dilution. However, reactions can occur. Seven out of ten patients will experience a so-called 'aggravation' after ingestion of a homeopathic medicine—a short-lived worsening or fresh outbreak of some of their symptoms.

Differences and similarities between the GPs and the CHs in expected effect

The GPs and the CHs represent two very differing social constructions of expected effects. Whereas the GP may use the effect of a drug to confirm a diagnosis, the CH seeks to confirm whether a curative process has been initiated. For the GPs it is central that the drug works directly on the asthma and allergy symptoms. The drug is given for a symptom and should have a specific effect on the symptom. CHs assume that homeopathic medicines work indirectly. There is also a difference in the type of effect which GPs and CHs aim to achieve. CHs aim at cure. GPs aim at function and symptoms. As the GPs see it, however, it often becomes harder to keep symptoms at bay as time passes, and they are very aware of the risk of drug dependence.

A dilemma the GPs expressed is that drugs can cause adverse reactions. In contrast, the CHs assume that homeopathy does not cause adverse reactions, provided it is the right homeopathic medicine and in the right potency. But homeopathic medicine can cause reactions such as 'aggravations'. This is seen

by the CHs as a sign that the curative process has begun, and that the vital force, has been activated.

To what extent does a logical connection exist among the components in the GPs and CHs treatment models?

The treatment models of GPs and CHs can be differentiated in that there apparently is not in all cases a connection between the understanding of asthma and allergy and treatment in the GPs' treatment model, while such a connection is reflected in the CHs' model.

The GPs in this project have a multifactorial understanding of asthma and allergy, but it is not fully consistent with the treatment methods they use. For instance a GP may understand the disease as more than the manifested symptoms, but still choose to treat the physical symptoms and not a possible underlying cause. This lack of connection is acknowledged by the GPs. Some are frustrated by this and try, either themselves or by referral to other therapists, to treat several aspects of the person. Other GPs state they know they are only treating part of the problem, but maintain that it is the conditions they work under that hinder them from treating it otherwise.

There is a more direct connection between the CHs' theory of health and disease and their treatment, as the homeopathic medicine is given in order to initiate a curative process. The CHs learn that disease is due to a disturbed vital force, and therefore, the treatment intends to rectify the disturbance; not its consequences (symptoms). The CHs monitor the effects of treatment based on Hering's Law and miasm theory.

Conclusion and discussion

In Figure 2 we summarize the GPs' and the CHs' descriptions of the components of their treatment models related to patients with asthma and allergy.

What are the differences and similarities between the GPs and the CHs treatment models?

Differences

The differences between the components of the GPs and CHs treatment models indicate that we are dealing with very different understandings of asthma and allergy and treatment. The different discourses do not just represent different understandings of diseases and treatment, they also construct or 'constitute' them and position people in different ways as social subjects (eg as doctors, as alternative therapist or as patients) and further constitute the social relations between them.³¹ Seen from this perspective investigation and reflections on different treatment models is an important aspect of bridge building.

The main difference is in the description of the purpose of treatment. For the GP the purpose of medical treatment is to neutralize or curb the symptoms directly. The medicine is understood as designed to be destructive (breaking down) in nature and not constructive (building up). The purpose of homeopathic treatment is to set a recovery process into motion by stimulating the person's self-healing powers or vital force. The CH seeks to support and strengthen the organism's own innate, constructive way of making itself healthy. A prerequisite for stimulating life forces is finding the right homeopathic medicine. The challenge for CHs is to find the right medicine. This has a double meaning. It is not certain that the CH is able to find the right homeopathic medicine for the specific patient, or that the homeopathic medicine has yet been discovered.

Similarities

We found similarities in the way GPs and CHs think. On the basis of clinical experience we found GPs moving from a focus on asthma and allergy as symptoms to a focus on 'something underlying'. But the GPs didn't have useful diagnostic approaches to the underlying problem, nor relevant treatment options. To capture this 'something underlying' the CHs use the concepts 'underlying imbalances' or 'a disturbed vital force (life force)'. The GPs consider a successful treatment as one which optimizes the person's life possibilities; the CHs consider a successful treatment as one that gives the person more freedom. Both GPs and CHs perceive treatment effects to be dependent on contextual conditions linked to the person's life situation and ability to learn and make changes related to psychosocial issues. For both GPs and the CHs treatment effects cannot be reduced to the treatment technique (drug or homeopathic medicine). It is important to activate and build up the person. Therefore the dialogue with the person is important for both the GPs and the CHs.

Emphasis on the subjective dimension in assessing improvement or cure is important for both GPs and CHs. An objective improvement is not sufficient to say whether or not a treatment is effective. We find this interesting because it indicates that treatment effects cannot be completely isolated, a prerequisite for RCTs.

We believe the similarities and differences described above in GPs' and CHs' treatment models to have potential for bridge building activity. The conceptualization of these models is the first phase of a research project analysing prerequisites for bridge building between conventional and alternative therapists. Discourse theories³¹ and social oriented learning theories,^{32,33} applied to differences in treatment models hold great potential for learning and for new forms of integrative care to develop. It is a fundamental theoretical premise of our research project that the different treatment models are socially constructed and capable of change.

To what extent does a logical connection exist among the components in the GPs and CHs treatment models?

The treatment models of GPs and CHs differ in that there apparently is not always a logical connection between the understanding of asthma and allergy and treatment options in the GPs' model, while such a connection is reflected in the CHs model. The GPs' awareness of this lack of a logical connection indicates openness to new understandings of disease and treatment to be applied individually or in cooperation with CHs. Cooperation that could lead to a boundary-crossing understanding of asthma and allergy, but also to new ways of treating the disease.

GPs and CHs self-critical attitudes

GPs are far more self-reflective and self-critical than the CHs. This may reflect different interests in participating in the project. While the GPs motives for participating were primarily a desire to explore treatment to the extent it is rational, and an openness and curiosity in finding treatments that can work better for their patients, the CHs participated primarily to initiate co-operation with GPs. Reflective and self-critical attitudes on both sides are essential for bridge-building.

Are the results of the investigation valid and transferable?

We conducted internal validation of the results both in relation to the individual interviews with GPs and CHs, and in relation to the analysis. All therapists read and evaluated the reports on their treatment models, and had the opportunity to offer corrections and changes. It is very clear that self-selection occurred in recruitment of GPs for the project. The GPs who participated in this project are motivated to enter into dialogue with CHs, and critical toward the treatment effects they can achieve with drugs. We conclude that the transferability of the findings is limited. The CHs are representative of CHs educated at The School for Classic Homeopathy in Denmark, and who have more than 2 years of clinical experience with treatment of patients with asthma and allergy.

The next phase of the research project

The next phase of the research projects include therapist-researcher seminars conducted with participation of GPs, CHs and researchers. The intention is to create a forum for exchange of experience between therapists who practice with different models. We also wish to understand therapists' attitudes towards bridge building between conventional and alternative health care. The description of the different treatment models created the basis for a constructive dialogue and for the development of a questionnaire and interview guide for qualitative interviews with users of GP's and CH's treatments.

Acknowledgments

We thank the general practitioners and classical homeopaths who participated in the project, and the Aase and Ejnar Danielsen's Fund and IMK General Fund for economic support for the project. Lee Bellows translated parts of the manuscript. The article is based on a working report in Danish written by Charlotte Grum (www.cbis.dk).

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