Patients' motives for choosing a physician: comparison between conventional and complementary medicine in Swiss primary care

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Abstract

Background: The study is part of a nationwide evaluation of complementary and alternative medicine (CAM) in primary care in Switzerland. The objective was to identify patients' expectations and reasons governing the choice of complementary medicine compared with conventional primary care (CONV).

Methods: The data were derived from the PEK study (Programm Evaluation Komplementärmedizin), which was conducted in 2002–2003 with 7879 adult patients and parents of 1291 underage patients, seeking either complementary (CAM) or conventional (CONV) primary care. The study was performed as a cross-sectional survey. The respondents were asked to document their (or their children's) self-perceived health status, reasons governing their choice, and treatment expectations. Physicians were practicing conventional medicine and/or complementary methods (homeopathy, anthroposophic medicine, neural therapy, and traditional Chinese medicine). Reasons governing the choice of physician were evaluated on the basis of a three-part classification (physician-related, procedure-related, and pragmatic/other reasons).

Results and Discussion: Patients seeing CAM physicians tend to be younger and more often female. CAM patients referred to procedure-related reasons more frequently, whereas pragmatic reasons dominated among CONV patients. CAM respondents expected fewer adverse side effects compared to conventional care patients.

Conclusion: The majority of alternative medicine users appear to have chosen CAM mainly because they wish to undergo a certain procedure; additional reasons include desire for more comprehensive treatment, and expectation of fewer side-effects.

Background

Interest in and utilization of complementary and alternative medicine continue to grow in developing countries, including the USA [1-4]. Understanding the attractiveness of CAM is therefore crucial for providing better service in primary health care. The reasons of choice of patients for complementary medicine are based on both rational and emotional factors [5]. On one hand, those dissatisfied with orthodox medical treatment (who tend to cite impersonal service, low cost efficiency or general mistrust) turn to alternative medicine [1]. Others, in contrast, do not express such disappointment, but rather view CAM as supplementary measures in order to achieve the best possible results for their health [6].
The growing popularity of CAM methods might be explained by postmaterialistic trends that place individual perspectives ahead of scientific rationalism, and holistic interpretative models of health and disease, the "new age" values\[7\], which contradict conventional biomedical concepts and embrace a holistic approach based on a bio-psycho-social model. Though it is not possible to describe all users of CAM as a sole homogeneous group\[8\], the reasons to chose CAM may be influenced by socio-ethnic attributes of populations and/or the nature of disease \[9-11\]. For instance, some Swiss studies show that there were more often female, with higher education, from upper middle class and aged between 30 and 50 among the CAM-users\[6,12\]. This group generally tends to have less children, thus it remains unclear whether the subgroup of parents of underage patients would match the profile of a typical Swiss CAM-user in terms of choice of treatment. However, motives and reasons to choose a particular physician may affect the extent of utilization of health related resources That is why we have chosen to examine whether the preferences of both adult patients and parents acting on behalf of minors differ with respect to complementary or conventional medicine Following a political discussion, the Swiss Federal Department of Home Affairs decided in 1998 to add five methods of complementary medicine to the benefit package of basic health insurance for a period of five years. The methods included homeopathy, anthroposophic medicine, neural therapy, herbal medicine, and traditional Chinese herbal medicine. Because of the provisional status of coverage for CAM procedures in the health plans, a nationwide evaluation of CAM including several studies was performed \[13\]. As part of this evaluation, our study focused on the individual reasons and motives, and main health problems for seeking complementary and conventional care. We also examined whether the preferences of adult patients and parents acting on behalf of minors differ with respect to complementary or conventional medicine.

Methods

Design

Participating CAM physicians were selected from membership lists of societies for complementary medicine (Swiss medical associations for homeopathy, anthroposophic medicine, neural therapy, and traditional Chinese medicine) were obtained, and all CAM-certified physicians working as primary care physicians were asked to participate in the project. A list of all primary care providers (i.e. GPs, general internists) in Switzerland was additionally obtained from the Swiss Medical Association (FMH), from which a random sample of primary care providers not certified in any CAM discipline was selected and asked to participate. It was assumed that these physicians were less motivated to participate in the project. Therefore 1.5 times more non-CAM-certified physicians were sampled. This sample was proportionally matched to the regional distribution of physicians certified in complementary medicine.

The eligibility criteria for participating physicians required training and license to practice as a medical doctor in conventional medicine, medical activity in primary care for at least two days per week, and having at least five documented consultations within the study. For practitioners in alternative medicine, an additional qualification (recognized by the Swiss Medical Association, FMH) in one or more specific CAM disciplines was required. Physicians performing CAM procedures without a corresponding certification were excluded from the study. Physicians were therefore classified into two categories based on their own declaration about their use of CAM and on the legal framework of reimbursing complementary medical services in primary care during the time of the study:

- Providers of conventional primary care only (CONV group)
- Providers of both conventional and complementary care, with additional professional certification in CAM (CAM group)

As for the patients, there were two inclusion criteria: willingness to participate, and ability to read and write in German, French, or Italian. Patients within the CONV and the CAM group respectively were further classified into two sub-groups:

- Adult patients over 16 years of age
- Minor patients (children) under 16 years of age, whose parents responded to the survey

Additional information about the scope and design of the entire project can be found in the final project report and other related publications \[12-16\].

Data collection

Physicians and their staff were instructed to sample all patients attending their practices on each of four given days during a 12-month period in 2002/03. Patients were asked to fill out a questionnaire prior to their consultation in a waiting room. Questions related to their socio-demographic characteristics, duration and severity of complaints, general health status, expectations, and motives for choosing a particular physician. Motives were recorded as free-text entries in a single text field. A preliminary analysis of a sub sample the data was performed in order to reduce dimensionality and to identify basic reasons and motives choice. This process was achieved inductively and yielded 22 basic reasons for choosing a particular physi-
cian, i.e. categorization was allowed to emerge from the data (figure 1). In the case of multiple disjunctive entries the first entry was selected. This classification scheme was then used to record the data in the database For interpretation and statistical analysis, these basic reasons were then further reduced into three broad categories, denoted as physician-related (competence, trustfulness of GP, etc.), procedure-related (holistic treatment, specific procedure desired, dissatisfaction with conventional medicine, etc.), or pragmatic (attachment according to family practitioner model, preventive medical check-up, geographic proximity, etc.). Reduction of dimensionality and classification of data was performed by a research group consisting of multiple physicians, a social scientist and an epidemiologist. Most text entries of the patients were equal or very similar in their wording, however, in case of uncertainty, classification was achieved after reaching consensus within the research group.

Physicians were asked to document the same consultations with reference to type of consultation, general health, severity and duration of symptoms of their patients.

All questionnaires were developed in close cooperation with an external and interdisciplinary group that included experts in conventional and complementary medicine.

Based on demographical data provided by the FMH and Santésuisse (the association of the Swiss health insurances) our data could be validated with reference to geographical distribution of practices and age and gender of patients. The ethics committee of the Canton Bern raised no objection to the study.

**Data management and data analysis**

Data were recorded using a relational database. The free-text answers related to patients’ main health problems were coded according to the main chapters of ICD-10.

**Figure 1**
Choice of physician.
Coding was performed by two physicians and one pharmacist. Data analysis was performed with chi-square tests and multivariate regression procedures. All analytical procedures accounted for non-independence of observations at the practice level using Taylor series expansion procedures; 95% confidence intervals (95% CI) of means and proportions were calculated accordingly. The level of significance was set at \( p < 0.05 \) throughout the study.

**Results**

**Study physicians**

262 physicians who responded met the selection criteria and were included in the study, representing 4.3% of all Swiss primary care providers in 2002. 78 physicians (30%) were practicing conventional medicine solely (CONV) and 184 physicians (70%) were certified either in one of the alternative methods (homeopathy, 42%; anthroposophic medicine, 9%; neural therapy, 7%; traditional Chinese medicine, 20%) or had multiple CAM certificates. Among practitioners documenting five or more patients, the average number of patients registered per physician during the sampling period was 33 for CONV and 36 for CAM.

**Socio-demographic attributes of patients**

Table 1 summarizes socio-demographic data of all participating patients (\( N = 9170 \)). Almost one-third of all patients consulted a conventional physician, whereas two-thirds consulted a complementary physician. There were nearly six times more adults as children in the sample. The average age was slightly lower in the CAM group compared to CONV (adults: 49 and 51 years; children: 7 and 11 years, respectively). The proportion of female patients overall and of women over 16 years was significantly higher in the CAM group, whereas the percentage of girls was significantly lower in the CAM group.

**Health status of patients**

There was no significant difference in the self-perceived health status between the CONV and CAM group both among children and adult patients (results not shown).

The proportion of severe health conditions (physician-rated) was significantly higher in the CAM group for both children and adult patients (table 2). In a gender- and age-adjusted logistic regression model the proportion of chronic conditions (duration > 3 months) was found to be significantly higher in the CAM group for all patients (table 2).

Significant differences between CAM and CONV physicians were also found with reference to the type of consultations: As many as 7% of consultations were classified as emergencies by CAM physicians vs. 11% in CONV, and 6% of consultations with CAM physicians were related to accidents vs. 8% in CONV.

**Main health problems patients attended their physicians for (based on patient data)**

The majority of adult CAM patients visited a physician for musculoskeletal (25%, most notably back pain), respiratory (10%, acute upper respiratory tract infection, asthma, chronic sinusitis, bronchitis, and allergic rhinopathy), nervous system (10%, migraine, multiple sclerosis, and sleep disorders) or mental and behavioural problems (9%, most frequently depression). The details are shown in figure 2.

In CONV patients musculoskeletal problems (22%) were also most common, followed by the diseases of the circulatory (13%) and then respiratory (10%) systems.

Figure 3 shows the main reasons for consultations for parents seeking care for their children. Respiratory problems

### Table 1: Socio-demographic characteristics of patients (\( N = 9170 \))

<table>
<thead>
<tr>
<th>Physicians</th>
<th>CONV (( N = 2575 ))</th>
<th>CAM (( N = 6595 ))</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>78 30 95% CI 184 70</td>
<td>118 9 1173 91</td>
</tr>
<tr>
<td>Children (( N = 1291 ))</td>
<td>118 9 1173 91</td>
<td>5422 69</td>
</tr>
<tr>
<td>Adults* (( N = 7879 ))</td>
<td>2457 31 5422 69</td>
<td>All 57 28 6595 72</td>
</tr>
<tr>
<td>All</td>
<td>2575 28 6595 72</td>
<td>6595 72</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proportion of female, patients</th>
<th>CONV (( N = 2575 ))</th>
<th>CAM (( N = 6595 ))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children**</td>
<td>72 61 52–70 537 46 43–48</td>
<td></td>
</tr>
<tr>
<td>Adults***</td>
<td>1405 57 54–60 3866 71 70–73</td>
<td></td>
</tr>
<tr>
<td>All**</td>
<td>1477 57 54–61 4403 67 65–68</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mean age, patients</th>
<th>CONV (( N = 2575 ))</th>
<th>CAM (( N = 6595 ))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>11 years 7 years</td>
<td></td>
</tr>
<tr>
<td>Adults</td>
<td>51 years 49 years</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>49 years 41 years</td>
<td></td>
</tr>
</tbody>
</table>

**>16 years old**
were the leading issue among children. There was little difference between CAM (27%) and CONV (29%) groups. Significant differences in favour of complementary medicine were detected for diseases of the skin – (CAM 13%, CONV 2%; principally dermatitis) and mental and behavioural disorders (CAM 8%, CONV 2%; ADHD, followed by personality disorders, behavioural disorders and anxiety disorders:).

**Patients reasons for choice and expectations**

Patients and parents cited 22 basic reasons for physician visits (figure 1), which fell into three broad categories, denoted as physician-related (competence, trustfulness of GP, etc.), procedure-related (holistic treatment, specific procedure desired, dissatisfaction with conventional medicine, etc.), or pragmatic (preventive medical check-up, geographic proximity, etc.).

![Figure 2](http://www.biomedcentral.com/1472-6882/7/41)

**Main health reasons adults attended their physicians for.**

### Table 2: Patient population: general health status (physician-rated)

<table>
<thead>
<tr>
<th></th>
<th>CONV</th>
<th></th>
<th></th>
<th>CAM</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>95% CI</td>
<td>#</td>
<td>%</td>
<td>95% CI</td>
</tr>
<tr>
<td>General health (physician rated)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>19</td>
<td>16</td>
<td>13–29</td>
<td>415</td>
<td>35</td>
<td>41–51</td>
</tr>
<tr>
<td>Adults</td>
<td>1067</td>
<td>43</td>
<td>52–58</td>
<td>3135</td>
<td>58</td>
<td>67–73</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>1086</td>
<td>42</td>
<td>50–57</td>
<td>3550</td>
<td>54</td>
<td>63–69</td>
</tr>
<tr>
<td>proportion of chronic conditions**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>11</td>
<td>9</td>
<td>5–15</td>
<td>189</td>
<td>16</td>
<td>16–22</td>
</tr>
<tr>
<td>Adults</td>
<td>476</td>
<td>19</td>
<td>19–24</td>
<td>1376</td>
<td>25</td>
<td>25–29</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>487</td>
<td>19</td>
<td>19–24</td>
<td>1565</td>
<td>24</td>
<td>24–27</td>
</tr>
<tr>
<td>proportion of severe conditions**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>11</td>
<td>9</td>
<td>5–15</td>
<td>189</td>
<td>16</td>
<td>16–22</td>
</tr>
<tr>
<td>Adults</td>
<td>476</td>
<td>19</td>
<td>19–24</td>
<td>1376</td>
<td>25</td>
<td>25–29</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>487</td>
<td>19</td>
<td>19–24</td>
<td>1565</td>
<td>24</td>
<td>24–27</td>
</tr>
</tbody>
</table>

**Significant difference (p < 0.05) between CONV and CAM groups (age and gender adjusted analysis)**
Adult CAM patients gave the following reasons for choosing their complementary physician: relying upon recommendations of their family and friends, desire for specific procedures, holistic treatment, mild treatment, or dissatisfaction with conventional medicine. CAM patients significantly more frequently cited a preference for certain procedures, whereas physician-related and pragmatic reasons were more often mentioned among CONV-patients (table 3). Significantly more CAM patients expected healing, alleviation, mild treatment, fewer side-effects and/or lower costs. The largest difference was found with respect to adverse treatment effects: CAM patients and parents expected them less often (table 4).

Children were treated by complementary physicians most often because a specific procedure was desired by their parents, followed by the parents’ belief and trust in the competence of the physician, and by their preference for a comprehensive treatment. About one-third of the parents made their choice due to physician-related reasons (in both groups, table 3). Considerable differences between groups were found with regard to procedure-related and pragmatic reasons. While 46% of parents in the CAM group chose their physicians on the basis of procedure-related grounds, none did so in the CONV group. CONV patients more often cited pragmatic reasons (66%).

**Discussion**

**Sample characteristics**

Socio-demographic variables and current health status of patients distinguished CAM users and non-users [12]. Though several authors[7,17] argued that neither sex nor age predicted CAM use, we found a significantly higher percentage of women in among the CAM group, which is in accord with the U.S[18,19]. In our sample, CAM patients were younger (in both children and adult groups). One of the most surprising results was that in spite of a significantly higher proportion of chronic and/or severe conditions among CAM users (consistent with [19], no significant differences in the patients self-perceived health status were found (in contrast to results of [8,19,20]).

**Patients’ reasons for choice of physician and expectations**

Substantial difference between two groups was found in terms of procedure-related motives. CAM patients stated that a preference for a specific procedure, desire of a comprehensive/mild treatment, and their personal conviction were of great importance to them. At the same time, very few CONV patients mentioned those reasons.

Twice as many CAM patients (compared to CONV) chose their practitioner because of recommendations. Parents’
reasons for choices on behalf of their children were similar to those of adult patients.

There are currently three main reasons explaining patients' choice of alternative medicine[7].

1. Dissatisfaction with orthodox medicine: necessity to treat conditions unresponsive to conventional treatments and/or negative past experiences with conventional medical services. This theory implies that people are choosing alternative health care for expedient reasons: CAM methods are perceived not only as effective, but also as milder and causing less adverse side-effects [1,17,21].

2. Determination for more personal involvement in the healing process in order to keep control over own health care decisions. This may result not only in sole preference for CAM, but also in a choosing of combined use of CAM and CONV methods [7,22].

3. Philosophical compatibility: CAM therapies are attractive because they are perceived as more congruent with patients' spiritual/religious values, beliefs or philosophy regarding the nature and meaning of health and illness [23-25].

The first theory does not account for all patient choices but plays a certain role along with the other two [26]. The latter two are not related to clinical success and are often associated with globalization, and include more sophisticated consumer choice and increased competition among health care providers. Such competition leads, in turn, first to a power shift from provider to consumer, and then to commercialization of values and tradition [26]. This raises a question: should the application of public funds be directed by consumer demand? The population of CAM patients apparently uses health care resources more frequently [27] and in a more diverse way [12,17] and it cannot be excluded that this behaviour is related to the

Table 4: Patients expectations

<table>
<thead>
<tr>
<th>Expectations (patient-rated)</th>
<th>CONV</th>
<th></th>
<th></th>
<th>CAM</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>95% CI</td>
<td>#</td>
<td>%</td>
<td>95% CI</td>
</tr>
<tr>
<td>Healing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>71</td>
<td>60</td>
<td>51–69</td>
<td>853</td>
<td>73</td>
<td>70–75</td>
</tr>
<tr>
<td>Adults</td>
<td>1248</td>
<td>53</td>
<td>50–55</td>
<td>3112</td>
<td>57</td>
<td>56–59</td>
</tr>
<tr>
<td>All*</td>
<td>1369</td>
<td>53</td>
<td>51–56</td>
<td>3965</td>
<td>60</td>
<td>58–62</td>
</tr>
<tr>
<td>Symptom alleviation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
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<td>16–30</td>
<td>357</td>
<td>30</td>
<td>27–33</td>
</tr>
<tr>
<td>Adults</td>
<td>984</td>
<td>40</td>
<td>37–43</td>
<td>2420</td>
<td>45</td>
<td>43–47</td>
</tr>
<tr>
<td>All*</td>
<td>1011</td>
<td>40</td>
<td>36–42</td>
<td>2777</td>
<td>42</td>
<td>40–44</td>
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<td>Milder treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>13</td>
<td>11</td>
<td>5–17</td>
<td>177</td>
<td>15</td>
<td>13–17</td>
</tr>
<tr>
<td>Adults</td>
<td>112</td>
<td>5</td>
<td>3–6</td>
<td>487</td>
<td>9</td>
<td>8–10</td>
</tr>
<tr>
<td>All*</td>
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<td>5</td>
<td>4–6</td>
<td>664</td>
<td>10</td>
<td>9–11</td>
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<tr>
<td>Fewer adverse side-effects</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>9</td>
<td>8</td>
<td>2–13</td>
<td>280</td>
<td>24</td>
<td>21–27</td>
</tr>
<tr>
<td>Adults</td>
<td>212</td>
<td>8</td>
<td>7–10</td>
<td>1221</td>
<td>23</td>
<td>21–24</td>
</tr>
<tr>
<td>All*</td>
<td>221</td>
<td>9</td>
<td>7–10</td>
<td>1501</td>
<td>23</td>
<td>21–24</td>
</tr>
<tr>
<td>Lower costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>0</td>
<td>4</td>
<td>3–5</td>
<td>50</td>
<td>4</td>
<td>3–5</td>
</tr>
<tr>
<td>Adults</td>
<td>34</td>
<td>1.4</td>
<td>0.7–2</td>
<td>257</td>
<td>5</td>
<td>4–5</td>
</tr>
<tr>
<td>All*</td>
<td>34</td>
<td>1.3</td>
<td>0.7–2</td>
<td>307</td>
<td>5</td>
<td>4–5</td>
</tr>
</tbody>
</table>

* Significant difference (p < 0.05) between CONV and CAM groups (bivariate analysis)
was evaluated as an undifferentiated whole; no attempt
diversity of views and motivations of patients, which may
few coding categories. Such categories may not reflect the
analysis the broad variety of motivation was reduced to a
motivation, and due to the requirements of statistical
deep assessment of absolutely all aspects of the patients
of research. The questionnaires did not allow for an in-
tutive medicine in Switzerland, and therefore may suffer
This analysis is only one part of a larger study of alterna-
ture in this context refer to the fact that only CAM proce-
dures provided by certified physicians were included in
the study. However, the evaluation of CAM provided by
other care providers or self-care CAM or CAM was not in
the scope of the main project.
Low response was a problem in this study as physicians
perceived the entire project as a government project[15],
which led to some reservations to participate. A formal
evaluation of the proportion of participating physicians
could not be performed due to the fact the proportion of
physicians providing CAM procedures without corre-
sponding certification was not known prior to the study.
It is therefore also not possible to calculate the sampling
fraction of physicians performing no CAM procedures at
all (CONV group). However, it can be assumed that the
motivation among participating physicians was different,
since CAM physicians were under pressure to demonstrate
effective methods – which was not the case for CONV
physicians. It can only be speculated that the motivation
of CONV physicians is more attributable to a general
interest in primary care research. In a strict sense, the
generalisability of our results is therefore reduced to physi-
cians with these distinct motivations.
Health insurer data, information of the Swiss medical
association and data from other recent studies in Swiss
primary care[16,33,34] were used to check our data for
potential biases. Based on this additional information, we
have no reason to consider our sample as well as our
results as biased with regard to geographical distribution
and gender of physicians and to health status of patients.
Nevertheless, this is the first study of its type in the coun-
try, with substantial sample size and sufficient time span.
That is why we are reasonably sure that the results accu-
ately describe the motivations CAM patients to consult a
primary care physician in Switzerland.

Conclusion
The study findings may serve to better the understanding
of patients’ needs in shaping future health care policies
and for promoting mutually beneficial integration of con-

fact that these patients have more often a specific proce-
dure in mind when they seek a physician.
The fact that CAM users less often cite pragmatic reasons
for seeing a physician may also be related to the observa-
tion that CAM physicians care for only a specific subset of
patients in primary care [28]; that is, they provide signific-
antly less emergency care and have fewer accident
patients, and less often make home visits – a pattern not
fully in line with the general definition of general practice/
family medicine [29]. Furthermore, other data within the
main project showed considerable differences between
physicians for the self declared extent of medical activity
in primary care where CONV physicians declared 77.4%
(median 90%) of their activity as primary care and CAM
physicians only 36.8% (39%)[14]. The observed differ-
ces in reasons of choosing a particular physician may
therefore not only be related to distinct differences in the
decision-making process of patients[12] but also to
attributes of physicians themselves.
From a health system perspective, however, our results
have several implications:

- There may be a downside to boundless shopping around
for physicians and procedures. There are inverse relation-
ships between patient empowerment and cost effective-
ness in health care [4]. Limiting the choice of patients in
managed care practices, for instance, is associated with
reduction of health care costs while quality of outcomes
are maintained [30,31]. It may be argued in this context,
that CAM provides more efficient care than CONV as
patient satisfaction in CAM is higher and cost appear to be
equal to CONV[13,14,32]. However, this gain of effi-
ciency may by compensated at system level by the fact that
CAM patients tend to utilize health related resources more
frequently than CONV patients[14].

- The obvious mismatch of defined and self-concept of
practice activity may adversely affect decisions on resource
allocation and reimbursement policy for CAM in primary
care.

Limitations and strengths
This analysis is only one part of a larger study of alterna-
tive medicine in Switzerland, and therefore may suffer
from several limitations and caveats common for this type
of research. The questionnaires did not allow for an in-
depth assessment of absolutely all aspects of the patients
motivation, and due to the requirements of statistical
analysis the broad variety of motivation was reduced to a
few coding categories. Such categories may not reflect the
diversity of views and motivations of patients, which may
be grounded in different philosophical traditions. CAM
was evaluated as an undifferentiated whole; no attempt
was made to distinguish between various types of alterna-
tive medicine practices (for example, motives of patients
attending a traditional Chinese medicine practitioner
could differ from those attending a homeopath). A further
problem in this context is related to the rationale of using
only the first entry in the questionnaire as the motive to
consult a specific physician. However, the text field in the
questionnaire provided only little room for handwritten
entries and multiple motives of consultations were conse-
quentially very rarely given by patients. It is therefore
unlikely that differences in patient’s motives between
groups were affected by this restriction. Additional limita-
tions in this context refer to the fact that only CAM proce-
dures provided by certified physicians were included in
the study. However, the evaluation of CAM provided by
other care providers or self-care CAM or CAM was not in
the scope of the main project.
ventional and complementary medicine. Growth of societal awareness and willingness to assume more control over personal health care decisions reflects an ongoing shift in the interrelationship between availability and utilisation of medical resources in populations with practically non-restricted access to health services. A substantial number of patients tend to choose their CAM practitioner out of a wish for a specific procedure (unrelated to clinical success). With all due respect to personal right to participate actively in the healing process, patient-centered medical practice is not reducible to mere fulfillment of every patients’ desire. Another crucial task of the care providers is to improve clinical success while keeping costs under control.

Competing interests
The author(s) declare that they have no competing interests.

Authors’ contributions
VW wrote the manuscript. AB conducted the study; he set up the database, performed all statistical analyses and reviewed and completed the manuscript. Both authors read and approved the final version of the manuscript.

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References
34. Künzi B: Swisspep Qualidoc®: A balanced score card to capture and extend the added values of general practice/family medicine Houten, NL: Bohn Stafleu van Loghum; 2004.

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