



Practicing Alternative Medicine in Israeli Hospitals

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Citation: Shuval JT (2018) Practicing Alternative Medicine in Israeli Hospitals. J Family Med Prim Care Open Acc 2: 119.
DOI: 10.29011/2688-7460.100019

Received Date: 05 July, 2018; **Accepted Date:** 23 July, 2018; **Published Date:** 01 August, 2018

Abstract

There is growing evidence that alternative health care practitioners and conventional physicians are working together in collaborative patterns. The paper examines these collaborative patterns in hospital settings in Israel. On the theoretical level the specific issues relate to theories concerning relationships between dominant institutional structures which enjoy the benefits of epistemological legitimacy as well as extensive, supportive social structures and groups of non-conformists who seek to attain many of the same goals by utilizing different methods based on other epistemologies. In the most general sense the issues involved concern processes of accommodation and social change.

In an effort to examine the dynamics of the processes involved, data were collected twice: In 2000-2001, in an extensive research undertaking when CAM was beginning to show its presence in hospital settings and again in 2015 when a more modest second round of supplementary research was undertaken in an effort to observe changes over time.

In 2000-2001 data were collected by means of semi-structured, qualitative interviews in four general hospitals in Jerusalem 19 persons were interviewed including 10 alternative practitioners working in a variety of fields and 9 conventional medical practitioners who worked with them (6 physicians and 3 nurses). Interviews focused on background and training, reasons for entry into the hospital, length of practice, status in the hospital system, mode of remuneration, content of work, modes of interaction with others in the hospital and problems encountered.

In 2015-2010 in-depth interviews were carried out with CAM practitioners and policy makers in the Israel Ministry of Health and in a variety of health care institutions. These interviews focused on the role and functions of CAM in Israeli hospitals over the intervening period. Observations were carried out in selected hospital settings. An in-depth literature search regarding research and policy statements on the role of CAM in Israeli hospitals during the intervening period provided an overview of empirical changes.

The paper discusses the early modes of entry into Israeli hospitals, the dilemmas faced and the mechanisms used to overcome barriers. The findings of the first wave of interviews suggest a dual process of simultaneous acceptance and marginalization of alternative practitioners. While small numbers of alternative practitioners were found to be practicing in a wide variety of hospital departments and in a broad spectrum of specialties, they were in no cases accepted as regular staff members and their marginality was made clear by a variety of visible structural, symbolic and geographical cues. Considerable increases in the number, activity and visible presence of alternative practitioners in the hospitals occurred by 2016. These are discussed along with the mechanisms utilized to expand their presence in Israeli hospitals.

Keywords: Alternative; Complementary Medicine; Integrated Practice; Hospitals; Israel; Bio-medicine

Introduction

In recent years, more and more people in Western societies seek alternative or complementary health care (CAM) even though they continue to use conventional medicine. So much so, that it seems useful to view CAM as an important component of the overall health care system. Before discussing the research findings and analysis, we will present some definitions of the central concepts considered in the paper.

We will use the term “Conventional Medicine” to refer to the commonly established form of Western medicine taught in most medical schools which exercises a dominant, often exclusive monopoly over legitimate medical care in many societies. Other names for this include allopathic, Western, and mainstream medicine.

Hospital medicine may be viewed as the ideological, epistemological and institutional core of conventional medicine. Within its structure, physicians exercise control from positions of power and determine policy on both a macro and micro level. Despite the increasingly invasive stance of third parties on the policy and financial levels, physicians maintain their professional autonomy and remain the critical decision makers on the immediate level of hospital practice [1]. They are therefore gatekeepers defining the boundaries of the medical domain with regard to the admission or non-admission of non-bio-medically trained personnel and practices.

With regard to alternative modes of health care, many physicians prefer to use the term “Complementary Medicine” to refer to unconventional modes of health care. This stance reflects a medico centric view which implies greater validity and centrality to conventional medical procedures and a lesser status to unconventional practices which “Complement” them. The term “Alternative” is viewed by some in the medical establishment as offensive and challenging to their exclusive hegemony. At the same time, many alternatives see their mode of practice as an alternative or enrichment to the arsenal of techniques and procedures of contemporary health care practice.

In order to avoid the pitfalls associated with both of these terms, we will use the term “CAM” (Complementary and Alternative Medicine) to refer to the combined array of non-conventional health practices commonly in use in Western societies.

The National Centre of Complementary and Alternative Medicine (NCCAM in the U.S.) defines CAM as “a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine” These have also been referred to as holistic, natural, unorthodox, fringe and unconventional [2].

The principal forms of CAM practiced in Israel include homeopathy, Chinese medicine, acupuncture, herbal medicine, reflexology, shiatsu, tai chi, chiropractic, biofeedback, hypnotism,

Ayurvedic medicine, yoga, naturotherapy, massage techniques, Bach flowers, Feldenkrais, anthroposophy, Dwina, osteopathy, Alexander technique, Paula and others. While this list is not comprehensive, these are the forms of CAM practice which have been incorporated into the clinics of the public medical care system and in many of the private clinics in Israel. Traditional forms of health care, which may also be viewed as a form of CAM, will not be considered in this paper.

There is as yet no formal licensing system regarding CAM practice in Israel. In 1988, the Israeli Minister of Health appointed a public committee to examine all aspects of “natural medicine,” including “homeopathy, acupuncture, reflexology, chiropractic, etc.” [3]. Although the committee submitted its report in 1991, to date, few of its recommendations have been implemented. The Israel Medical Association issued a number of public declarations during the following decade seeking to assert the unquestioned hegemony of conventional medicine.

The Ministry of Health, despite prolonged deliberations, has not been able to reach a formulation regarding licensing and regulation acceptable to the relevant interested parties, including the Israel Medical Association, CAM professional associations, the sick funds and others. This absence of regulation legitimizes the monopoly of the conventional medical system by denying access to medical practice by non-physicians.

The result has been that in Israel, the Doctors’ Ordinance of 1976 remains the sole jurisdictional mechanism through which CAM practice attains legitimacy. This ordinance provides that only licensed physicians may engage in medical care but that physicians may supervise the clinical work of unlicensed health care providers. It is the latter provision that provides legitimacy for CAM practice by non-physicians in Israel [4].

Increased Use of CAM

There are many reasons suggested in the literature for the growth of CAM since the 1980s in many countries, including Israel. We will refer to those most frequently cited [5-10].

Increased use of CAM has been explained by objections of consumers to the invasiveness and excessive use of technology of bio-medicine. Consumers are increasingly aware of iatrogenic effects of modern medicine and prefer to ingest fewer drugs. Many object to the traditional dominance of doctors often seen in the physician-patient relationship. In a period of hyper-differentiation in biomedicine, when it is practiced in large organizations where there is minimal attention to the individual and to her/his social and psychological needs, CAM offers a non-invasive, holistic alternative that is increasingly attractive to many, in particular to the better educated, more affluent segments of the population. There is more awareness among consumers of the relationship of lifestyle to morbidity especially when bio-medicine is unable to provide relief or cure. It has also been noted that in the post-modern period, with on-going globalization, there has been an overall decline in faith in the ability of science and technology to solve health problems. This is seen in the lesser acceptance of many types of authorities

including physicians as people seek increased control over their life and health. Globalization has been accompanied by increased migration of populations and the transmission of therapies and medical theories among different societies.

These factors have combined in Israel as in other nations, with demographic changes such as aging of populations which is accompanied by an increase in chronic health problems that are less responsive to the methods of biomedicine.

Goals

Our goal in this paper is to explore the relationships between conventional and alternative practitioners in Israeli hospitals in which these types of health care providers practice within the same institutional structure. The specific theoretical questions considered are the following: how are epistemological differences resolved in a context of medical dominance? How permeable are the boundaries between conventional-medicine and alternative practice? How can conventional medical practitioners work collaboratively with the 'unproved' techniques of alternative practitioners which-in most cases-have not been examined by controlled, evidence-based, quantifiable experiments? How do alternative practitioners fit into the social and geographical space of the clinic and hospital structures? What mechanisms or rituals of acceptance or rejection are visible in the practice settings? These questions guided our field work and analysis of the data collected.

Data Collection

Empirical data were gathered in Israel where this phenomenon has been systematically studied since 2000 [11-14]. In an effort to examine the dynamics of the processes involved, data were collected twice: In 2000-2001 when CAM was just beginning to show its presence in hospital settings and again in 2015 when a second round of supplementary research was undertaken in an effort to observe changes over time.

Our overall approach is phenomenological and seeks to understand the experiences and perceptions of individuals from their own perspectives by gaining insight into their motivations and behaviour [15-17].

This strategy dictated the use of semi-structured, in-depth interviews, focusing on the nature of providers' professional background, the decisions which led them to practice CAM and their strategies of handling epistemological and other dilemmas that arise in the course of their practice. These interviews along with on-going observation yielded detailed narratives from a variety of individuals working with hospitalized patients. These provided the empirical data through which we sought to understand the underlying social processes involved in these unique health-care situations [15,18,19].

In 2000-2001 data were collected by means of semi-structured, qualitative interviews in 4 general hospitals in Jerusalem. 19 persons were interviewed including 10 alternative practitioners working in a variety of fields and 9 conventional

medical practitioners who worked with them (6 physicians and 3 nurses).

Interviews focused on background and training, reasons for entry into the hospital, length of practice, status in the hospital system, mode of remuneration, content of work, modes of interaction with others in the hospital and problems encountered.

Subjects were chosen by theoretical sampling which assures that participants are drawn from a wide spread of contexts [20]. A second round of interviews was carried out in 2015 when 10 additional in-depth interviews were carried out with CAM practitioners and policy makers in the Israel Ministry of Health and in a variety of health care institutions. These interviews focused on the role and functions of CAM in Israeli hospitals over the intervening period. Observations were carried out in selected hospital settings. An in-depth literature search regarding research and policy statements on the role of CAM in Israeli hospitals during the intervening period provided an overview of empirical changes.

CAM in Bedside Care

The admission of CAM practitioners to hospital practice in Israeli hospitals has been a slow and laborious process. There is no formal policy structuring this phenomenon. It developed informally through personal contacts and networking rather than by formal decision making. Collegial and personal connections are the principal mechanisms and are multi-directional. A hospital physician may feel that patients would benefit from a CAM practitioner in the department and seek one out, personally checking on candidates' credentials and reputation. The direct connection of the hospital physician can be to a CAM practitioner based in that hospital's ambulatory CAM clinic or through colleagues and friends.

The reverse process also occurs when CAM practitioners take the initiative to approach a hospital physician in order to persuade her or him that a useful contribution to the work of their department could be made by a CAM practitioner.

When this process started toward the end of the 1980s, most senior doctors in positions of authority in Israeli hospitals looked askance at the idea of allowing CAM practitioners to work with hospitalized patients. Many expressed overt rejection of the idea. However, a variety of levels of acceptance or rejection can be found among physicians. In 2001, the director of a hospital department, when approached regarding the possibility of having a CAM practitioner in his department, said, "Over my dead body." Ten years later, acceptance of CAM had increased considerably.

Efforts to bring CAM practitioners into a number of hospitals started by an effort to limit such candidates to licensed conventional practitioners who were also trained in a CAM field. These included physicians practicing acupuncture, physiotherapists practicing osteopathy and nurses practicing naturopathy. While such individuals were slowly accepted in hospitals, in reality, this policy proved difficult to implement because there is a limited supply of

conventional medical personnel who are also trained in CAM specialties. Physicians with an interest in CAM most frequently train in acupuncture or homeopathy and less frequently in other fields of CAM, such as reflexology, Feldenkreis, the Alexander technique, the Paula technique, biofeedback or aromatherapy.

At the turn of the century, small numbers of CAM practitioners were providing bedside care in hospitals in a variety of departments: orthopaedics, oncology, paediatrics, internal medicine, obstetrics, neonatal intensive care, psychiatry, gastroenterology, neurology and pain clinics. They were never located in surgical facilities, radiology units, imaging units or emergency rooms.

CAM practitioners working in bedside care in Israeli hospitals face an entirely different work context than that found in the community clinics devoted to CAM. Our research has shown that in the well-developed networks of community CAM clinics in Israel, the senior practitioner is an MD but is generally also a CAM practitioner. Her/his role is limited to screening patients at the time of their first visit to the CAM clinic by checking their medical records to make sure they are such as to permit the individual to undertake CAM treatment. In some cases, the patient may be referred to undertake additional tests before being admitted to CAM treatment [12-14]. Most of the remaining personnel in these clinics are CAM practitioners; very few are also trained as conventional practitioners. They are virtually independent of supervision and have no direct contact with mainstream medicine in the course of their day to day work. Thus CAM practitioners are able to feel comfortable and unthreatened in the context of a community CAM clinic environment.

Hospitals are characterized by the dominant presence of conventional medicine in which physicians set the tone regarding all aspects of work. The majority of other workers-nurses, aides, social workers, physiotherapists and others-are also trained in and committed to conventional medical norms, values and modes of health care. When working with hospitalized patients, CAM practitioners come in direct and frequent contact with conventional medical practitioners, many of whom have little knowledge or interest in CAM.

Gaining Legitimacy in Hospitals

In the context of bedside care in an Israeli hospital, where evidence-based medicine is the norm, CAM practitioners are, at first sight, “strangers” in a community of conventional practitioners. As outsiders, they seek recognition and acceptance by the other health care workers. Many of the latter are unfamiliar with the newcomers’ status and are ambivalent about their qualifications. There may be overt hostility from some.

A number of mechanisms are used to gain legitimacy for CAM workers in hospital departments. One is to describe the work of the CAM practitioner as “research” or “experiments.” For example, joint efforts by a physician and a CAM practitioner to improve the quality of life of patients in an oncology department are referred to as clinical experiments and research that could demonstrate the efficacy of alternative methods of treatment.

This mechanism has an additional advantage of making it clear that the CAM practitioner is not a permanent presence in the department so that she/he does not threaten the core of conventional health care providers since research and experiments are always temporary.

Another mechanism used by CAM practitioners to gain legitimacy is their dress code, which generally resembles that of physicians or nurses. The furnishings and decor of their clinic settings are like those of their biomedical colleagues.

In addition to gaining legitimacy among hospital workers and colleagues, patients often need to be persuaded that CAM practice in conventional medical hospitals is legitimate. Patients have been heard to remark, “I want to see a ‘real’ doctor,” or, “I don’t believe in this hocus pocus.” If the CAM practitioner has a sponsor in the form of a physician in the department, this physician’s intercession encouraging acceptance of CAM can be most effective. But CAM practitioners themselves try to persuade patients of the effectiveness of their treatment and to alleviate their doubts.

Clearly, success in treatment is the most effective way of gaining recognition and legitimation. The head of a department, who was a supporter of CAM, was heard making the following remark:

To my mind, there are a lot of things whose workings we do not understand. In my medical work I use a lot of techniques that, if you were to ask me, do I know exactly how and why it works, the answer would be, ‘I don’t know.’ And I also think that the majority of doctors don’t know exactly how everything works. And the story that you can’t use something if you don’t know exactly how it works, if there is no substantial proof, that too doesn’t seem to me correct. For example, take aspirin. They discovered its effectiveness in 1920. Now they are starting to discover that it has all sorts of effects they didn’t know about: new things, good things they didn’t know about. Theory changes every ten years [12,13].

When practicing bedside care in hospitals, CAM practitioners are often viewed by the conventional medical staff as a type of para-medical worker. Virtually all of the CAM practitioners are employed on a part-time basis, most often one or two days a week. None have regular appointments to the clinic staff, as do the majority of the conventional practitioners. They have individual contracts with the employer and some serve as volunteers. Most maintain their own private clinics elsewhere.

CAM practitioners who also possess biomedical credentials enjoy a higher status. But their CAM identity may act to detract from full equality in the eyes of some conventional medical colleagues who look askance at their presence in hospitals.

CAM practitioners working with hospitalized patients are excluded from one of the most important daily rituals of hospital practice: hospital rounds. This emphasizes their marginality in the hospital setting. In the rare cases where they are included, they are

located at the tail end of the hierarchical procession which follows the head of the department from bed to bed [21].

In general, it may be said that the work of CAM practitioners in hospital bedside care focuses primarily on patients' pain, suffering and quality of life. There are no CAM practitioners engaged in diagnosis, cures and life-saving procedures. However, CAM is increasingly used in settings specializing in palliative care [22,23].

Change and Stability over Two Decades

In 1991, the first CAM-dedicated community clinics were established by the sick funds. The initial structural pattern which they established then has provided an imprinting effect that was reproduced by all the of the sick funds and in the outpatient clinics run by the hospitals. These continued in their original structural form for over two decades and still show little evidence of change. The only changes that have occurred have been the adoption of additional fields of CAM practice [12-14].

On the other hand, during this period, the hospitals have become increasingly accessible to CAM practitioners who provide bedside care to a growing number of patients. Our early research in 2000 found CAM practitioners to be very sparsely spread in numerous settings, with rarely more than one to a department. At that time, no one department contained a critical mass of CAM practitioners large enough to be visible to the public or the staff. CAM practitioners working inside hospitals encountered numerous barriers which made clear their marginality and that their presence was met with considerable reservations.

At that time, there was little contact between hospital-based outpatient CAM clinics and inpatient care. By the end of a decade, we found that the CAM presence inside Israeli hospitals had increased considerably and had become more visible in a variety of forms. In addition to increased bedside care, a number of hospitals had established special courses to train CAM workers for work with hospitalized patients. Clearly, many hospitals now view CAM in terms of an ongoing presence in hospital care.

For the large part, the changes were spearheaded by individual initiatives undertaken by determined and energetic integrative physicians who were imbued with a keen desire to establish integrative medical care. Many are inspired by examples from the United States on which they seek to model their services, especially in the field of oncology (Sloan Kettering, Dana Farber, Anderson). Working in a concerted effort, these individuals successfully introduced integrative CAM services in a variety of settings within the public hospitals in Israel.

There has been no official policy decision regarding the presence of CAM in the hospitals by the hospitals themselves or by the Ministry of Health. For this reason, the changes initiated differ from hospital to hospital and depend to a large extent on the interests or specialization of the local medical initiator.

Unwilling to accept the total separation of the outpatient clinics from in-patient care, a number of directors of outpatient

clinics engaged in intensive efforts to persuade hospital departments of the importance and usefulness of CAM for inpatient care. The success of the highly-regarded Hadassah Hospital in Jerusalem is a case in point. This hospital has operated an outpatient CAM clinic since 1991 but the CAM practitioners' contacts with hospitalized patients were at first extremely limited. Following several years of active efforts by the clinic's director, the central administrative body of the hospital invited her to open a CAM unit within the hospital's department of oncology and to work with hospitalized patients in other departments as well.

In fact, the most developed CAM programs in the hospitals are geared to accompany conventional oncological treatment. Such programs have been established inside several hospital departments or near them. They offer patients a wide variety of therapies to assist in mitigating the side effects of radiological treatments and chemotherapy, reducing tension, alleviating pain, minimizing tissue damage and strengthening coping strategies. The CAM techniques utilized include acupuncture, herbal remedies, naturotherapy, shiatsu, reflexology, touch therapies, hypnosis, biofeedback, meditation, yoga, tai-chi, Reiki, music therapy, art therapy, guided imagery and others. Some programs offer workshops in yoga and tai chi as well as psychological services to patients and their families. Information and guidance are provided on nutritional supplements and herbal products

Within this context, conventional medical modes prevail. Patients are assured of regular medical supervision and consultation services in the CAM setting as well as coordination with their primary medical oncological therapist in the hospital. Informed consent is a precondition for CAM treatment. Some hospitals treat only adults with children being treated in a setting which specializes in paediatric oncology (www.rmc.org.il).

A number of hospitals run research programs to evaluate the effects of CAM treatment. Since hospital care is fully covered by the National Health Insurance, patients cannot be charged for CAM services while they are in hospital.

As in other countries, the establishment of CAM services inside hospitals is often dependent on volunteers or on a "motivated champion"-an individual or family who takes the initiative to recruit support and funding for CAM services. Such champions are generally persons who themselves or whose family members have benefited from CAM treatment. They are active in mobilizing support for CAM at a variety of levels in the medical system. The initial arrangement for organizing these services are often informal and based on personal relations with conventional medical figures who are unable or unwilling to seek support for CAM inside the official administrative structure of the hospitals.

In recent years, the labelling of CAM in the hospitals has begun to change. In the past, physicians were careful to refer to CAM as "complementary" and this term was widely used in referring to the CAM clinics in the hospitals and sick fund clinics. Recently, some of the hospitals have expanded their formal titles to include the term "integrative." This change carries important

symbolic implications. Rather than viewing CAM as a secondary complement to bio-medicine, the term “integrative” implies a greater measure of equality between the fields of practice and highlights the partnership of conventional and alternative medicine.

While oncology is the most frequent area into which CAM has expanded, it has developed in a variety of other hospital departments as well. Among these are neurology, dermatology, gastroenterology, orthopaedics and pain clinics. In addition, some gynaecology and obstetrics departments offer CAM treatment to menopausal women. Pregnant women at a number of hospitals are offered CAM before birth and CAM assistance during birth, using such methods as acupuncture, reflexology, shiatsu, guided imagery and breathing techniques. Women and their partners are offered guidance in use of CAM methods before and after birth. Women in fertility programs in some hospitals are offered Chinese or Japanese medicine [24-28].

A paediatric CAM clinic at one of Israel’s hospitals offers care for sleep disturbances, digestive problems, respiratory difficulties, headaches, anxiety, depression and behavioural problems. A preventive program in a cardiology department offers CAM treatment in addition to its conventional program to reduce high blood pressure, control unstabilized diabetes, prevent obesity and stop smoking.

In the past, departments of surgery and especially operating theatres have been strictly off bounds to CAM in Israeli hospitals. In 2010, an experimental program was activated in a Haifa hospital utilizing CAM in pre- and post-surgical settings. The new program makes use of several forms of CAM, such as acupuncture, hypnosis, reflexology, bio-feedback, guided imagery and touch techniques to control anxiety and tension, ease pain, reduce nausea, reduce post-operative complications and speed recovery.

The experiment is defined as a research project; all of the CAM procedures are meticulously monitored including patients’ responses to treatments. These are recorded in the patients’ clinical medical records—a procedure that may be viewed as a breakthrough in itself. While the operating theatre itself remains closed to CAM, its surrounding territory, where pre- and post-surgical procedures occur, have accepted CAM practitioners.

A special course was designed by the department of surgery in this hospital to prepare graduates of a Chinese medicine course to work in this setting under the direction of the medical staff. The course, taught by members of the surgery department, involved, seven hours a day of study over 11 days, of which 60% is spent learning clinical techniques. The approximate cost is EUR 945.

In 2014, another leading hospital in Haifa opened a course for graduates of a Chinese medicine course to prepare them for work in the following hospital departments: neurology, nephrology (kidney disease), oncology and pain clinics. The stated goal was to train CAM practitioners to practice integrative medical care in hospital settings. The course includes 120 hours of theoretical and clinical training over a period of 20 weeks and is taught by

integrative physicians, who are trained in both conventional medicine and in CAM. The cost is approximately EUR 1,440.

Six public hospitals collaborate with the Reidman College for CAM in providing supervised internships for students in various CAM fields. In addition, in 2010, the Abarbanel Mental Health Centre accepted Reidman College graduates, allowing them to provide CAM treatment both in the hospital system and in an outpatient clinic.

Another training program to prepare CAM practitioners for practice in psychiatric departments was set up in collaboration with the DAO College at HaEmek Hospital. Graduates of Chinese medicine courses are accepted for a course of 28 meetings, six hours each, covering both theoretical and practical subjects relating to psychiatric treatment in the hospital department. In recent years, CAM has also been introduced in rehabilitation hospitals.

Conclusion

The presence and activity of CAM in Israeli hospitals has increased markedly during the past twenty years, principally as a result of energetic efforts by individual directors of outpatient CAM clinics who have taken on the mission of promoting integrative medicine in the hospitals. There are now small but critical masses of practitioners, with and without conventional medical credentials, working in hospital settings. This has increased the visibility of CAM in the context of conventional medicine. But CAM is not included in the budget structure of public hospitals and is therefore supported by research grants or by voluntary contributions.

The introduction of palliative and rehabilitative care for cancer patients served as an effective spring board for the introduction of CAM into the heart of hospital practice because of its primary focus on care rather than cure. Creative use of evidence-based research regarding CAM has promoted the acceptability of CAM in settings where it was previously rejected. It has also induced important changes in the protocol of hospital care, such as the inclusion of the record of CAM treatment in the patient’s file.

The numerous innovative CAM programs described above suggest that this form of health care will increase its presence in Israeli hospitals in future years and that its growing entry into the mainstream of health care is well on its way.

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