



Research paper

Integrative medicine in Dutch curative and long-term healthcare centres: Mapping the field

Miek C. Jong^{a,*}, Martine Busch^b, Erik W. Baars^{c,d}^a Mid Sweden University, Department of Health Sciences, Holmgatan 10, 851 70, Sundsvall, Sweden^b Van Praag Institute, Springweg 7, 3511 VH, Utrecht, the Netherlands^c Louis Bolk Institute, Kosterijland 3-5, 3981 AJ, Bunnik, the Netherlands^d University of Applied Sciences, Zernikedreef 11, 2333 CK, Leiden, the Netherlands

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ABSTRACT

Introduction: Little is known about integration of Complementary and Alternative Medicine (CAM) in the Dutch healthcare system. The aim of the present study was to investigate how Integrative Medicine (IM) is practiced and how CAM is integrated with conventional medicine in curative and long-term healthcare centres in the Netherlands.

Methods: A mixed methodology was applied, including a systematic internet search, an online survey and focus groups among healthcare professionals.

Results: Most hospitals (92%) offered some form of CAM to treat anxiety (72%), restlessness (68%), pain (65%), sleeping problems (50%), stress (48%) and fatigue (36%). Mostly offered modalities were relaxation exercises (88%), art therapy (44%) and mindfulness (42%). Similar percentages of CAM use were found in other healthcare centres. Most CAM modalities were implemented without organizational vision, guidelines or protocols. Only 5% of implemented CAM was labelled as IM. Focus groups with health care professionals revealed the need to increase knowledge and to develop a vision for integration of CAM with conventional medicine, as well as to support effectiveness research in this area.

Conclusions: This study is the first in the Netherlands to quantitatively map the extent of CAM integration in conventional health care. The number of CAM interventions offered at conventional health care settings was surprisingly high. However, integration was fragmented. Guidelines, education and research programs are needed to further integration of CAM, preferably organised in a Dutch Consortium for IM.

1. Introduction

Complementary and alternative medicine (CAM) is defined as a group of diverse medical and health care systems, practices and products that are not generally considered part of conventional medicine [1]. More specifically, if a non-mainstream practice is used together with conventional medicine, it is considered “complementary” and if a non-mainstream practice is used in place of conventional medicine, it is considered “alternative” [1]. Worldwide, the use of CAM has increased during the last decades [2]. In 2016 in the Netherlands, a total of 14% of the general population had used at least one CAM therapy during the last 12 months [3]. CAM use is on average two to fourfold higher in specific patient populations [3]. One-third of children visiting a general paediatrician [4] and 42.4% of children visiting a paediatric oncologist had used CAM [5]. CAM use in patients with chronic joint complaints was found to be as high as 86% [6]. Reasons for CAM use are mostly

that patients want to combine the best of conventional medicine and CAM and want to be treated from a holistic perspective [6,7]. In the Netherlands, CAM is mainly practised outside the setting of conventional medicine by practitioners in their own private practices [8]. Furthermore, health insurance companies only reimburse costs for CAM, or parts thereof, if patients have additional health insurance [8]. Although Integrative Medicine (IM) is more than just the sum of conventional medicine plus CAM, most research and interventions in the field of IM focus on the integration of CAM into the main healthcare system [9,10]. IM has become an established part of the healthcare system in the United States, where education, information and research on IM is advanced by the Academic Consortium of Integrative Medicine and Health (ACIMH), to which now more than 70 academic institutions are affiliated [11]. In 2011, the Bravewell Collaborative commissioned a survey to determine how IM was being practiced across the United States. This survey was distributed to 29 IM centres and demonstrated

* Corresponding author.

E-mail addresses: miek.jong@miun.se (M.C. Jong), mbusch@vanpraaginstituut.nl (M. Busch), e.baars@louisbolk.nl (E.W. Baars).

that most centres offer integrative consultative care to adults of which the majority is self-referred. CAM services that were most provided in these 29 centres were food/nutrition, supplements, yoga, meditation, TCM/acupuncture and massage [12]. In the Netherlands, IM was practiced in the paediatric clinic at the Slotervaart Hospital in Amsterdam [13] and still is practiced at the Center for Integrative Psychiatry (Lentis) in Groningen [14]. However, nothing is known about IM or integration of CAM into other Dutch healthcare centres. Therefore, the present study was initiated to investigate how IM is practiced and CAM is integrated in curative and long-term healthcare centres in the Netherlands.

2. Methods

2.1. Study design

A mixed methodology was applied, including a systematic web search, a survey and focus groups among healthcare professionals with the aim to investigate 1) the practice of IM and integration of CAM within the Dutch healthcare system and 2) the needs of healthcare professionals with respect to integration of CAM and research on CAM into current healthcare practices. As this study did not involve experiments with patients or study subjects, according to the Dutch Medical Research in Human Subjects Act (WMO), it was exempt from ethical approval.

2.2. Defining CAM

An overview of CAM modalities that were included in the present study is depicted in Fig. 1. Fig. 1 was adapted from the National Center for Complementary and Alternative Medicine (NCCAM), presently known as the National Center for Complementary and Integrative Health (NCCIH), who classified CAM within the following five major domains: 1. Whole medical systems, 2. Mind-body interventions, 3. Biologically based treatments, 4. Manipulative and body-based methods, and 5. Energy therapies [15]. CAM modalities were added, such as anthroposophic medicine, therapeutic touch, music therapy and art therapy, from which it was known that they were practiced in the Netherlands and/or were classified as CAM modalities by health

insurance companies.

2.3. Systematic web search

A systematic search was carried out between July 15–September 18, 2014 on websites of all hospitals (N = 91) in the Netherlands, with the aim to investigate the integration of CAM into these conventional healthcare centres.

The following search terms were applied (or variants thereof): acupressure, acupuncture, anthroposophic, aroma therapy (aroma care, essential oil, etheric oils, odours), baby massage, chiropractic, complementary, art therapy, guided imagery (visualization, imagination), haptonomy (haptotherapy), homeopathy (homeopathic), hypnotherapy (hypnosis), massage (chair massage, foot reflex massage, foot reflex therapy), mindfulness (attention-training), music therapy (music), naturopathy (phytotherapy, orthomolecular therapy), relaxation exercises (relaxation, relaxation techniques), osteopathy, Tai-chi, therapeutic touch, warmth/coldness, yoga.

Hits to web pages of hospitals describing that the respective CAM modality was implemented, provided or used in clinical practice were saved as url links. Url links to pages or documents from before 2012 were excluded from analysis. The following hits were also excluded from analysis: wellness days or other events in which CAM modalities were offered to healthcare personnel, invitations to patients to bring music to the hospital for distraction during medical interventions, psychomotor therapy, physiotherapeutic massage and the oncology supportive program: ‘Herstel en Balans’, unless it was explicitly stated that it included relaxation exercises. Dietary supplements and nutritional advice were also excluded from the analysis since no specific information was provided on which supplements were used or what nutritional advice was provided.

2.4. Survey

Between April and September 2014, a survey was carried out among healthcare professionals to investigate 1. The practice of IM and the integration of CAM within the Dutch healthcare system and 2. Their needs with respect to integration and research on CAM were quantitatively assessed. Because of the diversity of chosen organisations

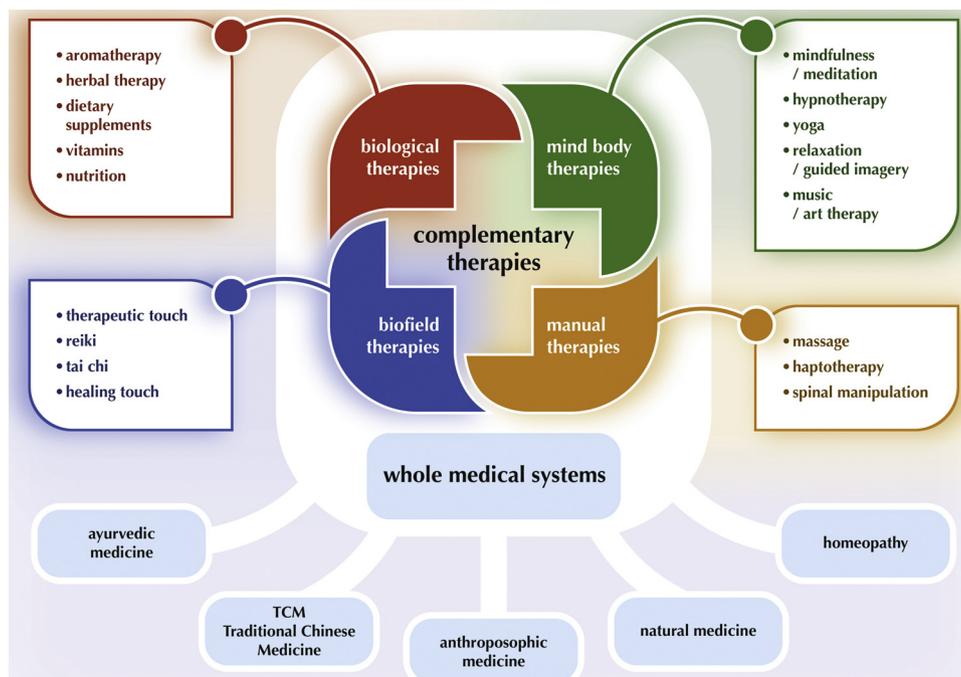


Fig. 1. Overview of CAM modalities.

Table 1
CAM modalities offered at hospitals as identified in the web search.

| CAM therapy | Hospitals (N) | Hospitals (%) |
|-------------------------|---------------|---------------|
| Relaxation exercises | 74 | 88 |
| Art therapy | 37 | 44 |
| Mindfulness | 35 | 42 |
| Hypnotherapy | 26 | 31 |
| Baby massage | 24 | 29 |
| Massage | 20 | 24 |
| Music therapy | 17 | 20 |
| Aroma therapy | 12 | 14 |
| Guided imagery | 11 | 13 |
| Haptotherapy | 10 | 12 |
| Yoga | 8 | 10 |
| Warmth/coldness | 5 | 6 |
| Acupuncture | 2 | 2 |
| Therapeutic touch | 2 | 2 |
| Foot reflex therapy | 2 | 2 |
| Osteopathy | 1 | 1 |
| Acupressure | 0 | 0 |
| Anthroposophic medicine | 0 | 0 |
| Homeopathy | 0 | 0 |
| Naturopathy | 0 | 0 |
| Tai-chi | 0 | 0 |

within the Dutch healthcare system and lack of cross-disciplinary organizing structures for healthcare staff in CAM, a convenience volunteer sample was obtained through snowball sampling. All CAM pioneers belonging to the network of the Dutch Society for Integrative Medicine (NIKIM), the Van Praag Institute, the Louis Bolk Institute, the V&VN complementary care and the Levensboom were approached by email to distribute a link to an online survey within their network. Each healthcare professional approached was asked to respond to the survey and subsequently to forward the survey to other healthcare professionals working with IM or CAM within or outside their organisation. Through this snowball sampling, starting with the CAM pioneers, it was aimed to reach out to as many healthcare professionals as possible that had some involvement with IM or CAM services within the Dutch healthcare system.

The survey consisted of a structured, anonymous, self-reporting questionnaire that was modified from previously used questionnaires among Dutch healthcare professionals [16,17]. The survey consisted of thirty-five questions on CAM and IM. First demographic questions (age, sex, location, organisation, specialisation and work experience) were surveyed. Secondly, healthcare professionals were asked for CAM modalities within their healthcare organisation. A list of CAM modalities was provided, according to Fig. 1. The survey was to assess the percent of patients who were provided with CAM within their healthcare organisation, for which complaints, whether they asked patients for CAM use, whether they had guidelines, protocols or other work instructions concerning CAM and whether this was based on the principles of IM, Planetree (<https://www.planetree.org/>) or others. Needs with respect to CAM such as education, research, management support and information were also surveyed. Descriptive statistics were used to tabulate the demographics of the respondents and their responses to the questions. Data were analysed using SPSS 22.0 (IBM Corp. Released 2013. IBM SPSS Statistics for Windows. Armonk, NY: IBM Corp.).

2.5. Focus groups

The aim of the focus groups was to investigate the needs of healthcare professionals with respect to integration of CAM within their organization. Three focus groups were carried out between September–December 2014. One focus group was with healthcare professionals working in a hospital where several CAM modalities were provided to patients (N = 5 participants). A second focus group was in a hospital where relatively few CAM modalities were provided (N = 9

participants), and a last focus group took place in a nursing home where several CAM modalities were implemented (N = 4 participants). In all three focus groups, it was planned to have a mix of healthcare professionals from the healthcare organization, i.e. managers (board of directors), (specialized) doctors, nurses and a CAM coordinator (if available). The following main questions were addressed in the focus groups: 1. What can CAM add to patient care within your healthcare organization? 2. What are the needs to integrate CAM within your healthcare organization, both from the perspective of the healthcare professional and the organization? 3. What is the need for respect for CAM research, which research outcomes are important? The focus groups lasted for two hours and session were recorded and field notes were taken. Data analysis consisted of repeatedly examining the texts, coding key points, and grouping codes into themes about the needs of healthcare professionals with respect to integration of CAM within their organization.

3. Results

3.1. CAM in hospitals: web search

The web search identified that 92% (N = 84) of all hospitals (N = 91) in the Netherlands offered some kind of CAM. The total number of CAM modalities offered per hospital ranged from one to eight, but on average three to four CAM therapies per hospital were found. Table 1 gives an overview of the different CAM modalities that were offered by the 84 hospitals. Mind-body interventions, such as relaxation exercises, mindfulness and hypnotherapy were among the top five of most offered CAM modalities. None of the hospitals offered acupressure, anthroposophic medicine, homeopathy, naturopathy or Tai-chi. CAM was offered in total by 308 hospital departments, with on average four to five CAM modalities per hospital. Most CAM modalities at the hospitals were offered at psychiatric departments (22%), followed by paediatrics (11%), medical psychology (10%), heart rehabilitation (10%) and lung rehabilitation (5%). Five out of all eight academic hospitals in the Netherlands were within the top ten of hospitals that offered most CAM (results not shown).

3.2. CAM in curative and long-term healthcare centres: survey

A total of 380 healthcare professionals responded to the survey, working at 180 different healthcare centres in the Netherlands. As shown in Table 2, respondents worked mainly at five different healthcare settings, representing on average 40% of all hospitals, 40% of all mental healthcare centres, 21% of all hospice care, 10% of all nursing homes and less than 1% of the home care organisations within the Dutch healthcare system. Little less than one quarter of respondents (23%) worked at a large variety of other healthcare settings such as primary care, community care, youth care, disability care, other palliative care settings, acute care, own practice, rehabilitation care, addiction care, prison care and others (results not shown).

Respondents were a large variety of healthcare professionals, including doctors, nurses, therapists, managers, coordinators and researchers (results not shown). Table 3 depicts the CAM modalities as

Table 2

Main work settings of respondents in the survey.

| Healthcare centres | Number (N) | Percentage (%) | Percentage of total ^a (%) |
|--------------------|------------|----------------|--------------------------------------|
| Mental healthcare | 52 | 29 | 40 |
| Nursing homes | 43 | 24 | 10 |
| Hospitals | 39 | 22 | 40 |
| Hospice care | 26 | 14 | 21 |
| Home care | 20 | 11 | < 1% |

^a Calculated percentage of the total number of respective healthcare centres in the Netherlands.

Table 3
CAM modalities offered at the main healthcare centres as identified in the survey.

| CAM therapy | Total (%) | Mental Health (%) | Nursing home (%) | Hospital (%) | Hospice care (%) | Home care (%) |
|-----------------------------------|-----------|-------------------|------------------|--------------|------------------|---------------|
| Art-, music- and creative therapy | 56 | 85 | 78 | 30 | 26 | 18 |
| Mindfulness, meditation | 36 | 65 | 12 | 52 | 11 | 18 |
| Massage, foot reflex therapy | 34 | 6 | 55 | 26 | 83 | 77 |
| Guided imagery | 34 | 46 | 29 | 36 | 0 | 32 |
| Other | 28 | 37 | 31 | 17 | 20 | 46 |
| Aroma care | 28 | 1 | 61 | 14 | 91 | 77 |
| Therapeutic touch | 25 | 2 | 39 | 24 | 3 | 50 |
| Food, nutrition, supplements | 21 | 23 | 26 | 21 | 0 | 36 |
| Yoga, Tai-chi | 11 | 16 | 16 | 10 | 0 | 0 |
| Herbals or homeopathic remedies | 7 | 2 | 8 | 3 | 11 | 36 |
| Manual therapies | 5 | 1 | 0 | 14 | 0 | 0 |
| Acupuncture | 5 | 1 | 0 | 10 | 0 | 5 |
| Hypnotherapy | 5 | 1 | 0 | 17 | 0 | 0 |
| Homeopathy | 3 | 1 | 0 | 2 | 6 | 9 |
| Naturopathy | 3 | 2 | 0 | 2 | 23 | 9 |
| Anthroposophic medicine | 2 | 0 | 0 | 1 | 11 | 0 |
| Moerman therapy | 0 | 0 | 0 | 0 | 0 | 0 |

Table 4
CAM use by patients at the main healthcare centres as identified in the survey.

| Percentage of patients | Total (%) | Mental health (%) | Nursing home (%) | Hospital (%) | Hospice care (%) | Home care (%) |
|------------------------|-----------|-------------------|------------------|--------------|------------------|---------------|
| 0–5% | 19 | 8 | 22 | 35 | 6 | 27 |
| 6–25% | 26 | 15 | 43 | 28 | 23 | 32 |
| 26–50% | 13 | 13 | 18 | 3 | 29 | 0 |
| 51–75% | 12 | 20 | 4 | 7 | 23 | 9 |
| > 75% | 16 | 29 | 6 | 10 | 17 | 18 |
| Unknown | 14 | 14 | 6 | 17 | 3 | 14 |

offered at the five main healthcare centres. Overall, music-, art- and creative therapies were the most offered CAM modalities within the Dutch healthcare centres, followed by mindfulness/meditation, massage and guided imagery and aroma care. However, the percentage of CAM modalities differed considerably between the respective healthcare centres. Music-, art- and creative therapies were mostly offered at mental healthcare centres and nursing homes, whereas mindfulness and meditation were mostly offered at mental healthcare settings and hospitals. Aroma care was practiced most in nursing homes and hypnotherapy, manual therapy and acupuncture almost only in hospitals. Other therapies in Table 3 consisted of a larger variety of different therapies such as running therapy, psychomotor therapy, energy therapies, haptonomy and others. Overall, most respondents reported that CAM was used by 6–25% of the patients in the five main healthcare centres (Table 4). However, in mental healthcare centres, almost one third of respondents reported that CAM was used by more than 75% of the patients (Table 4). CAM was mostly applied for anxiety (72%), restlessness (68%), pain (65%), sleeping problems (50%), stress (48%) and fatigue (36%).

As shown in Table 5, only 5% of respondents reported that principles of IM were implemented in their organisation. Most CAM modalities offered were based on other principles such as department-, professional- or multidisciplinary guidelines (Table 5). Remarkably was

Table 5
Guidelines for CAM use at the main healthcare centres as identified in the survey.

| Guidelines | Total (%) | Mental health (%) | Nursing home (%) | Hospital (%) | Hospice care (%) | Home care (%) |
|----------------------|-----------|-------------------|------------------|--------------|------------------|---------------|
| Integrative Medicine | 5 | 5 | 4 | 6 | 11 | 5 |
| Planetree | 5 | 3 | 8 | 9 | 0 | 0 |
| Other principles | 32 | 40 | 22 | 18 | 57 | 36 |
| Not known | 32 | 44 | 45 | 20 | 14 | 18 |
| No guidelines | 29 | 12 | 22 | 51 | 20 | 41 |

the finding that the majority of respondents from hospitals reported that no guidelines were available on the basis of which CAM was offered to patients. Furthermore, many respondents did not know whether such principles or guidelines for CAM integration existed (Table 5). The majority of respondents from mental health centres (73%), nursing homes (71%) and hospitals (70%) reported that they had no specific CAM coordinator, or did not know if they had one. 80% of respondents from hospices and 55% of respondents from home care organisations reported that there was a CAM coordinator present. Furthermore, the majority of respondents (54%) reported that their organisation has patient information (for example in the form of brochures) on CAM.

With respect to respondents needs and CAM, 47% reported need for evidence, 44% need for budget, 38% need for education, 37% need for organisational support, 37% need for guidelines and 29% need for CAM integration. With respect to research and CAM, most respondents preferred effectiveness research in the areas of psychiatry (54,2%), elderly care (48,9%), palliative care (42,6%), oncology (36,1%) or paediatrics (32,6%).

3.3. Needs for integration of CAM: focus groups

All three focus groups concluded that integration of CAM within their institutions is a bottom up development, either initiated by individual or small groups of nurses or medical doctors. Analysis of the focus groups with healthcare professionals revealed themes that could be categorized in barriers or facilitators for CAM integration into conventional healthcare centres, as well as prerequisites for further integration of CAM. Barriers for CAM integration that were identified: 1. Lack of support from physicians and managers, as CAM is controversial amongst the medical profession in the Netherlands, is being offered by only a small number of health professionals within the institutions and is not practiced within a formal and transparent infrastructure. 2. Lack of policy on CAM as CAM is not seen as a priority and budget and time are scarce. 3. Lack of knowledge about CAM among healthcare professionals as there is no national information and knowledge centre on CAM in the Netherlands, nor is CAM a subject in formal medical and

nursing education. 4. Fragmentation of CAM practices within a healthcare centre and lack of strategy, and 5. No research or evaluation of CAM. Facilitators for CAM integration that were identified: 1. Official working group on CAM within the healthcare setting, with a broadly accepted road map based on strategic choices, and low profile in action, 2. Support for CAM from the board of directors, 3. Implementation of CAM within existing programmes, instead of developing new CAM-related treatment programmes, 4. CAM aligns with the new, and in the Netherlands well-accepted, definition of Positive Health [18,19], and 5. Emphasizing CAM in relation to care, instead of cure. For reasons of strategy, all three centres were searching for less controversial terminology than CAM, such as comfort care, stress reduction techniques or evidence-based complementary treatment. Prerequisites for further integration of CAM into conventional healthcare centres that were identified were firstly to increase the knowledge of healthcare professionals on CAM and to support them in their communication about CAM use with their patients. Secondly, to develop a vision and guidelines for integration of CAM, preferably in accordance with relevant themes within the institution, such as patient-centered care, and for conditions that are difficult to treat conventionally or for which medical treatment leads to burdening side effects. Other prerequisites identified were to exchange experiences with CAM and to install a CAM coordinator within the healthcare centre, to structurally offer a variety of evidence-based CAM modalities and to initiate and support research on CAM with respect to its effectiveness, patient experiences, implementation, and to a lesser extent cost effectiveness. Safety was an issue but more in terms of safe practice than of safety research.

4. Discussion

4.1. Major findings

The present mapping study demonstrated widespread implementation of CAM into the Dutch healthcare system. In 2014, CAM was offered to patients in 92% of hospitals, and at least in 52 mental healthcare centres, 43 nursing homes, 26 hospices and 20 home care organisations in the Netherlands. Despite this widespread implementation, CAM did not seem to be fully integrated into the health care system. It appeared that implementation of CAM modalities was fragmented within one healthcare centre, without existing vision or guidelines for full integration. These findings are in line with a previously published study among healthcare centres in the US, demonstrating lack of policy and guidelines on integration of CAM in clinical practice [20]. Another study also reported on the need for educational programs and long term vision to further integrate CAM and conventional medical care [21].

So far, few studies have investigated to what extent CAM is offered within a country's dominant healthcare system. A recent systematic analysis of websites in the USA showed that the majority of National Cancer Institute-designated cancer centres provide some form of IM modality to their patients and that the IM content on their websites is growing [22]. A survey from Norway [23] and Switzerland [24] demonstrated that the majority of hospitals (64%) offered some form of CAM, whereas only one-third of hospitals in Denmark offered CAM [25]. Remarkably, acupuncture was the most frequent CAM method offered in Norwegian, Danish and Swiss hospitals [23–25], whereas this more traditional whole medical system was hardly offered at Dutch healthcare centres. Most frequently offered CAM modalities in the present mapping study were mind-body interventions such as relaxation exercises and mindfulness. In healthcare centres across the USA, nutrition, supplements and mind-body interventions were most frequently prescribed across all conditions [12]. Therefore, the Dutch IM setting appears to be more similar to the setting in the USA [21], than to those in other EU countries. Furthermore, in the present study it was found that CAM modalities were mostly applied to treat patients with anxiety, restlessness, pain, stress and fatigue. This is also in line with

previous publications from studies at IM healthcare centres in the USA, where patients were treated for conditions such as stress, pain and fatigue [12,26].

4.2. Limitations

The present mapping study had its limitations, which need further reflections. First of all, CAM modalities offered at hospitals were investigated amongst others through a systematic website search. Websites of healthcare organizations might not always be up to date. To minimize possible overestimation of CAM integration, it was decided to exclude web-pages that were older than two years from the analysis. Furthermore, since the effectiveness of CAM is debated in the Netherlands [27], hospitals might not actively communicate about CAM on their website. For example, the systematic website search showed that hospitals did not offer homeopathy, naturopathy or anthroposophic medicine. However, the survey in the present study revealed that those CAM modalities were offered at least in some hospitals. Another limitation was that the survey was distributed via snowball sampling and may not have reached all healthcare professionals working with CAM. It is therefore more likely that the percentages of CAM offered at Dutch healthcare centres as found in the present study is an underestimation, rather than an overestimation. Last, it is important to further reflect on the definition of CAM. In the present study, relaxation exercises, mindfulness, supplements and art- and creative therapy for example were defined as CAM. However, some of these modalities might have become more accepted as the evidence builds up. For example whereas mindfulness or probiotics were considered to be CAM in the past, due to an increased number of scientific publications demonstrating effectiveness [28,29], they may now be regarded as a conventional treatment approach. This shift has to be taken into account upon interpretation of results in the current study.

4.3. Practical implications

Based on the findings in the present study, several recommendations can be made to further integration of CAM in the Dutch healthcare setting. First of all, healthcare centres are advised to develop a broadly accepted vision on IM, followed by the development of guidelines for appropriate implementation of CAM. Secondly, it is recommended that healthcare centres coordinate CAM on a central level, preferably by a member of healthcare staff who is appointed as CAM or IM coordinator. Furthermore, it is recommended to initiate and support research to investigate the therapeutic benefit of integrated care as to build up the evidence for certain CAM modalities. It has been reported that it is challenging to conduct outcome research of integrative treatment programmes in healthcare settings, due to the multidimensional and complex nature of these programmes [30]. Barriers identified were organizational culture, resources, environment and logistical challenges [30]. Nevertheless, most of the surveyed IM centres (86%) in the USA actively performed research in this area [12] and cost-effectiveness of integrative treatment programmes has been demonstrated [31,32]. From the present study it can be suggested that in the Netherlands, there is most openness for research on IM and CAM in psychiatry, elderly care, palliative care, oncology and paediatrics. As mentioned earlier, the development of vision, information and research on IM in the USA is advanced by the Academic Consortium of Integrative Medicine and Health [11]. It therefore seems to be a logical next step as to invite those healthcare centres who offer CAM modalities to patients, to join in a Dutch consortium on IM. Steps were taken by the Dutch Organization for Health Innovation and Research (ZonMW) with two policy statements and two invitational conferences on IM, informed by the results of this national mapping study, resulting in the instalment of a steering committee to form such a consortium. As of January 2018, six health care institutions agreed to explore this possibility together, in close collaboration with the American ACIMH [33].

5. Conclusions

The present mapping study demonstrated widespread implementation of CAM into the Dutch healthcare system. It appeared however, that implementation of CAM was fragmented within one healthcare centre, without existing guidelines or vision for full integration. In order to further CAM integration, it is recommended to develop vision and guidelines on CAM and to support research on the (cost) effectiveness of integrated treatment programs, preferably coordinated by a Dutch consortium for integrative medicine and health.

Conflict of interests

The authors declare that they have no conflict of interests and confirm that the research has been done by the authors.

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