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Why do Norwegian nurses leave the public health service to practice CAM?

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a b s t r a c t

This paper explores a number of issues associated with the recent increase in nurses choosing to leave the Norwegian health care system in order to become independent practitioners of complementary and alternative medicine (CAM).

The paper suggests that in Norway, nurses perceive medical hegemony continues to persist. Nurses perceive restrictions in their ability to develop their professional roles and status. CAM would appear to offer many nurses, the opportunity to develop their clinical skills in an autonomous, egalitarian and more holistic environment.

1. Introduction

In Norway, as in many western cultures complementary or alternative medicine (CAM) use continues to increase.

This is, to some extent related to the limitations and adverse effects of the public biomedical health care service.[1,2] Recent surveys have shown that in Norway, every second member of the population has visited a CAM practitioner.[3]

It would seem that increasing numbers of registered nurses are choosing to leave their jobs in the public health service, preferring instead to train to become CAM practitioners.[4] In 2004, there were 80,000 registered nurses in Norway, 7500 of who were not working in the public health service; however, to date, the number of nurses practicing CAM is unknown.

2. Norwegian health care system

Norway has an extensive publicly funded health care service, which is virtually free for country's 4 million inhabitants. The health service is founded on biomedicine and divided into somatic and psychiatric health care, with somatic wards usually described in terms of body organs. Nurses, like all health workers, receive a state-run education that follows national guidelines. Completion of this education leads to official recognition, which is essential for employment. In Norway there is currently no formal national education for nurses or undergraduate nurses in the field of complementary therapies or holistic nursing (as a nursing speciality). Thus, in order to practice CAM, nurses must exchange their professional role from that of a registered nurse to become referred to as an ''alternative therapist'' and practice privately outside the health care service.

To date, no research has been conducted in order to identify why nurses choose to become 'alternative therapists'. A smaller study among nurses in Denmark[5] suggested that Danish nurses who offer CAM felt that CAM was ''just another way to be a nurse'' ''what distinguishes nursing and alternative therapy first and foremost are the working conditions'' (5, p. 1).

The development of the Norwegian health service has been studied from a number of perspectives. In medical sociology discussion has focused upon tensions between the biomedical/natural sciences and the social/humanistic sciences.[6] Historically oriented descriptions of the modern health care service hark back to the dualistic thinking of Descartes. Dualism draws distinctions, for instance, between disease and people who are sick, between body and soul. Traditional biomedical views of disease and cure/treatment tend to be reductionist, but continue to dominate western health care practice.

The Norwegian health care service has been influenced by capitalism and demands for evidence and productivity. The tension between humanistic ideals (as in caring and nursing) and productivity and financial economics has detracted significantly from individualized patient care. This propensity to measure patient outcome based upon financial resources (and resultant from filling) rather than health and healing affect the essence of nursing care and by definition reduces nurses' ability to spend their time caring for patients' care. Watson[7] warned against this development over a decade ago suggesting that nurses would become nothing more than highly trained technicians. Despite the accomplishments of modern medicine, Watson[7] even suggests that the culture in which western medicine is practiced is in crisis, caring is threatened, and nursing is practiced under poor conditions. She points out the need

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for a paradigm shift towards a more balanced health care approach described in eastern terms as Yin (nursing, feminine, healing) and Yang (medicine, masculine, curing). Nursing then should focus on the whole being, body, mind, and soul. Ideally it should draw upon and be influenced by eastern philosophy, quantum science, the arts and humanities. Watson argues for the integration of metaphysics and science, wherein nursing can be viewed as a metaphor and an archetype of the feminine, pointing out that feminine healing energy has been marginalized.

Included in this 'new paradigm shift', Watson highlights complementary and alternative approaches to health and nursing.

3. Methods

This research was performed within a nursing framework, inspired by cultural science. The main purpose was to understand why registered nurses choose CAM and how this choice affected them. A qualitative research design was adopted using fieldwork and an ethnographic approach for data collection.[8,9]

Interviews, observations, conversations, and documents were used for data collection.[10] Nurses who practice CAM were recruited through advertisements in local and national journals. Inclusion criteria were:

1. Subjects were registered for Norwegian nurses
2. Minimum of 1-year experience working in the public health sector.
3. All currently offered CAM in private practice.

All participants were registered nurse therapies and they defined as CAM.

Therapies identified are listed in Table 1. Eighteen interviews were conducted. Participants competed an informed consent form ensuring the anonymity of the participants and subjects were free to drop out at any time. All data were coded, stored under lock and key in eight work venues.

The data also included field notes from 10 different conferences, meetings, and lectures.[11]

Inductive data analysis similar to grounded theory yielded four main categories:

1. Reductionist health care service: A perception of the public health service as reductionist and CAM as an opportunity to work holistically;
2. Care and cure divide: A perception of an inappropriate division between care and cure;
3. Perception of medical hegemony: An unwillingness to be a doctor's assistant;
4. Perception of medicine as reductionist vs humanist. A wish to follow what is perceived as feminine values and energies.

These categories appeared to highlight the main reasons nurse participants choose to leave the public health service and follow a career in CAM.

Table 1
Acupuncture/Chinese medicine.

Kinesiology
Homeopathy
Healing/spiritual healing
Reflexology
Aromatherapy
Rosentherapy
Bach flower essences
Ma-Uri massage
Psychodrama therapy
Craniosacral therapy
Nutrition/diet
Bioresonance
Naturopathy
Phytotherapy
Ayurvedic medicine
Anthroposophic medicine

4. Results and discussion

4.1. Holism and reductionism

Participants in this study often described their experiences as registered nurses in the public health service in terms of 'splitting, specializing, focused on diagnosis,' or 'centered around disease and cure'.

They described their own CAM therapy as holistic. Participant Anna (pseudonym) referred to her work environment as the ''Holistic Center'', saying: I experience that my work now is based on a holistic perspective. At the hospital, the diagnoses, not the persons, were the focus. I experience that in CAM, we think differently about relations, contexts, and the causes of diseases than we did in the public health service. For instance, it is not essential to divide humans into physical and psychological dimensions, and the life history of the patient is more important. In nursing, there was too much specialization and splitting up, and the patients were in for such a short time. I had the feeling I could never do anything well. It is different here.

Another nurses claimed that practicing Chinese medicine gave her the opportunity to work holistically.

Becoming educated in complementary therapy is a way to return to the understanding and ideology of nursing as it was 30 years ago when I graduated in nursing. At that time, I learned that a human being was part of a greater context, both socially, emotionally, and spiritually. My supervisors in nursing education were conscious and determined that nurses should have a holistic perspective and never accepted that patients were treated as a ''case'' or a ''diagnosis''. What I have learned through Chinese medicine is much more than just sticking needles in the right spots. I have been introduced to a holistic approach to healing which fascinates me a lot _ I think the public health service handles people to a large degree as if they were just a physical body and the bodily symptoms are understood as diseases. Maybe the symptoms are a signal that a person is not feeling well, is suffering because of bad life choices, bad life styles, wrong eating habits, etc. When a person suffers, it is more than just the body that is suffering. The whole person is body, mind, and spirit.

The word ''holistic'' can be a synonym for alternative therapies. By using this word, the participants appeared to be emphasizing a perceived distinction between CAM and the public health service they had left. By choosing CAM, they felt that they were moving away from biomedical diagnosis and fragmented care. Instead they now saw their roles form a 'holistic perspective' that allowed them to see the person as whole, with body, mind, and soul connected to the environment.

Interestingly, only one participant, who practiced acupuncture, appeared to be questioning whether her actions actually were so different from biomedical health care. By saying, I have started to wonder if it (acupuncture) is necessarily more holistic to use needles than pills? This would suggest that perception of health care practice is an influential factor, it may also be not about what tasks are done but how a task is completed; thus CAM, biomedicine, and nursing may all be reductionist or holistic, depending on the way certain concepts are used and understood.

Although holism has been debated in international nursing for a long time,[12–15] concept of holism. Reductionism has been, the concept of ''holism'' is still not well defined within nursing.

Cultural scientists[16,17] have examined the increase in CAM and related this to the recent expansion of new religiosity or the New Age. They claim that holism is a religious concept.

In Norway, a religious group called ''The Holistic Federation of Norway'' (www.holisme.no) describes their religious view using eight statements[a].

One refers to CAM by emphasizing the connection between body and soul. They state that people should be able to choose what medical treatment they want to use. This is unusual in Norway, since religious groups do not usually make definitive statements about body, medicine and treatments. For some participants, the role of religion appears to be an intrinsic part of the therapy they practice: in my study, this suits them well and like a lot of CAM practitioners they are members of this federation.

One who practices healing and massage, said:

> When I give a massage, I feel energies flowing between me and the patient, and I try to transfer energy to the person I massage. I do not know if this is from God or what the power is. I just open up for the light and let it flow through me.

However, other participants do not want to be associated with spiritual or religious practices. Another participant stated

> I am a reflexologist, and there is nothing religious about what I am doing.

She does not consider it connected to the spiritual or religious aspects of the word.

The perception of understanding of holism as a religious or spiritual concept blurs the line between 'healing and treating' and between religion and concepts of the spirit. Poorly defined terminology can also lead to misconceptions and undermine the use of particular therapies that may be efficacious in treating a number of ailments. Although, the theoretical and international understanding of holistic health care and holistic nursing includes a spiritual dimension, not all nurse participants in this study want to include a spiritual dimension to their practice.

4.2. Care and cure

I think the division between cure and care constitutes a factor that hampers registered nurses, who as a result always remain subordinate. Now when I practice CAM, I am independent of this distinction.

The terms ''cure'' and ''care'' seemed to be used to distinguish between administering treatment and caring for the sick. Thus, disease refers to an objective, measurable diagnosis. Illness, to some extent also involves the patient's own perception and experience of being sick implying a most holistic stance towards health recovery.

One participant a homeopath, introduced a third perspective – that of, ''challenge''. Homeopathy supports a person's capacity for self-healing. A child develops his health through challenge, through being cared for by people who are close to him, and through good and adequate medical treatment when necessary. A balance between ''care'' – treatment that leads to improvement – ''cure'' and ''challenge'' is essential.

In her opinion, the goal is that persons be given the opportunity to sort out for themselves how to strengthen their power of resistance. Thus, the therapist is someone who supports the patient as they deal with their personal challenges (in this instance illness). The participants in this study also appeared to claim that homeopathic medicine, acupuncture, reflexology, etc., affect people's inherent potential for self-healing – it seemed to enable individuals to overcome their personal challenge in regaining their health.[18]

Although the barrier between care and cure is blurred, the Norwegian health care system continues to be divided about the exact nature of this distinction. For instance in health care practice, nurses are increasingly responsible for tasks orientated care, whereas caring appears to be increasingly performed by enrolled nurses. This appears to have resulted in a degree of frustration among Norwegian registered nurses, who feel that they assist doctors rather than practice and administer independent nursing care.[19,20]

The recent ''Law on Alternative Treatment'' (Act No. 64 of 27 June 2003 relating to the alternative treatment of disease, illness, etc.) accepted in 2004,[21] states that there are restrictions when it comes to treating serious diseases. However, CAM therapists are free to administer therapy to serious ill persons to strengthen their immune systems, enhance self-healing or ease complaints related to the disease. However, there continues to be uncertainty among nurses who are also CAM practitioners regarding what they can and cannot do therapeutically.

Participant A, a nurse and spiritual healer, stated:

She said: I am a spiritual healer. My focus is not on curing a disease, but healing the person in a caring way. I will never be able to settle into a system that wages war on people's bodies like biomedical health care and doctors do. My experience in my healing practice is that this is ''real nursing'' and I am very interested in exploring what illness really is.

In the Norwegian public health care system, the allocation of tasks and areas of responsibility between doctors and subordinate groups are determined along the following lines. Doctors are responsible for biomedical treatments (including those performed by the nurses), and nurses, together with enrolled nurses and other health care workers, are responsible for nursing care. Svensson[6] highlights this dualism when referring to the distinction between care and cure which seems to parallel the distinction between nurses and doctors. In turn such role differentiation creates distinct worlds and cultures, in which there are differences in status, power, and working conditions rather than a collegiate and egalitarian working environment. It can also foster different attitudes towards patients. It would seem that nurses who choose to practice CAM do not accept this dualism preferring instead to create innovative health care structures and environments.

This was highlighted by one participant who stated:

In my opinion, nurses are an undervalued resource in the public health service, because they are always overridden by doctors, and because formally, they are not supposed to have any responsibility for treatment.

Although nursing is the profession closest to the patients, the participant believed that nurses either have not been given or have not assumed the authority due to them. This is one of the main reasons that she undertook education in CAM and started her own business.

A Norwegian survey entitled, ''The Patient First''[20] describes how task orientated health care appears to have eroded traditional nursing roles.

> The nurses were gradually taking over tasks that used to be performed by doctors. This contributed to nurses gradually perceiving their work on an independent basis, and not only as a utility function to the doctor or a residual of the medical profession. This has obviously led to conflict, in particular in relation to the doctors, whose position in the hospitals has so far been unchallenged (20, p. 25).

[a] The Holistic Federation of Norway differentiates between spirituality and religion and represents a non-dogmatic approach to spirituality. They have 8 statements with these headlines: 1. Changing world, 2. Spirituality and religion, 3. The spiritual world can be experienced, 4. The relation between reason and spirit. 5. Ethics, 6. CAM, 7. Ecology and 8. Rituals and ceremonies.

The process in which nurses take over tasks formerly performed by doctors continues to evolve.

One subject noted that should CAM become integrated into the Norwegian health care system medicine may attempt to absorb CAM as yet another treatment rather than form of care.

Just wait, now that acupuncture is evidence-based, the doctors will make it their own, and start deciding when and when not to use it.

The importance of patient safety and efficacy cannot be overestimated, however once a therapy has been proven to work, it may simply be absorbed as 'just another task'

The subject is concerned about what will happen if doctors are made responsible for CAM. She is afraid that she will lose some of her independence and professional authority. How will a nurse, who has undertaken five years of training in Chinese medicine, be appreciated compared with a biomedical doctor who has attended a brief course in acupuncture?

According to Arney and Bergen[22] and Freidsons,[23,24] doctors dominate health care service and are often unwilling to cede the power of their clinical position. They argue that if doctors are faced with the threat of being reduced to just one of many therapists, they will develop ideologies and visions to defend their old positions.

4.3. Masculine and feminine

The participants in this study were women only (more than 90% of Norwegian nurses are women, and most CAM practitioners and users are women). In their opinion, biomedicine is masculine and CAM/holistic nursing is feminine. Participant Karen expressed this as: The battle between biomedicine and CAM is like the battle between the masculine and feminine. Participant said: Academic medicine is part of the masculine rationality, which I think is destructive for our society, and which must be combated. Based on this opinion, she is one of the initiators of the Holistic Medical Association of Scandinavia. Another participant

Their positions are largely supported by Watson, who said:

> We all recognize that the western cultural cosmology, while changing, still continues to endorse the hierarchy of men over women and therefore medicine over nursing (masculine archetype over feminine archetype), rather than promoting the idea of two co-equal, flowing, intermingling energies needed to make a whole (7 p. 15).

Achterberg,[25] has explored the role of women in western traditions of healing from a time when women held an independent and esteemed role as therapists, through the witch trials, to the evolution of the professions of midwifery and nursing. She argues that male-dominated western medicine gradually became predominant and like Watson,[7] highlights the crisis in the public health service, within a gender perspective. Achterberg[25] suggests that female therapists have been attributed different roles and perceived differently through the ages. Female therapists have been evaluated and their terms defined based on the culturally predominant perception of reality in their times.

Thus, academic medicine has evolved according to premises set by men, and valuable knowledge has been lost.

Historically, it would seem that it is true that women have been shut out of the institutions that produced and administered medical knowledge.[26] Thus, knowledge and skills were developed but were inaccessible to women. The knowledge that developed through the 19th century became increasingly specialized, and as the intellectual era advanced, the spiritual era withered. Achterberg[25] claims that women were trapped in a deep chasm between the lost terrain of the supernatural and the advance of new science. Right up until today, she claims, women have lacked the energy, tools, and possibilities required to rise from the chasm and bridge the gap between the old and new worlds, between nature and science, and between body and soul.

Women of today can choose to become doctors. The percentage of female medical doctors has gradually increased over the years. In Norway, more than 60% of medical students are women.[27]

Although Annfelt[27] suggests that discourses and practices with masculine connotations are given priority, and subjects based on natural science are regarded as most prestigious, it would seem that along with the increasing numbers of women training to become doctors in Norway, a change in the way in which health care is perceived and managed for future generations may alter. To date, surveys concerning doctors' attitudes, knowledge, and experience regarding alternative therapies have shown a high degree of skepticism among both male and female doctors.[28,29] However, one survey noted that:

> CAM will probably strengthen its position in a future health service with more female doctors and more nurses in leading positions (28, p. 604).

5. Conclusion

It would seem that despite increasing numbers of females training to become doctors in Norway health care system, the biomedical model of care does not marry well with CAM. Difficulties encountered by nurses wishing to provide care rather than task orientated treatment have felt unable to perform the role for which they were trained. Coupled with increasing emphasis upon time management, statistics and patient throughput, some nurses have chosen to step outside the state health care system.

In doing so there is a perception on the part of nurses that CAM is more closely aligned with nursing ideals and ethos that caused them to become nurses in the first place. Here, then CAM is seem to take these nurses 'back to their roots'. It allows them not only to treat patients, but to do so in a caring and meaningful way. Furthermore, CAM nurse practitioners are able to create a more egalitarian, positive and autonomous work environment.

Perhaps this approach will highlight the way forward for health care practice.

Conflict of interest

There is no conflict of interest.

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