Evaluation Research as a Tool in Bridge Building in a Controversial Field between GPs and Classic Homeopaths in Health Care in Denmark

Laila Launsø, Associate Professor, MSc; DSc.
Department of Social Pharmacy, DFH, Universitetsparken 2, 2100 Copenhagen Ø, Denmark; National Center for Research in Complementary and Alternative Medicine, University in Tromsø, Norway.
E-mail: LL@dfh.dk

&
Jonas Rieper, BA, stud.comm. University of Roskilde; Center for Bridge Building in Health Care, Teglgårdstræde 4 F, 1452 Copenhagen K.
Denmark.
E-mail: jrieper@worldonline.dk

Abstract
This paper is based on knowledge gained from a current research project involving evaluation of the treatment given by general practitioners (GPs) and classic homeopaths to patients with allergy/asthma. The aim of this project is to develop a model through evaluation research for bridge building between conventional and unconventional/alternative practitioners. As a precondition for bridge building, the evaluation focused on a conceptualization of the differing treatment models of the two different kinds of practitioners. A treatment model consists of four components: the practitioner's understanding of disease, diagnostic system, treatment methods and expected courses of effect, and final outcome. The assumption behind this model is that understandings of disease produce a causal reasoning that legitimates specific treatment methods and specific "outcome optics". We are dealing with social constructions or discourses that define and permit different scopes of action for practitioners and patients. A report on the practitioners' different treatment models was sent out to the practitioners in order to provide background for discussion at the practitioner-researcher seminar. In relation to this seminar and the following seminar, we focus on describing learning processes and prerequisites for establishing bridge building between conventional and unconventional therapists in health care. The project should be seen as an example of how one can use differences in program theory to stimulate boundary-crossing learning processes.
**Introduction**

Internationally, the established medical community and alternative/unconventional practitioners are beginning to combine and work together. In Denmark, as in other countries, the most common initiatives for combination occur when GPs, physical therapists, psychologists, and nurses get training in different alternative methods of treatment and then practice these within the established medical community (1-3). In a few instances, there is even cooperation between GPs and alternative practitioners (like acupuncturists, homeopaths, reflexologists, biopaths, kinesiologists and nutrition therapists) (4-6). In university education in other countries, teaching of alternative methods takes place increasingly (7).

When we use the term “bridge building” here, we are referring to the establishment of dialogue and cooperation between practitioners who work with differing treatment models.\(^1\) While the term “cooperation” in its common meaning can refer to something ad hoc, the term bridge building here refers to the construction of a more lasting cooperation within an institutional framework. Here, there is a continuum from dialogue to cooperation. In terms of images, bridge building here refers to the establishment of a “permanent connection” between “territories” and/or landscapes, each with its own rationale for treatment of diseases and illnesses.

As far as we know, there is no research-based knowledge about what kind of learning processes bridge building may initiate in the medical establishment and among alternative practitioners, or about what the factors may be that either hinder or enhance, and thus weaken or strengthen, bridge building. Ever more patients use alternative methods, both as their main source of treatment or in combination with established treatments (8), and since both patients and practitioners are looking for active bridge building in the public health system, there is a need for a systematic approach in mapping out the pre-conditions for and consequences of bridge building between the established medical community and alternative practitioners.\(^2\)

We think that evaluation research can function as an important tool for developing and testing models of bridge building between established and alternative practitioners. The attempt to create “permanent connections” between established and alternative practitioners is obviously a

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\(^1\)The concept “treatment model” refers to the following components and the connection between them: the practitioner's understanding of disease, diagnostic systems, methods of treatments, and expectations about the effects of treatments.

\(^2\)This is to say that we differentiate from, for example, GPs' practices by actually combining or integrating established medical and alternative treatment methods.
controversial enterprise in Denmark in terms of both practice and research. This is reflected in the following conditions:

1. There is no teaching of alternative methods within any of the forms of established medical education. This means that most of the people in the medical establishment know very little about alternative treatments and the effects of these treatments.
2. Research in alternative methods of treatment has been viewed as unscientific.
3. Alternative practitioners, GPs and pharmacists who work in unconventional ways question the relevance and validity of the randomized controlled trial in connection with research into a number of alternative treatments.
4. GPs and alternative practitioners have very differing and conflicting ways of understanding disease and health as well as widely different treatment methods.

In the year 2000 we started a research project to discover what the pre-conditions are for building a bridge between GPs and classic homeopaths. Bridge building between the two groups is problematic since their basic understandings of disease and treatments are very different and in some ways directly opposite. But at the same time, precisely these conflicting understandings and practices provide the basis for starting or facilitating what is called in learning theory “boundary-crossing learning processes” (9, 10). Such learning processes can promote development of new understandings and actions in places where there are differing and conflicting understandings and where current practices do not give satisfactory results that is, in areas where practitioners feel that it is necessary to find new and better ways of doing things. This can then be transferred to practitioners who think that treatment of diseases and conditions can be improved by changing the existing modes of understanding and treating disease.

We have decided to confine our project to allergy and asthma because these are common conditions in the modern society. Medical treatment by a GP is the most commonly used treatment for allergy and/or asthma. Classic homeopathy is the most frequent, or next to most frequent, alternative treatment in many European countries, and it is used often in treating allergy/asthma. This is a form of treatment that probably will gain wider use in Denmark since it is relatively cheap and since patient

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3Homeopathy was founded by the German GP Samuel Hahnemann (1755-1843). He discovered that a given substance in diluted form could alleviate the same symptom that the substance would cause in its normal concentration in a healthy person. Homeopaths who practice classic homeopathy treat only with homeopathic remedies and only after certain principles. In Denmark the school for classic homeopathy was founded in 1987. There are forty trained and practicing homeopaths in Denmark. Forty more are in training. The training is private and takes four years. Classic homeopathy is an alternative form of treatment that is increasingly used by practitioners in Denmark and the rest of Europe.
organizations have begun putting more pressure on politicians to allow this, as well as other alternative methods to be subsidized.

The recruitment of GPs has been difficult. In the year 2000, we contacted 140 GPs by letter and asked if they wished to participate in the project. Only six of them wanted to. The reasons that most gave for not wanting to participate were lack of time and the feeling that engaging in dialogue with homeopaths would involve crossing forbidden boundaries. The six GPs who agreed to participate had the following characteristics: they were motivated to engage in dialogue with homeopaths, they wanted to evaluate their own model of treatment as well as their own limitations in relation to homeopathic treatments, and they wanted to engage in reflection about their own possibilities and limitations in treating patients with allergy and/or asthma.

The recruitment of homeopaths occurred through the School of Classic Homeopathy. Eleven homeopaths were chosen according to the following criteria: they had education as homeopaths: they had several years of clinical experience and they had experience treating people with allergy and/or asthma. The 11 practitioners we asked all wanted to participate in the project.

We assumed that one prerequisite for bridge building would be that those who are building the bridge know each others' models of treatment, and their strengths and their weakness, and that they have the opportunity to get to know one another and “exchange” experiences based on evaluation research that takes its departure in description of practitioners’ treatment models and that evaluate treatment results while respecting the premises of the practitioners. With this assumption, we planned a research project that would aim to develop and test a model for the way in which bridge building might be established between GPs and homeopaths. We wanted to reveal the prerequisites for this bridge building involving the treatment of people with allergy/asthma.

**First phase of the project: conceptualizing the models of treatment**

In order to conceptualize the treatment models used by GPs and homeopaths for people with allergy/asthma, we conducted qualitative interviews regarding the following: the practitioners' understanding of disease, diagnostic systems, choice of treatment, and assumptions about the effects of treatment. The interviews were printed out and sent to all the practitioners interviewed so that they could validate what they had said and what had been written. Of most importance in this process was that the rationale behind the treatment chosen was made apparent. In the following we give a brief summary of the results of the interviews, partly in the form of figure 1 that sums up the characteristics of the treatment models of the GPs and homeopaths, and partly in the description of similarities and
differences between treatment models.

(Figure 1)

GPs say that they are trained to understand allergy and asthma as independent entities with reference to physiological reactions and conditions. On the basis of their experience in practice, however, they develop a much more multi-factored explanation for allergy/asthma. Many of these GPs begin to speculate whether allergy and asthma are real diseases or whether they are reactions to something else.

For homeopaths, allergy and asthma are reactions of something underlying, and it is what is underlying that homeopaths focus on when they understand allergy and asthma. Homeopaths work from the assumption that symptoms can be connected and that they reflect underlying imbalances that must be seen in the context of hereditary disposition or predisposition, the strength of the life force, and living conditions.

While the GP uses medical history and technical measurements or tests, or uses the effects of medication to diagnose the allergy/asthma patient on the basis of common patient reactions, the homeopath orients himself/herself in finding the remedy toward the given patient's unique reactions and bases his/her revelation or discovery of the problem exclusively on conversation, the patients' own report, and the homeopath's observations. It is each person's unique reactions that direct the homeopath's choice of a remedy.

While GPs do not have experience with using homeopathic methods of diagnosis, homeopaths do have experience using medical diagnosis to determine what is common reactions and what is unique in a person's reaction. Homeopaths “eliminate” the common and focus on what is unique in a person's reaction when they choose a homeopathic remedy. This is the opposite of the GP's practice where the common decides the choice of treatment. Homeopaths also use medical diagnosis to rule out a life-threatening illness. Through his/her familiarity with the medical diagnosis and the medical treatment, the homeopath gains knowledge that puts him/her in a state to differentiate between diseases/illnesses that can be caused by medication and reactions that express a person's constitution. Homeopaths experience that people who come to them with the same diagnosis often need differing homeopathic remedies.

Both GPs and the homeopaths see their treatments as individualized. The GPs in this project have explicitly chosen to work outside the hospitals in order to get away from the standardized treatment
that they have experienced as dominating there. Simultaneously, the GPs say that more individualized treatment demands more experience than standardized treatment. For homeopaths a treatment based on a patient's constitution is always individual.

Both GPs and homeopaths prescribe medication or remedies but from completely different principles of treatment. For the GP, the aim of medication is to fight or alleviate symptoms. A GP explains it thus: “medication is designed to be destructive (to break down) by its very nature, not constructive (to build up)”. Here the GP must supplement medication with suggestions for changing behavior. Medication is exclusively aimed at the symptom. Classic homeopathy distinguishes between treatment of an acute condition and a constitutional condition. But in both cases the remedy is given in order to initiate a healing process and thus is not aimed at the symptom. In acute conditions, remedies are given to strengthen the person's ability to fight the present problem. Constitutional remedies are given in order to correct a basic imbalance. The aim of the homeopathic treatment is thus to strengthen the person so that he or she can manage the disease. This is done through the remedy and by mobilizing a person's own physical, psychological, and mental tools. Conversation with the patient is also important here, but it is not seen as a sufficient means in itself for initiating the healing process.

Common to all practitioners is the view that they, as practitioners, should help the patient there where he or she is and that they should base their treatments on the patient's desires and aims in treatment. Otherwise, as one of the GPs says, things go wrong, so patients become noncompliant or that they refuse medical treatment if they are not listened to. In this project we deal with practitioners who view themselves as catalysts for growth, development, and change, rather than as omnipotent experts.

While homeopaths focus intensely on finding the right homeopathic remedy and then center their attention on the remedy, GPs, we observe, try to avoid medication in an attempt to find other means to help and activate the patient.

GPs say that medication makes people functional and that it can extend and improve life, but that people often develop a dependency on it. A GP uses the expression “steam-power medicine”, or medicine that corrects defects in the apparatus in order to express the power that medication has. GPs experience that they can treat immediate symptoms so that physical discomfort disappears over a certain period. But they can't cure diseases. An important measure of whether a treatment has worked involves whether the patient gets better, that is, whether the patient himself or herself registers that the treatment has worked, whether he or she feels subjectively better. It is observed that an objective improvement is not a sufficient criterion to say whether or not a treatment has worked. In
regard to asthma, medication can remove the symptoms and prevent lung function from worsening.\(^4\) In regard to allergy, medication can also alleviate some of the bothersome symptoms and make it possible for the person to function normally. When GPs decide for a rigorous treatment of asthma with medication, the reason is that they believe that steroid treatment can protect lung tissue in the long run and that it is best to avoid under-treated asthma that can result in progressive loss of lung function.

To homeopaths effects reflect that a remedy has facilitated a curative process due to certain laws of healing. A course of treatment is monitored based on these laws.

There is a fundamental difference between the way GPs and homeopaths understand effect. While a GP uses the effect of a drug in order to confirm or reject a diagnosis, the classic homeopath tries to find out whether a healing process has been started. For GPs it is essential for medication to work directly on allergy and/or asthma symptoms. Medication is given to combat symptoms, and it must have a specific effect on the symptoms. Homeopathic remedies are assumed to work indirectly, that is, without having a specific direct effect. The homeopathic remedy is designed for the patient and not the symptom. There is a difference between the effect that GPs seek and those that homeopaths seek. Homeopaths aim at healing. The treatment by GPs aims at making people functional and shortly symptom-free. GPs experience that it often becomes more and more difficult to keep symptoms from reappearing as time goes by, and they are very aware that use of medication can develop into dependency on medication.

A clear dilemma that GPs cite is that medication has side effects. Homeopaths, on the other hand, maintain that homeopathy does not have side effects if the patient gets the right remedy in the right amount. But homeopathic remedies can cause reactions like a brief immediate worsening or outbreak of symptoms.

The treatment models of GPs and homeopaths differ in that there is apparently less connection between GPs' understanding of allergy and asthma and their treatment of it compared to the homeopaths. Even though the GPs involved in the project have a multi-faceted understanding of health and disease, it appears that it is not always possible to act on this understanding in practical treatment. It is evident that a GP can have an understanding of disease as something other than the symptoms manifested (for example, that allergy can be a reaction to something else), but that he or

\(^4\)One of the GPs does not believe that it has been documented that asthma medicine prevents lung function from worsening.
she chooses to treat the physical symptoms and not a possible underlying cause. GPs acknowledge this lack of connection. Some of them are frustrated by it and try either to refer patients to other practitioners or to treat several aspects of the patient themselves. Other GPs say that they know that they are only doing something about part of the problem but maintain that these are the conditions of the institution under which they work, and that this prevents them from acting in other ways.

We observe a greater correlation between the homeopaths' theory of health and disease and their course of treatment since a remedy is given in order to start the healing process. The homeopaths learn in their training that disease comes about because of disturbed life force, and therefore their treatment aims to correct the disturbance and not the consequences (that is, the symptoms) of it. Homeopaths work to monitor the course of effects on the basis of Hering's laws and miasma theory.

In the interviews with GPs and homeopaths, we learned that GPs are much more critical of themselves in regard to their treatment models than homeopaths are. This may be because the GPs selected themselves to participate in the project, but it may also have to do with the differing interests among GPs and homeopaths for participating in the project. The GPs' motive for participating in the project was primarily to avoid treatment with medication as far as that is rational, and the GPs were therefore open-minded and curious to find other treatments that might work better for their patients. Homeopaths, on the other hand, participated in the project primarily in order to establish cooperation with GPs because they are convinced that their treatments work and can supplement or even replace treatment with medication.

Second Phase of the Project: Seminar for practitioners and researchers

In this phase, a practitioner-researcher seminar took place at which practitioners, on the basis of a report that dealt with their models of treatment, had the opportunity to meet and discuss similarities and differences between their different treatment models. This seminar was followed by qualitative interviews with a number of practitioners who had participated in the seminar. The seminar took place in pleasant surroundings in a room at a restaurant that had been rented for the occasion. It was the first time that the participants in the allergy/asthma project had met one another. Ten homeopaths and two GPs, as well as two researchers and two students, took part. Before the seminars the participants had received a draft of the report mentioned above that dealt with GPs’ and homeopaths’ differing models of treatment. The seminar lasted a busy 3 2 hours. There were two main points on

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5. These practitioner-researcher seminars are planned to occur once a year. The second seminar just took place in June 2002.
the agenda: first, a discussion of similarities and differences between the differing treatment models, and second, the practitioners' evaluation of a draft of a questionnaire about the effects and results of their treatments that the practitioners would afterward give out to patients.

The practitioner-researcher seminar was meant to create an open forum in order to stimulate practitioners to exchange experiences across the differing treatment models. There are not yet any institutional venues where such exchange of experience can take place in daily clinical work.

On the basis of the project's first two phases, and with the practitioner-researcher seminar as an important point of departure since it was here that the practitioners met face to face, we were interested in investigating the possibilities for learning. Here we are especially interested in the possibilities for new and better models of treatment and better treatment results. Our focus here is on the conditions required for initializing and facilitating the learning processes that can involve the crossing of boundaries between some of the fundamental understandings and treatments in relation to people with allergy/asthma. In this part of the project, the focus was on illuminating the following research question: what form of learning in regard to the understanding of disease and the treatment of people with allergy/asthma can come about when GPs and homeopaths, who work with differing and conflicting models of treatment, actually meet?

The word “meet” here refers to participation in the research project's first two phases.

**Theory of learning**

Our research question here is based on the following fundamental premises: The GPs and homeopaths have widely differing and in some ways opposite models of treatment; the differing understandings of disease and health that homeopaths and GPs work with are socially constructed⁶ and that in order to establish successful bridge building work a certain amount of individual learning that involves boundary crossing must be achieved if people who work with widely differing models of treatment are ever to understand one another and cooperate in the long run. We are dealing with a process that is marked by the possibility that the practitioner's feelings can come into play and a process that demands strong motivation in the individual practitioner. Likewise the concrete social context plays

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⁶The socially constructed aspect that we capture in this research project is the practitioners' accounts of their understanding of and their rationale for treating people with allergy and/or asthma. We do not say here that the physical manifestations of disease are socially constructed. This problem is addressed by, among others, Finn Collin in the book *Social Reality* (16).
an important role in the learning process (11). The social context in this project includes the “virtual room” that participation in a research project can create, the practitioner-researcher seminar, and of course the other professional and institutional contexts that the practitioners are part of.

By far the most common form of learning occurs through assimilation. This means that the new things that one experiences are added, so to speak, to the existing schemes and patterns in which one usually thinks and acts. One's understanding of disease, diagnostic system, treatments, and expected effects remains uncontradicted or unchallenged.

In some situations, or on the basis of many years of clinical experience one may, however, experience some changes in one's pre-understanding that one cannot immediately relate to one's professionalism or to things learned earlier. If one does not completely reject the experience but instead feels that it is important and that it demands reflection and possibly different ways of understanding and acting, a boundary-crossing learning experience may begin. But we can first speak of a boundary-crossing learning when a person gives up and reconstructs earlier understandings and attempts to solve problems in new ways. This process can seem difficult, energy consuming, and threatening because of the recognition that one must understand or accept something that in many ways is new and different. But it may "feel right" and it can in the intermediate learning process involve a complete break in orientation in relation to earlier methods of understanding and acting. Defense mechanisms are a formidable barrier that must be gotten over before new boundary-crossing learning can become a reality. Boundary-crossing learning involves being challenged and involves breaking the boundaries for what is considered legitimate and usual, and therefore it involves the experience of conflict (1, 9-15). In these processes it is not just one's own defense mechanisms that can cause a block but also the institutional frame in which one works (1).

We base our approach to the learning processes that we will investigate in connection with the first phases of the project on a constructivistic and a constructionistic understanding. We assume that the individual practitioner constructs his or her own learning from his or her own readiness in play with psychological, emotional, cognitive and social conditions (1, 13). This means that we cannot just offer a process of learning to the practitioners who participate in the project. It is the practitioners themselves who must determine whether the learning process should start or be facilitated and how it should come about. Here we speak primarily of an inner determination that cannot, of course, be understood apart from outer social relations and contexts. The evaluation project is part of this since

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7 Constructivism points out the unique experience of each of us focusing on the meaning making activity of the individual mind. Constructionism points to the collective generation of meaning (17).
we challenge the practitioners' understanding and actions by initiating discussion of differences and similarities between the differing models of treatment, and then initiate discussion of effects experienced by patients and patients' evaluation of them. In order to gain access to the learning processes in connection with this intervention, we bring in the practitioners' thoughts, experiences, and reflections as the most important sources of data, supplemented with data from observation of participants at the practitioner-researcher seminar.

Methods and Materials
In order to illuminate some of the learning processes that the research project could perhaps initiate, we used a case-study design in connection with the seminar and used participant observation combined with qualitative research interviews after the seminar. On the basis of participant observation and a video recording of the events at the seminar, we conducted qualitative interviews with a GP and two homeopaths immediately afterward. Only one of the two GPs who participated in the seminar wished to be interviewed about the seminar. The criteria for the choice of the two homeopaths for the interviews were that one was a homeopath with established training in the medical health professions and the other a homeopath without training, and that the two chosen homeopaths had called attention to themselves at the seminar by being in disagreement about the important elements in the homeopathic treatment model for asthma and allergy.  

The focus of the observations was the contents of the seminar in respect to practitioners' understanding of allergy and asthma, as well as disease and health generally, as they were expressed at the seminar through the emotional climate and the body language of the practitioners. The qualitative interviews played an important role in capturing the practitioners' understanding of the learning processes, or lack of them, that the first phases of the project brought about. In addition, learning processes have an inbuilt time perspective, which is why it was necessary to bring in phases via interviews both before and after the seminar. The video recording of the practitioner-researcher seminar that formed the basis of the thematic guide for the qualitative interviews and the qualitative interviews themselves have become the object of qualitative analysis and interpretation.

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8 Their positions were expressed partly by the practitioners' verbal testimony and partly by their body language.

9 Over the next years, the learning processes of the practitioners will be followed. The project is planned to run for four years altogether.
Results
Analyses of data from participant observation at the first practitioner-researcher seminar and from the qualitative interviews show that the GPs before the seminar were in a boundary-crossing learning process in relation to the understanding of disease that they were originally educated to. In that connection, our analysis shows that the first phase of the project played an important role in stimulating the boundary-crossing learning process. Both GPs were especially critical and reflective toward the system that they themselves are part of and in which they work. The meeting with homeopaths gave the learning process new nourishment:

“I feel that until now existence has been a long process of waking up in which my realization of many things has increased more and more. I really think that the 30 years I've been in this field have given me a different perspective. When I started, I was very oriented toward biochemistry and natural science. Genes and molecular biology are also incredibly fascinating. At first, I also thought that intensive hospital work was very exciting. Something I have been thinking recently since the meeting with the homeopaths (. . .) is how much we really know. Here I can say that very little has happened the last 30 years. We can now do a couple of transplants. But if one looks at it systematically, it really is notoriously minor. And the other thing is that we don't know the causes of most diseases B I can hardly use the word anymore (. .) We don't know a thing about it (. .) There are thousands of questions that were unanswered when I started and thousands that still are unanswered. This just means that I feel humble in relation to something that is considerably bigger and more complicated than what we learned when I was in medical training, when we just pulled something out or tightened or loosened a screw so that the mechanics of it functioned again. Maybe it is in that perspective that homeopaths come in and that words like life force and self-healing powers gain meaning. There is no doubt that such things are at play”.

“People have an inner balance that can be disturbed, and they have self-healing powers. These are some of the things that I have brought to consciousness via the seminar, but I can still hear my colleagues and teachers during my medical training speaking mockingly of something diffuse like life force, spirit, soul and healing powers as nonsense. But if one takes a look at people and takes a step back and looks at everything in the context of modern medical science, one can profitably operate with those sorts of concepts. It isn't that often that one does it, but it is completely clear that right there under the surface is something of great significance. What is one's life like, one's view of existence; is there a meaning in life; what possibilities does one have in the future, and so forth.

The following section uses only a selection of quotations because of space limitations.
These things are part of a whole that one calls life force or something else. There is something that drives people through life and drives the individual cell always to attempt to survive. There are metaphysical principles that we cannot explain. (...) I think it is good to bring these perspectives out in the open, and I have nothing against calling it life force”.

This GP's recognition of and open-mindedness about how things may be different enables him to reflect about his pre-understanding and lets him view other understandings of disease and treatment methods in relation to himself.

From the perspective of learning theory, the learning process that the GP quoted was undergoing, and which the first phase of the research project helped stimulate, can be characterized as a double-loop learning process marked by reflection over how the practitioner himself thinks, that is what the rationale is for the practitioner's design and implementation of treatments (13: 100). A considerable part of this reflective work has been the conceptualizing of the practitioner's treatment models with the aim of laying bare the rationales that practitioners use to design and implement their treatments. This means that interviews and reports that deal with practitioners' different models of treatment have helped expose a tacit knowledge, that is, a knowledge that has not previously been verbalized or reflected over. For the GP quoted, homeopathic concepts like life force and self-healing powers may capture some of the things that after many years of clinical experience he feels convinced are at play in the course of disease, but that he until now has had only as tacit knowledge for which he had no concepts.

We have characterized the long-running learning process that the GP has expressed as a form of double-loop learning process. As already noted, such a learning process involves reflection over the rationale behind a practitioner's way of acting and treating diseases. In that connection, it is interesting that in relation to the treatment models, we could point to the lack of a connection between GPs' understanding of allergy/asthma and the treatment prescribed by their treatment models. From the perspective of learning theory, it is relevant to ask whether the lack of a connection in the treatment model will lead to new treatment methods for allergy/asthma that may take the form of real cooperation between homeopaths and GPs. If this becomes the case, then it will be possible to speak of a boundary-crossing learning process that does not just lead to a boundary-crossing understanding of allergy/asthma but also to new ways of solving problems, acting upon and treating diseases.

The lack of connection between the components in GPs' treatment models can be interpreted from a learning-theory perspective as a double-bind situation understood as a paradox that cannot be solved
within the existing set of possibilities for treatment. The double-bind situation is a prerequisite for a particular kind of boundary-crossing learning that is characterized by transgression of conditions constructed through earlier learning (11). Here, in contrast to the kind of double-loop learning mentioned earlier, it is appropriate to speak of a more extensive and radical form for boundary-crossing learning in which the collective and social dimensions play an important role in gaining insight and thus freedom from conditions constructed through earlier learning.

It is probable that the lack of connection between GPs’ understanding of allergy/asthma and the treatment prescribed by their treatment model is an important factor in their curiosity and open-mindedness about alternative treatment models, including that of homeopathy. Furthermore, in the meeting of the homeopathic treatment model and that of GPs in relation to allergy/asthma there is a clash that must be assumed to hold some exciting learning possibilities.

The homeopaths who were interviewed were generally more reticent about what they had gotten out of the report and the meeting with the GPs at the seminar. While one homeopath (I) focused in the interview on differences in the understanding of disease and health, the other (II) focused on GPs' treatment of allergy and/or asthma through conventional medications that are viewed as directly opposite to the kinds of treatments within classic homeopathy. After her homeopathic training, this second homeopath (II) had chosen to study to be a nurse. For this homeopath the medical training is strongly rooted in a phenomenological and subject-oriented frame of understanding that lies over and directs her work both as a nurse and as a homeopath:

“Whether I am acting as a nurse or as a classic homeopath, my starting point is the Humanities. My view of people is based on my knowledge of the Humanities. I work phenomenological as a nurse. I listen to people, I look at people, I smell people. If I find that something is wrong, I contact a GP, or I act on my knowledge and training as a nurse. I use exactly the same method whether I am acting as a nurse or a homeopath. (. . .) The truest way of finding out something must be the phenomenological method. That is, what the patient himself or herself says is what is important. My opinion does not enter into the matter. I can suggest some possibilities, but it is the patient’s own choice as an individual and autonomous person. It is important to signal respect for the choice the patient makes. It is only that person who is making a choice about his or her own body or life who has the right to speak” (homeopath II).

11Several of the homeopaths who participated in the seminar had also been through an established medical education either before or after training as a homeopath.
When directly asked if the meeting with the GPs had contributed new knowledge, the second homeopath said the following:

“No, they didn't bring me any new knowledge. I have a number of patients in treatment for asthma. The course of treatment they have been through was based on exactly the same principle by which one of the GPs said he worked. ( . . ) But I think that it is really nice that someone is interested in cooperation” (homeopath II).

The first homeopath (I) had a different experience of the meeting with the GPs. The discussion about who has the right or the competence to decide when a person is healthy had started up some interesting thoughts in the mind of this homeopath:

“There was something about disease and healing. Who decides when a person is sick? (This issue) gives me a greater understanding of the choices people make, whether it is the GP or the client” (homeopath I)

Precisely this example that homeopath (I) gives about the question of who has the right to decide when and if a person is healthy, is one of the more concrete returns of the seminar. It is interesting because his attitude about who has the right to determine whether a person is sick B the practitioner or the patient himself or herself B apparently hits right at the center of an internal conflict among homeopaths, who divided the waters for us at the seminar in an unexpected way. The homeopath quoted operates with a division between partial and complete healing, with the understanding that it is the homeopath himself who has exclusive knowledge about when a person is defined as fully cured. A diametrically opposite view was expressed by the GPs and shared by a number of the homeopaths at the seminar. This view is that only the individual person can decide when he or she is cured. But this internal disagreement was quickly smoothed over at the seminar.

When asked about the returns of the seminar, homeopath (II) answered that the most profitable thing had been the revelation of the internal differences among homeopaths:

“We homeopaths do not all work after Hahnemann's principles ( . . ). We actually sat and muttered a bit in the corners [at the seminar]. ( . . ) I felt uncomfortable about some of the things the other homeopaths said ( . . ) It made a big impression on me that we disagree so strongly ( . . ) It is really troubling ( . . ). One person at the seminar said that he/she felt that one could still do more for patients even though they felt themselves to be healthy, and I thought, no, the world is going to stop, because if a person who feels healthy and does not want to continue treatment is ordered to anyway . .
so we are almost over in the other “camp”. We do not have the right to do that. That is completely wrong. I got really agitated about it” (homeopath II).

The seminar was characterized by the following, among other things: “Incredibly positive ( . . . ) an atmosphere marked by mutual respect and openness” (GP I); Avery fertile and exciting and dynamic” (homeopath II); “there was a positive atmosphere” (homeopath I).

“The positive atmosphere at the seminar and the openness among the participants, who one assumes have a different view of matters, differentiated it from the role that our system has come to have in rejecting and reacting arrogantly to people who think differently. The opposite is openness in which people are interested and open to one another, as it was here” (GP I).

Characteristic for the practitioner-researcher seminar was that it could accommodate both conflicts and openness in a positive atmosphere, which is a necessary prerequisite for learning to take place.

Conclusion and discussion
What characterized the two GPs who participated in the seminar was that they already before the seminar were in a boundary-crossing process in regard to the treatment model that they had been trained to in their medical education. These two GPs could be characterized as “boundary walkers” (1). Both GPs were critical toward the results that they could achieve by treating people with medication, and they were very receptive to the homeopathic model of treatment. One GP spoke of how the meeting with the homeopaths brought both consciousness and concepts to something that until now had been tacit knowledge B a tacit knowledge that the GP also thinks many GPs already have. The revelation of this tacit knowledge had stimulated boundary-crossing learning for him. The Japanese researcher Ikujiro Nonaka (14) has investigated within an organizational context how tacit knowledge,12 as an important source for creation of new knowledge, can be made explicit and useable via interdisciplinary cooperation. The prerequisite for such a mobilization of participants’ tacit knowledge is, according to Nonaka, the creation of a place of trust with room for difference.

It is worth noting that the GPs showed a more open attitude and more curiosity for the treatment models of the homeopaths than the other way around. This may reflect the different learning processes that the practitioners are in the course of and the interests that GPs and homeopaths had in participating in the project. While the GPs were motivated to find new ways, the homeopaths were

12Nonaka’s concept of “tacit knowledge” includes a cognitive dimension (schemata, paradigms, mental models) that he also calls a “perspective”, as well as a technical dimension (concrete know-how, abilities) (15: 74).
more interested in getting the GPs’ acceptance of their treatment model. Here the homeopaths do not define the space to discuss a collective critical attitude to the homeopathic treatment model or to discuss at length the differences that came out between homeopaths at the seminar. Participation in the seminar made it clear for the homeopaths that they are not in agreement about fundamental questions regarding, for example, who determines when a person is cured. Is it the practitioner or the patient? We further have to reflect on the fact that homeopaths beforehand knew quite a lot about the GPs’ treatments either through their own experience or through their patients’ reports.

While the GPs could be said to be characterized by being in a boundary-crossing learning process, the learning processes that homeopaths were involved in were more assimilative and characterized among other things by the need for agreement within the group of homeopaths.

These differences may be connected to GPs’ publicly recognized position in society as authorized practitioners who have a recognized education and many years of clinical experience, and thus the legitimacy that can give them the strength to look through new windows of possibility. Contrary to them, the homeopaths do not have a publicly recognized position and are not authorized practitioners with a recognized education behind them. In this position it can be problematic to show disagreement or just generally to be in disagreement about fundamental matters. Here it is worth saying that it is brave of the homeopaths to participate in a research project in which their treatment models and results get critical scrutiny. This in itself is a demanding process, and perhaps there will be more room for boundary-crossing learning after the results of their treatment as assessed by patients are brought forward. Of course, it depends also on the results of the patient-evaluation. If we look at the reasons why GPs and homeopaths were interested in participating in the project, we can also see that they are different. While the GPs agree on their experience that the effects or results of symptomatic medical treatment of people with allergy/asthma can be frustrating or depressing and that they therefore are looking for a window to provide new understanding and treatments, the homeopaths are interested in spreading knowledge about their treatment models. They also want to show how the classic homeopathic treatment model can give effective results for people with allergy and/or asthma and can replace or supplement medical treatment in order to cure people with allergy/asthma. A considerable interest is also recruiting new patients in the long run.

In order to develop bridge-building cooperation between GPs and the homeopaths the next step must be to formulate common values for such work. But in order for this to take place as the research

\[\text{We write Acan@ because the openness and curiosity that the GPs in the project exhibit is not typical for GPs in Denmark.}\]
project requires, this formulation of common values and aims must take place on the practitioners' own grounds and at a speed they themselves determine. An important matter in the longer run is to find out whether GPs in the project want to work to adapt classic homeopathy as an extended arm of their medical work, or whether they want cooperation on equal terms with practitioners who work with other models of treatment and thus want to contribute to institutionalizing a bridge-building cooperation. It is assumed that a bridge-building requires that practitioners – within as well as outside the established health care system - accept on a deep level that there is not just one truth for understanding disease and treating allergy/asthma and that one therefore can not have a monopoly on the “truth”.

In relation to what one could expect when practitioners who work with two different models of treatment meet, the practitioner-researcher seminar was held in an atmosphere of openness and mutual understanding for each others' treatment models. This is no doubt connected to the self-selection of the GPs in the project.

The results of the evaluation project described here point toward the way in which differences can have a strong effect in connection with bridge building in health work. The results of the project's intervention must be seen in connection with the individual learning processes that practitioners were already involved in, and in regard to the forces at work in the institutional and professional contexts.

The project should be seen as an example of how one can use differences in program theory to stimulate boundary-crossing learning processes. We see the treatment models that are worked with in the project as explicit examples of program theory. Important points in this process have been the work to conceptualize the treatment models of the two stakeholders and the work with a general discussion of similarities and differences between the treatment models based on practitioners' reading of a collected report about their treatment models.
References:


