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US military veterans' perceptions of the conventional medical care system and their use of complementary and alternative medicine

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Background. Use of complementary and alternative medicine (CAM) is growing quickly in the USA, prompting hypotheses about why people turn to CAM. One reason for increasing use of CAM modalities may be dissatisfaction with the conventional care system. However, recent studies suggest that dissatisfaction is not a major factor.

Objectives. This paper provides another perspective on the possible relationship between dissatisfaction with conventional care and the use of CAM.

Methods. Qualitative data collection, in the form of 12 focus groups with 100 CAM users, was used to inquire about issues surrounding the use of CAM. Focus group participants were military veterans enrolled in the Southern Arizona VA Health Care System, and their significant others. Qualitative analysis identified key themes emerging from the focus groups.

Results. Although participants were satisfied in general terms with their conventional care, there were particular aspects of the conventional care system that they criticized. Dissatisfaction with aspects of conventional care, particularly its reliance on prescription medications, was an important component in their motivation to use CAM. Results also suggest that the conventional medical system's lack of holism (inadequate information regarding diet, nutrition and exercise, and ignorance of social and spiritual dimensions) is also an important motivation for turning to CAM in this particular population.

Conclusions. Independent research and a sense of responsibility on the part of focus group participants for their own health seemed to be taking them outside the domain of the conventional health care system.

Keywords. Alternative medicine, complementary medicine, herbal drugs, holistic health.

Introduction

Complementary and alternative medicine (CAM) use continues to increase in the USA. Recent studies found that respondents using alternative therapies increased from 33.8% in 1990 to 42.1% in 1997.[1,2] Americans' total visits to alternative providers during that period increased 47.3%, and expenditures for alternative providers increased 45.2%.[2] Health maintenance organizations are also taking into account consumer demand for CAM modalities as a part of the health care regimen. In one poll, 67% of persons surveyed said that availability of alternative health care influenced their selection of a health insurance plan.[3] Several university departments of holistic or 'integrative' medicine have emerged, and some primary care providers are beginning to embrace CAM.[4]

There is an extensive range of CAM modalities. Eisenberg *et al.*[1] defined unconventional therapies as "interventions not taught widely at US medical schools or generally available at US hospitals". This definition potentially encompasses practices from traditional societies, non-mainstream Western practices

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(e.g. homeopathy), religious and spiritual practices believed to promote healing (e.g. laying on of hands), mind–body techniques and more recently developed non-mainstream technologies (e.g. chelation). The motivation for CAM use is equally diverse. Some CAM users may be rediscovering home remedies passed down through family or culture. Other users may be reacting against modernism by using a more natural approach, or exploring spiritual modalities.[5] In general, CAM users tend to be young adults, well off and well educated.[6–9] Studies also suggest that women use CAM more often than men.[8–10]

Motivation for CAM use may include a greater realization of the limits of conventional care in treating chronic conditions. The principal health complaints of CAM users have included chronic conditions such as back problems, allergies, fatigue, arthritis, headaches, neck problems, high blood pressure, sprains and strains, insomnia, lung problems, skin problems, digestive problems, depression and anxiety.[2] Astin's study of CAM use in the USA supports reports of chronic conditions associated with CAM therapies.[6] Furthermore, Astin notes that certain chronic complaints (back problems, chronic pain, anxiety and urinary tract problems), as well as overall poor health, are statistically predictive of CAM use. The findings reported by both Eisenberg and Astin are consistent with studies carried out in Europe and Canada.[7–9,11,12] These results suggest that some people may be turning to CAM because they have found little or no relief from conventional medical interventions.

There may be additional limitations to conventional medicine apart from adequate treatment options for chronic conditions. There is a growing desire among Americans for a more holistic approach to health, as well as for a more meaningful relationship with their primary care providers.[13] These limitations of conventional care raise the possibility that dissatisfaction with the *process* of conventional medical care (e.g. lack of preventive services), apart from its *outcomes* (e.g. failure to improve chronic conditions), has contributed to CAM use. In other words, while some patients are *pushed* toward CAM use due to poor outcomes of conventional medicine, others are *pulled* to CAM by its alternative array of values.[14]

The majority of studies that have provided reasons for, or predictors of CAM use have been carried out in Europe,[14–19] Canada,[7,9,20–22] or Israel.[8] The studies of Eisenberg *et al*.[1,2] have described types and costs of CAM use in the USA, whereas Astin,[6] Barrett *et al*.[13] and Owens *et al*.[23] addressed predictors of CAM use in US samples. Hence, an understanding of the patterns and predictors of CAM use in the USA is just beginning to emerge. Furthermore, most, if not all, of the preceding studies have utilized civilian populations. Very little information is known about CAM use among US military veterans who are seen by family or general practitioners. The intent of this study is to (i) help practitioners understand some of the motivations for CAM use among military veterans; (ii) assess whether or not these motivations are similar to those of civilian populations; and (iii) determine if dissatisfaction with particular issues (both process and outcome) can motivate CAM use among veterans who, simultaneously, may express overall satisfaction with conventional medical care.

Methods

Focus group recruitment and demographics

The data reported here were collected in the course of 12 focus groups involving veterans who are served by the Southern Arizona VA Health Care System (SAVAHCS). Participants also included significant others who had expressed an active interest in CAM. The use of focus groups allowed dense, efficient, semi-naturalistic data gathering from a relatively large number of people.[24,25] Recruitment procedures included (i) making telephone calls to 30 veterans known to be interested in CAM (list provided by a SAVAHCS nurse practitioner); (ii) displaying fliers in the SAVAHCS primary care clinics; and (iii) making telephone calls to a random sample of veterans who were enrolled in the SAVAHCS. Veterans were asked whether or not they used, or were interested in CAM and, if so, whether they would like to participate in a focus group. All respondents gave informed consent to the study, which was approved by the Institutional Review Board of the University of Arizona and the SAVAHCS Research and Development Committee.

One hundred people participated in the 12 focus groups. Group size averaged eight individuals (range 5–11). Sixty-nine of the participants were veterans. Other participants included spouses, significant others and a caregiver. Among the veterans, males predominated (62/69, or 90%). Since significant others were invited to participate, women were well represented overall (37/100). Of the 30 non-veterans, one was male. The average age was 63 years (range 24–83 years) for the 96 participants whose ages were listed. Of the 95 participants whose ethnicity was known, 87% were non-Hispanic white, 7% were Hispanic, 4% were African American and 2% were American Indian or Native Alaskan. The 69 veteran participants were not statistically different in age or gender from the overall SAVAHCS population. However, they were more likely to be 'separated' from their spouses (7.4% versus 3.1%, $P < 0.05$), more likely to be non-Hispanic white (88.2% versus 75.6%) and less likely to be Hispanic (5.9% versus 11.4%, $P < 0.001$).

Focus group setting, facilitation and analysis

Of the 12 groups, nine were conducted at the SAVAHCS hospital in Tucson, two at a satellite clinic at Fort Huachuca and one in Yuma, near another satellite clinic. The first two authors developed a focus group discussion guide and acted as facilitators. Discussion included such

topics as CAM modalities used, sources of CAM information, experiences with conventional providers regarding CAM and experiences with CAM providers. Other topics arose spontaneously. Focus groups were recorded on audiotape and transcribed for further analyses. The first two authors developed analytical categories based on project goals, as well as new information generated by participants. Transcripts were coded using Atlas.ti® qualitative analysis software (Scientific Software Development, Berlin, Germany).

Results

Overall findings

Participants used a wide variety of CAM modalities. Over 130 CAM remedies and treatments were mentioned during the course of the 12 groups (not including alternative diets). In addition to the ubiquitous use of vitamins and minerals, participants used a wide variety of herbs, nutritional supplements and other self-administered therapies. Participants also reported a variety of practitioner-administered modalities such as massage, manipulation, acupuncture, hypnotherapy, homeopathy, magnetic therapy, Rolfing, biofeedback and aromatherapy. The majority of CAM treatments were paid for out-of-pocket. Group members reported spending ~$55 per month on CAM (range $0 to ~$350).

There were >100 instances in which CAM remedies or treatments were mentioned in direct relation to one or more medical conditions. The majority of participants were using CAM to treat moderate to serious conditions such as chronic musculoskeletal pain, arthritis, pulmonary disease or cardiovascular disease. In addition, there were 92 passages (nearly eight per focus group) in which participants mentioned preventive measures, such as diet, nutrition or exercise. Some participants had discussed their CAM use with their conventional provider, but most had not.

Participants reported obtaining CAM information from a wide variety of magazines, newspapers and books by leading proponents of alternative or integrative medicine, such as Dr Deepak Chopra. Other resources included health food store employees, friends and acquaintances, radio, TV, the Internet and mail order catalogues. Occasionally, conventional providers referred patients to CAM.

Satisfaction and dissatisfaction with conventional medicine

Most focus group participants praised their conventional health care, and many participants noted that the SAVAHCS had made great improvements over the years. A male veteran said, "While we may poke sticks at our VA hospital, this is the best care that I have ever had in my life". When discussing their CAM use, however, participants often connected it to dissatisfaction with a few very specific aspects of conventional care. Most participants had experience with conventional care both inside and outside the VA system, and their comments seemed to refer to the conventional care system in general, rather than particular institutions or providers. The following aspects of conventional care were disliked the most:

- Prescription side effects, clinician drug monitoring and the pharmaceutical industry.
- Lack of emphasis on nutrition, exercise and preventive medicine.
- Desire for more holistic health care.

Prescription side effects, clinician drug monitoring and the pharmaceutical industry

The participants' single most common complaint was about side effects from prescription drugs. Many complaints focused on the strong and/or addictive nature of prescription medicines. Participants' descriptions of prescription medicines involved words such as "heavy", "strong" or "harsh". Some participants described their medical regimen, or themselves, as "toxic" (Table 1, #1).

Emphasis on the toxicity of prescription medicines is consistent with participants' understanding that prescription medicines are members of a class of 'chemicals', 'poisons' and other artificially synthesized or purified substances. The principle behind this way of thinking was particularly noticeable in a conversation about the medical use of marijuana. Several individuals (some pro, some con) discussed the relationship between marijuana and Marinol (a synthetic form of THC, the active ingredient in marijuana). The gist of the conversation was that Marinol was not to be trusted because it was no longer in its natural form (Table 1, #2).

This passage also suggested a mistrust of pharmaceutical companies—a theme that arose several times during the focus groups. Some individuals pointed out that herbs are in the public domain and are, therefore, unpatentable. They suggested that drug companies were eschewing research on herbal remedies because of higher profit margins available from refined or synthesized patent medicines. This, they said, contributed to the conventional medical system's emphasis on medicines that were more dangerous to patients than herbal medicines. Some individuals saw doctors, hospitals and pharmaceutical companies working together in a monolithic system. One male veteran stated, "The doctors ... they're taught this stuff and it becomes like a religion. And then, of course, the hospitals—that's their temples. And the pharmaceutical corporations—that's God". As further evidence of the dangers of patent medicines, several participants cited television drug commercials that state, in detail, the possible side effects of the drugs being advertised.

Some focus group participants were particularly wary of the long-term use of prescription medicine. For

Table 1 *Focus group participant sample statements*

No.	Subject (focus group no.)	Statement
1	Male vet (4)	I didn't drive for the first two months because I had too many pills in me. I mean, I was literally, what I consider toxic.
2	Female spouse (3)	So, in other words, they've taken the real thing and they synthesized it. It isn't, it isn't the real thing.
	Male vet response	So they can make a buck off it.
3	Female spouse (1)	Like everything that we eat, you know, any processed food that we pick up has got chemicals in it. There's some kind of thing in there to preserve it . . . Read the labels . . . there's stuff in the atmosphere that we're exposed to and I think that's one of the reasons why we should be taking, like, Vitamin E and things . . .
4	Female spouse (7)	He calls them back and says, "It's not doing anything." "Okay, fine, we will send you something new." They send him something new all right. It's a new name, but it's basically the same damn drug, has the same side effects, and in the PDR, it's listed under the same . . . it's the same thing with a different name. And it didn't do any good either.
5	Female spouse (12)	. . . years ago, we all ate a lot of eggs, and our chickens all ran out loose and they had a lot of natural things to eat. And now . . . they fill them full of all kinds of things to put that quick growth on.
6	Female spouse (1)	I know when D___ [husband] had open-heart surgery, I had a revolution going on in the hospital because I made such a fuss. His first meal was fried eggs, and bacon, and margarine, and toast. And I just screamed blue murder because this is the thing that got him there in the first place.
7	Male vet (8)	I have been going to [the] Tucson [VA] for a number of years now, and I have not received anything by the way of diet that might be a way of a guidance thing. And also, I have always believed that a proper exercise program is about 90 percent that it could head off [sic], and I have not seen any effort on that part.
8	Female vet (2)	I want preventative medicine. If I had known then what, what I know now, I would have started with the preventative medicine. Just like your car, you change the oil on it or you see the dentist every six months.
9	Female vet (11)	The majority of medical health care providers don't even think about your environment, and so they just look at your body as opposed to the whole thing. And it is your whole lifestyle that affects your entire health, and your mental, your physical, your spiritual, your emotional. And so the providers need to ask more encompassing questions because you could be deathly ill, and it could just be [an allergy to] your pillow.
10	Female spouse (6)	The migraines, oh, it has been an exciting [sic] to try to help those. I am going to acupuncture. I call her the porcupine lady. But what has been really great about that is not just the acupuncture, but the whole approach is a very holistic approach . . . She is teaching me to be well myself.
11	Male vet (10)	The problem today with physicians is if you went in with an obvious mental problem and he does not have the knowledge, or the time, or the inclination, whichever it may be, and maybe it is all three, to determine exactly what it is, it is much easier for him to prescribe a medication. And this is what they usually do rather than getting down to the root of the problem.

The statements exemplify 'prescription side effects, clinician drug monitoring and the pharmaceutical industry' (1–4); 'lack of emphasis on diet, nutrition and preventive medicine' (5–8); and 'desire for more holistic health care' (9–11).

example, a female veteran with chronic joint pain described her use of glucosamine sulfate and chondroitin sulfate (nutritional supplements) due to concern about prolonged use of conventional pain relievers. An important aspect of many participants' stories was that they felt they actually had been successful in finding natural and effective substitutes for patent medicines.

Another veteran worried about taking too much Motrin for his pain and finally found success with a chiropractor. His desire was to avoid standard medicines and find relief in a technique perceived to have few side effects. This was an example of a pervasive 'natural is better' attitude that emerged not only in remarks about prescription medicine, but also in statements about other distrusted 'chemicals', including food additives, air pollution and environmental synthetics, such as building materials, fabrics, resins, and so on (Table 1, #3).

Related to mistrust of patent drugs was the perception that providers are not always able to monitor patient drug regimens closely enough to warn of possible side effects, catch drug interactions and avoid overprescription. The SAVAHCS, like many health care organizations, is organized into primary care teams designed to facilitate co-operation between physicians and pharmacists to minimize these problems. However, from focus group participants' points of view, it was their primary care provider who was expected to manage patients' medical regimens. Several focus group participants felt that providers were not warning them adequately about potential side effects of their medications. One veteran actually researched his sister-in-law's drug regimen and found she had been taking a medication 2 years longer than was recommended.

It was not unusual for participants to have carried out extensive research, including journal reading at the University of Arizona library. A veteran's spouse told how her husband had experienced side effects from a medication, complained to a provider and received a

new prescription. She consulted the Physicians Desk Reference (PDR) and found that the provider had simply prescribed the same medication under a different brand name (Table 1, #4).

Participants also voiced a lack of confidence regarding their provider's knowledge of potential drug interactions. For example, a male veteran said, "I take eight medicines per day and some of them do react with each other . . . but most doctors don't know all the ramifications". This illustrates the clear perception on the part of some participants that multiple, dangerous substances were being recommended for their bodies without adequate assurances that there would not be serious interactions.

A desire for more natural alternatives was a strong motivation for CAM users wary of prescription medicines. The potential fallibility of providers was part-and-parcel of this danger. Participants did not conceptually separate the danger of the medicines themselves from the potential mistakes that providers can make. Their only access to prescription medicines was through providers. Although the SAVAHCS uses a team approach in which prescription responsibilities are shared with pharmacists, this co-ordination was essentially outside many of the participants' perceptions. Participants expected their primary care provider or specialist to be fully responsible for their drug regimen.

Lack of emphasis on nutrition, exercise and preventive medicine

Focus group participants often stressed the importance of preventive measures, diet and exercise in particular. Some participants talked about cutting down on fast food, some participants had changed their cooking methods (grilling instead of frying) and other participants talked about eliminating red meat from their diet. Occasionally, participants touted the benefits of Asian diets. One couple described buying a juicer, and reported feeling better now that they were drinking vegetable and fruit juices. Some participants avoided meat because of the way animals are raised, which is no longer as 'natural' as it used to be (Table 1, #5). There was general consensus that nutrition is important for health.

Several participants felt that while medical research has reinforced the importance of nutrition, the conventional health care system has largely ignored it. This was demonstrated to one participant when her husband was in the hospital for heart surgery, where he was fed what she considered to be an inappropriate meal (Table 1, #6). Two participants told of suffering abdominal gas following surgery. When advice from acquaintances to eat yoghurt proved helpful, they concluded that advice such as this should be standard in hospitals.

Several participants were dissatisfied with the level of advice about nutrition they received from providers. One participant said that in many years of being seen by doctors, he never received any nutritional guidance. Many group members lamented that doctors did not even seem to know very much about proper nutrition. For example, a male veteran said, "The care here is wonderful . . . but I find that doctors know nothing about nutrition".

Many participants also considered exercise to be very important. Several participants reported using regular exercise for chronic pain. One person recommended 'square dancing' for circulation and joint problems. Walking was often mentioned, even if one was suffering from chronic pain. Some group members had discovered that exercise made a difference in their general well-being. Some participants explicitly used exercise for stress reduction, and reported being counselled to exercise by alternative providers. Many focus group participants said that advice about exercise should also play a more important role in health care (Table 1, #7).

Interest in diet and exercise by itself revealed a desire for more preventive measures in participants' health care. In some cases, participants noted that their dietary or exercise practices were targeted at preventing the return of pain or some other particular condition. In addition to vitamin use, people were seeking herbs or supplements that would prevent disease. Some veterans stated openly that preventive medicine should play a greater role in health care. One female veteran lamented that if she had only known what she knew now, she would have been using preventive measures all along (Table 1, #8). It was clear that some participants saw conventional medicine as focusing too much on disease and not enough on maintaining well-being. A female participant said, "I think that the biggest thing is preventative health maintenance rather than, you know, fix it when it's broke."

Desire for more holistic health care

Discussion about prevention noted above (diet, nutrition and exercise) also suggested a desire for a more holistic form of medical care. One participant said that health care providers "should treat the whole person". A male veteran, who had been stationed in Germany, praised the more holistic German medical system. Another participant praised the National Center for Complementary and Alternative Medicine (US National Institutes of Health) for investigating more holistic approaches to medicine. Several other participants echoed this sentiment, and challenged the reigning model of care in which discrete maladies are differentially diagnosed and treated without reference to possible interconnections between psychological, social, spiritual and physical factors (Table 1, #9).

For some participants, understanding of these interconnections ran deep. They made comments about the role of the mind in healing, and the role of practices such as Tai Chi and meditation in bringing about a healthy mental state. The emphasis on holism seemed to derive, in part, from a realization that mind and body were

connected. In some cases, this realization had emerged from military action in which their mental focus in battle removed awareness of pain and injury. For example, a Second World War airman received a serious foot injury from exploding shrapnel. At the time, he perceived his left foot 'sweating' more than the right. On landing, he discovered serious bleeding. Experiences like these may have contributed to a greater willingness to entertain ideas of mind–body interconnectedness among some veterans and their families.

Some participants were also concerned with connections between physical and spiritual health. One female veteran described an interesting relationship between her Christian beliefs and her use of Eastern healing modalities. She equated the 'energy source' referred to by her Tai Chi instructor with the concept of the Holy Spirit. Another participant spoke of the physical health and spiritual benefits of daily 'contemplative prayer'.

Some participants' awareness of these issues was due to the University of Arizona's Program in Integrative Medicine, run by Dr Andrew Weil.[26] Many participants were aware of the programme's holistic outlook on integrative care, and seemed to have been influenced by it. They also told of experiences with alternative providers that were more satisfying and holistic than any they had ever had with conventional providers (Table 1, #10). Some participants also commented on how pharmaceutical and surgical interventions were consistent with an American culture that emphasized quick solutions, even though many illnesses involved poor health behaviour and developed over time (Table 1, #11). Not all participants had a sophisticated philosophy about holistic health care, but many did. When asked for suggestions about improving their health care, these participants mentioned including holistic providers within their conventional health care system.

Discussion

The overarching issues voiced by the focus group participants in this study included drug side effects, prescription monitoring, concerns with the pharmaceutical industry and interest in 'more natural' alternatives. Participants linked their CAM use to scepticism regarding these conventional care-related issues. They also reported wanting greater emphasis on preventive measures, such as nutrition and exercise. Finally, some participants said that medical care should be more holistic.

We found that dissatisfaction with certain specific aspects of conventional care was motivating CAM use, while at the same time veterans expressed overall satisfaction with conventional care. This contradicts some investigators, who found that dissatisfaction with conventional care did not play a role in CAM utilization. For example, Astin's four-item 'satisfaction' measure failed to predict CAM use.[6] Astin's satisfaction questions, however, addressed generalities rather than the specific issues in which respondents might find the conventional care system lacking. Our focus group participants probably would have had high satisfaction scores on such a measure. Satisfaction measures too often treat satisfaction as a unidimensional construct, and do not discriminate between patients' particular likes and dislikes.[27] Qualitative approaches, such as the focus group data reported here, can help to provide the finer discrimination lacking in global patient satisfaction measures.

Barrett *et al*.[13] also asserted that dissatisfaction with conventional medicine does not predict CAM use. They wrote, "In contrast, most patients who use CAM continue to utilize and appreciate conventional medicine, although they often do not tell their physician about their unconventional choices". Our results suggest that continued use and appreciation of conventional care does not preclude the possibility that frustration with a few specific aspects of conventional care is influencing use of CAM.

Other studies agree that, for the most part, CAM-using patients are not replacing conventional medicine with CAM.[6,8,10,28] There are several reasons why patients stay with conventional medicine, even when it does not meet all their needs. Our respondents, as well as those of Barrett *et al*.,[13] indicated that CAM affordability was a major concern. In both studies, respondents paid for most CAM expenses out-of-pocket. However, most conventional health care was covered by insurance. Individuals who have health care coverage were not likely to give up a service with such low out-of-pocket costs. In addition to having low out-of-pocket cost, conventional care is a highly socially legitimized service. Conventional medical care in the USA is generally considered to be among the best care in the world. Even apart from the issue of access, it would be hard for patients to walk away from what society, in general, considers an important, indeed, 'conventional', service. It is not surprising that our focus group participants had not given up on conventional care despite its inability to meet some needs.

Consistent with our findings, Chez and Jonas[29] have suggested that conventional medicine, with its emphasis on the mechanistic, reductionist, organ-specific approach to care, is lacking in the areas of comprehensive care and the management of chronic disease. Focus group participants' 'natural is better' attitude is part of a pervasive US folk model about the relationship between the natural world (generally benign) and artificial things (potentially more dangerous).[30]

Like our respondents, those in the study by Barrett *et al*.[13] often did not tell conventional providers about their CAM use. Rather than considering this a shortcoming on the part of patients, it might be seen as part of conventional medicine's failure to meet these patients' needs. Many participants hoped that conventional providers would become more knowledgeable about

CAM, acknowledge its potential usefulness and counsel them about CAM. Under current conditions, some patients may be avoiding conflicts with their valued conventional providers by simply not discussing CAM.

Also consistent with our findings, Barrett *et al.*[13] found a desire among patients for 'holism' and 'empowerment'. For Barrett *et al.*, the theme of holism included the ideas of a patient–practitioner alliance, mind–body integration, staying healthy and limitations to conventional care. This is similar to what our focus group participants said about preventive and holistic care. Barrett *et al.* also encountered the theme of empowerment, which implied responsibility and self-direction. Our focus group participants were also taking responsibility for their health care. These overlapping findings suggest that veteran CAM users are similar to civilian CAM users in their desire for conventional medicine to address these specific issues.

There are inherent limitations to this study. Since they were self-selected, focus group participants may have been among the more dedicated or vocal CAM users and may not have been representative of the average CAM user enrolled in the SAVAHCS. There were no comparison focus groups of non-users. However, we intentionally invited only CAM users in order to (i) expand our understanding of the reasons for, and patterns of CAM use, and (ii) use the themes emerging from focus groups as background for a larger random sample survey of SAVAHCS patients. Furthermore, focus groups with CAM non-users would not have addressed the question of the role of dissatisfaction with conventional medicine in motivating CAM use. While our participants generally reflected the demographics of the SAVAHCS population, they were probably older, more infirm and less financially secure than the non-veteran public. In addition, they may have had more chronic conditions, which are the least amenable to conventional care (and which were predictive of CAM use in Astin's[6] study). Due to their health status, our participants also may have experienced a higher rate of dispensed prescriptions, and a higher rate of side effects. Comparisons between veteran and non-veteran CAM use must be made with caution.

Despite its limitations, this study is one of the first to address CAM use among military veterans. The nationwide veteran population over 75 years of age is expected to rise 43% between 1997 and 2005.[31] This population is relatively less healthy than the non-veteran population, and has a higher rate of co-morbidity.[32] Substantial CAM use in this population would have serious implications for health care. For example, although many participants worried about potential negative interactions between prescription medications, few participants mentioned possible negative interactions between botanical remedies and prescribed medications (e.g. *Gingko biloba* interacting with anticoagulant and antiplatelet agents[33]). Potential lack of awareness of these interactions suggests that primary care providers should query patients regarding botanical remedies, as well as prescription and other over-the-counter medications they may be taking, and caution patients accordingly.

Conclusions

Our findings indicate that veterans in this study are taking a more active role in their health care by researching and monitoring their conventional care more closely, adopting CAM into their routine and using preventive measures as a part of their health care. Focus group participants had begun to move their care beyond the bounds of a conventional medical system that was not meeting all of their needs. They clearly linked these unmet needs with their use of CAM. Their dissatisfaction was with a few specific, well-defined aspects of the conventional health care system. Participants seemed to be dissatisfied with both the outcome of conventional care (e.g. failure to improve chronic conditions, control pain or reduce intolerable drug side effects) and with the process of conventional medicine (e.g. lack of preventive care or superficial encounters with providers). Since participants also expressed praise for the conventional medical system, it may be that some participants are simply recognizing its inherent limitations rather than expressing dissatisfaction *per se*.

Qualitative studies such as this can alert physicians to patients' widespread use of complementary and alternative remedies, and some of their motivations for doing so. The willingness of patients to take on this degree of personal responsibility toward monitoring their care and creating a healthier lifestyle should be incorporated into physician treatment planning.

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