Author’s response to reviews

Title: Determinants of public trust in complementary and alternative medicine

Authors:

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Author’s response to reviews: see over
Revision note

Dear Editors,

We will respond to the reviewers’ comments starting with the first reviewer.

Reviewer #1: Aslak Steinsbekk

Major Compulsory Revisions

1) As the authors also discuss, exposure to a health care service is likely to increase trust. As the vast majority of the population has used conventional health care, the actually report on something they have at least some experience with. Therefore I was expecting more emphasis on comparing trust among those who had and not had used CAM. This could e.g. by including new columns in table 1 and 3 for those having used and those not having used CAM and the result section in the abstract and the conclusion should include both the general trust (5) and also the trust among users. Would it be correct to include use of Cam as a variable to control for in the regression analysis?

Authors’ response: We agree with the reviewer that there might be a difference between CAM users and non users. Therefore, we have added this distinction throughout the article.

2) The text could benefit from being more precise about this being a study about the participants’ perception. I.e. use words like “perceived” and “reported”.

Authors’ response: We agree with the reviewer that the text could benefit from being more precise about the participants’ perceptions. We have revised the article accordingly and used phrases to emphasize that our data were collected through questionnaires that reflect participants’ perceptions.

3) The exact text in the question on CAM use should be given, especially to discern whether it is visit to CAM practitioners or also self treatment with CAM product/practices and for which time period it was asked (ever, last year?). The text in the article should be revised to be precise about this. My guess is that it is about visit to practitioners (re the listing of providers) and if this was the case, the text should include “visits to” instead on “use of”.

Authors’ response: The exact text of the questions on CAM use is now given in the method section. It was defined as visits to a practitioner as well as the usage of CAM products. Time period of visits-usage could be at this moment or anytime in the past. In the analysis we have used experience with CAM as having either used CAM products or visited a CAM provider anytime in the past. We reflect on this in the discussion.

4) As acknowledged by the authors, religious and political views are rather dubious proxies for Philosophy of life. I understand the choice of word, but find it more correct to use a term like “religious and political view”.

Authors’ response: We have left out these variables, also in response to other reviewers.

Minor Essential Revisions

5) As no numbers is given in the tables, were there no missing one the different questions or are missing coded as “No information”
Authors’ response: We agree with the reviewer that we should have mentioned the N on the different questions. We now made the N per question available in the Tables. To be clear: the missings were not coded as ‘no information’. The ‘no information’ category was used for respondents who have indicated that they did not receive information through e.g. their social network. Valid N is lower in tables and figures about public trust in CAM because respondents could indicate that they have no opinion about trust in CAM. These respondents were left out of the calculation of average trust in CAM.

6) In general I find it more correct to report the actual p-value. Therefore consider to include it as a column in table 3.

Authors’ response: we followed the convention by distinguishing between ‘p<0.05 and ‘p<0.001’. Reporting actual p-values runs the risk of information overload, while most of the readers would not use actual p-values in their evaluation of the results.

7) Legend on fig 1 should include the text of the endpoints: 0 (no trust) and 10 (complete trust)

Authors’ response: We have corrected this in the legend.

Discretionary Revisions

8) The title could include “in the Netherlands”

Authors’ response: We did not change the title of our article. However, we now start the abstract with ‘In the Netherlands’.

9) In the Background section in the abstract it seems more logical to have the aim before the hypothesis – as it is in the article.

Authors’ response: We agree with the reviewer that it is more logical to place the aim before the hypothesis in the abstract. Therefore, this was corrected.

10) Hypothesis under “1. Inst..”. I did not understand at first what types of institutional guarantees were meant. Could something be added to point to the types of questions asked?

Authors’ response: We added the following sentence to our article to introduce the term institutional guarantees: ‘In general one of the determinants of trust is formed by social institutions that reduce the risk of placing trust in someone or an organization.’

11) The abstract and result section should state clearly the proportion who have used CAM.

Authors’ response: In the abstract and result section we have stated the proportion of people who have experience with CAM.

12) The text in the first paragraph in Data analysis should be moved to the actual variables to make it easier to follow what was done.

Authors’ response: We have not moved the text to the actual variables, but we have adjusted the text in the section on data analysis in order to be more clear on the way we composed the variables.

13) The last paragraph under Inst. in Result section. The 28% should be 84% to “match” the 50 to 60%?
Authors’ response: We agree that this should be adjusted to match to 50-60%. We changed 28% in 86% (58% (increases trust) and 28% (highly increases trust)).

14) Under Network, res sect: I think it is wrong to use “minority” on 44% of a population – either omit or

Authors’ response: We have corrected this in the article.

Reviewer #2: Fuschia M. Sirois

This paper presents the findings from a large survey of health care users regarding their trust in CAM. The large data set is a strength of the research. There is, however, a need for a more thorough and critical presentation of the current relevant CAM literature, knowledge, and accepted standards, and how the current study and hypotheses are related to this existing body of knowledge. This is the most significant weakness of the paper and one which significantly limits its contribution to the literature. Below are a number of specific areas which are for the most part related to this issue, and which require attention.

Major Compulsory Revisions

1) On page 3 there are several statements made about the types of public trust, definitions of public trust, and expectations about how public trust may be used as a performance indicator. However, there are no references given. Do these statements reflect the authors’ opinions or are there any references to support these statements?

Authors’ response: We added references to the statements in the article.

2) On page 4 an anecdotal example is given as proof that negative media attention can impact trust in CAM. However, there are other sources which have not and should be presented – see Weeks & Strudsholm, 2008 BMC CAM for a review).

Authors’ response: In the introduction we present a major incident that took place in the Netherlands, which might have affected the populations’ trust in CAM. Weeks en Strudholm (2008) are not referred to in this part of the introduction. We have referred to their work in the paragraph on the hypothesis on trust and media.

3) It would be useful for the reader if a brief synopsis of the previously developed model could be presented so that he factors suggested to influence public trust can be better understood. Simply presenting the factors without the context of the model leaves the reader to take the author’s word about the model rather than allowing the reader to evaluate the suitability of applying this model to the current inquiry. Numerous models have been applied to understand CAM use and if the authors have a new model that might be useful for further research then it should be presented here.

Authors’ response: We agree with the reviewer that the model should be presented in the article. The model adjusted for the specific type of public trust we are studying in this article, viz. public trust in CAM, is added to the article. Note however, that our model is not about CAM use but on public trust in CAM. However, personal experience with CAM plays a role in this, according to our model.

4) On page 6 the authors present hypotheses regarding the influence of social networks on trust in CAM, but only cite one source which appears to have no
relation to CAM use. The hypotheses are stated in a way to suggest that the impact of social networks on CAM trust vis-à-vis CAM use has not been previously investigated. This is not the case and there have been a number of studies that have investigated the role of social networks on trust and therefore use of CAM, most notably Robinson & Cooper’s 2007 paper which specifically examined the use of trusted sources of information when people contemplated using CAM. This research should be reviewed and presented here as it 1) generally provides support for the hypotheses, and 2) not presenting it misleads the reader by not accurately presenting the current state of knowledge regarding the role of social networks in CAM use. Some papers that come to mind include Caspi, Koithan, & Criddle, 2004; Öhlén, Balneaves, Bottorff, & Brazier, 2006; Robinson & Cooper, 2007; Sirois & Purc-Stephenson, 2008. However, a much more thorough review of this segment of the CAM literature would reveal several others as well, and all require mention here as word limits are not an issue.

Authors’ response: We knew that there was research available on the role of social networks and usage of CAM. However, to our opinion public trust in CAM and CAM use are different phenomena. One can have a general feeling of trust CAM but still not use it, because for instance no relevant CAM providers are available or accessible or because at this moment there is no necessity to do so. However, we added research on social networks and CAM use in the part regarding the hypothesis with the additional remark that CAM use and public trust in CAM are different phenomena.

5) Similarly on page 7, the authors make speculations about the role of personal experiences with CAM and how this may influence trust in CAM, without referencing previous research that has suggested the same conclusions. This is another oversight that requires attention as it is again misleading as to the state of current knowledge regarding CAM use. Some studies that need mention include Sirois, 2008 BMC CAM; Luff & Thomas, 2000; but again a more thorough search should be conducted to present an accurate account of the current state of knowledge.

Authors’ response: see answer #4.

6) Again, on page 7 the hypotheses regarding the role of personal beliefs and philosophy have not been adequately grounded in the current literature and presented as if they are a new insight that will be tested for the first time in this study. Later in the discussion the authors refer to this as the “philosophical congruence hypothesis” and state that a longitudinal study is needed to confirm their results. The indicators used to test this idea that philosophical similarity with CAM (which by the way has been examined by numerous researchers over the past decade) are hardly reflective of overall life philosophy (religious and political views), and the authors have not provided sufficient justification for operationalizing these variables as true indicators of philosophy or beliefs. Moreover, the research that has been conducted to date has not been included. Much of this research has focused on holistic views of health as a key philosophical determinant of CAM use, but again there is no mention of this other research. The authors have referenced a small systematic review regarding beliefs in general and their role in CAM, but no other mention of more recent research on the role of beliefs in CAM use or the fact that there has been a fair bit of research conducted on this topic.

Authors’ response: We agree that the concept ‘philosophy of life’ is not covered by both religious and political views. Therefore, we have left out these variables.

7) On page 8, regarding the issue of trust in regular health care and CAM use,
the authors have not presented a balanced view of the topic, and left out much of the relevant literature. The issue of dissatisfaction with regular health care and CAM use is controversial and may be dependent upon when the issue is examined. Some recent research suggests that the reasons for CAM use have shifted in the past decade or so from negative reasons (i.e., dissatisfaction with CAM) to more positive reasons that have less to do with dissatisfaction (Sirois, 2008, BMC-CAM). Also, dissatisfaction may play a role in initial CAM use but not continued CAM use (see Sirois & Purc-Stephenson, 2008 CHPR for a full discussion of this issue). But if trust in CAM develops from greater experience with CAM then what role if any does dissatisfaction in regular health care play in trust in CAM? A more nuanced presentation and discussion of this issue is needed if the argument for dissatisfaction as a factor predicting trust is going to be made. Again, the current research on this topic has not been fully covered and presented and therefore misrepresents the current state of knowledge regarding CAM. A more thorough, balanced presentation of this topic is required as there is much recent evidence to suggest that dissatisfaction with regular health care may not have that much influence on CAM use.

Authors’ response: We have come back to this issue in the discussion section of the article.

8) It appears that the data was collected in 2001. What are the implications regarding the interpretation of the findings today from data that is 8 years old? Again, I refer the authors to the BMC CAM paper which found that the reasons for CAM use can significantly shift within an 8 year period (Sirois, 2008).

Authors’ response: The reviewer is right that the data is collected in 2001 and that we have to elaborate on the implications regarding a shift in trust over an 8 year period of time. We elaborated on this topic in the discussion. We argued to expect that there will be no differences in the associations between the independent variables and public trust in CAM if it was measured in 2009. Firstly, because public trust is a relatively stable concept. Public trust in conventional medicine, for instance, also did not change significantly over an 8 year period of time. Secondly, if the reasons for using CAM would shift from negative attitudes to more positive attitudes toward CAM, this would mean that public trust in CAM might increase. However, there is no reason to believe that there would be a change in the measured impact of positive or negative experiences, media information etc on public trust.

9) One major issue with this study is the lack of information provided regarding how CAM was defined. In the results it appears that paranormal therapy was included as a CAM. I believe that most CAM providers would find this inclusion offensive and delegitimizing. How was CAM defined? Which definitions informed the types of CAM listed in the survey? And if the categories described as CAM are different from what other researchers would included as CAM, such as those provided by NCCAM and other national agencies, is this because of accepted standards for CAM categorization in the Netherlands? A strong rationale for including certain therapies as CAM needs to be provided and presented to justify the very broad inclusion criteria that were apparently used for the current study.

Authors’ response: We have added the definition of the Cochrane Collaboration to the article and described our rationale for using CAM with regard to the Netherlands. With these adjustments we provided the readers with a clearer view on our definition and reasoning regarding the definition.

10) Given previous research suggesting that the amount of experience with CAM influences beliefs and judgments about CAM and its use, and the authors own hypotheses regarding the role of experience on trust, it is surprising that no mention is made of the limitation imposed by only assessing CAM use versus no
use in the current study and the implications of this for the conclusions drawn. Some mention of this is needed. Although the authors mention that trust develops over time and that longitudinal work may be needed, even a cross sectional analysis based on different levels of CAM experience would have been useful for examining the role of experience in the development of trust. This limitation warrants mention as do the following previous studies that have employed this approach: Sirois & Gick, 2002; Sirois & Purc-Stephenson, 2008; Shumay, Maskarinec, Gotay, Heiby, & Kakai, 2002.

Authors’ response: We agree with the reviewer that this information should be added and mentioned this issue in the discussion.

11) The last paragraph of the discussion regarding active seeking of information and trust in CAM is a bit confusing. CAM users are noted to be active seekers of information in comparison to non-users so the authors’ point regarding a further research needed here is a bit unclear. Is the basic level of trust referred to similar to a personality trait? There has been at least one study that I am aware of that found that people who score high on the trait of Agreeableness are more likely to use CAM to a greater extent (Sirois & Purc-Stephenson, 2008, JACM). Agreeableness is marked by a general trust in other people, and therefore would support this assertion.

Authors’ response: This paragraph was left out of the discussion.

12) Given the gaps in the literature review presented in the introduction and the lack of situating the current study amidst other relevant previous work, the discussion requires a much more thoughtful consideration of the conclusions made and their similarities and differences with previous work. Along the same lines, some of the statements regarding what can be concluded from the basis of the current findings should be toned down and stated with respect to the numerous study limitations. The findings are relevant for data collected in 2001, among the Dutch population, and in the context of a very liberal definition of CAM use, that has been dichotomized to omit information regarding actual experience with CAM – one time CAM users and those who may have used CAM for years are treated as a homogenous group with respect to the conclusions made regarding trust in CAM, when in fact there is compelling prior research to suggest that CAM consumers are a diverse group with diverse beliefs and needs. The current discussion does not reflect an acknowledgment of these important points.

Authors’ response: These points are taken in account in the discussion of the article.
Reviewer #3: Heather Boon

My overall impression is that this is a well written paper describing a study with a solid design and execution. My suggestions are primarily intended to improve the clarity of the description and interpretation of the data.

Major Compulsory Revisions

None

Minor Essential Revisions

1. Throughout the paper (including the title), the term complementary and alternative medicine is used; however, the authors never define what they mean by this term. For example, if a group is regulated are they still defined as CAM? If yes, then what makes them CAM?

Authors’ response: We agree with the reviewer that an exact definition of CAM was missing. Therefore the definition we used on CAM in our article was added.

2. Related to #1, I believe it would be more accurate (and more clear) for the authors to explicitly state that they are investigating trust in CAM practitioners …. Many definitions of CAM include natural products that are usually self-selected by individuals without any input from a practitioner. In North America for example, self-selection of natural products is far more common than visits to CAM providers and makes up the largest proportion of CAM “use” in surveys designed to measure this.

Authors’ response: As mentioned in #1 we agree that our definition should be more specific. The definition is added. We also have made more explicit statements in the article on the fact that we are conducting research on CAM in general, both CAM products and CAM providers. Apart from that trust questions were also asked on several types of CAM. Consequently, we did not solely investigate public trust in practitioners.

3. The authors use the term “regular” medicine to contrast with CAM. This implies they consider CAM “irregular medicine”. A term more common in the literature, although not necessarily less value-laden is to refer to the dominant health care system as “conventional” medicine. Some prefer “biomedicine.” Any language choice here has its problems, but “regular” is both value-laden and inconsistent with the rest of the literature so I suggest changing it throughout.

Authors’ response: The term regular medicine is changed to conventional medicine.

4. Background (p.3) – you indicate that Dutch people rate their trust in the conventional health care system as 7 on a 10 point scale and also that 90% of people trust GPs. How are these 2 statements related? i.e., what is the cut off for assessing that someone “trusts” on the 10 point scale – is it any value above 5? On another note, I believe this is first time you use the phrase general practitioner before switching to the acronym GP, so please note the acronym in brackets here.

Authors’ response: Trust in the health care system and trust in GPs are measured on different scales. Trust in the health care system is measured on a 1 to 10 point scale, trust in GPs on a scale from 1 to 4. This follows the measurement of public trust in health care as developed in Straten et al, [2002]. We
agree with the reviewer that this could be stated clearer in the article and added a clearer explanation in the article. We corrected the note on the GP, and placed the acronym in brackets.

5. Background (p.3-4) – you may wish to define the concept of a guarantee a bit more. You state that “Another guarantee is that patients who are visiting a caregiver in regular health care are treated by providers with a special education working to protocols based on best available evidence.” While there is likely little argument that they have special education, I think there is much more debate that all conventional health care providers are “working to protocols based on best available evidence” – this may be the ideal, but there is ample evidence that this is not necessarily a reflection of reality. I think I may be reacting to the everyday use of the word guarantee here, as opposed to the way it is used in your theoretical paradigm and suggest some clarification of this might help you make your point without raising other issues.

Authors’ response: We agree that the statement “working to protocols based on best available evidence” is to definitive. Therefore this parts of the sentence was changed into “often perceived to be working according to protocols”.

6. Results (p.12) – similar to #4, please clarify the cut off on the 10 point scale for determining trust for the finding “50% of the population trusts CAM”… Table 1 lists this as “much and very much” but it is still not clear how that relates to the 10 point scale.

Authors’ response: The reviewer refers to two different questions. There is a trust in CAM scale from 1 to 10, and questions on different types of CAM therapies, which could be indicated on a 1 to 4 scale. Both outcomes are not related. We have adjusted the text in the method section by describing the questions more explicit.

7. Throughout the results, I would find it much easier to follow the logic if the first sentence in each section was framed positively. For example on page 13 under the heading network knowledge you begin with the statement “A minority of people did not receive information from family and friends ….. then continue to discuss the people who DID receive information, which is confusing. It would follow more logically to provide the percentage of people who DID receive information and then provide the breakdowns for positive and negative information. I would recommend this approach throughout the results section.

Authors’ response: We agree with the reviewer and corrected this in the article.

8. Discussion – the data on CAM trust were collected in 2001 and you are comparing them with data con trust of the conventional health care system published in 2005 (I can’t tell when these data were collected) – was there a difference in time period of data collection and if so, is there any reason to believe overall propensity to trust may have changed over time?

Authors’ response: The data on the conventional health care system, we referred to, were collected in 2004. Trust in conventional health care is measured annually. The reviewer questions rightly whether there is any reason to believe overall propensity to trust may have changed over time. We expect there is no reason to assume that there were changes over time. A longitudinal study on changes of trust over an 8 year period of time learned that trust in the health care system is at a constant level. (Van der Schee et al, 2005).

Discretionary Revisions

9. Your finding that trust in CAM is not related to trust in conventional care is very
interesting because it has been assumed by some that at least some people only seek CAM after losing faith in conventional care … you might want to elaborate a bit more on this in your discussion.

Authors’ response: This issue is addressed in the discussion section of the article.

Reviewer #4: Marja Verhoef

This is an interesting paper comparing trust in CAM with trust in conventional medicine using data collected in a health care consumer panel. Unfortunately the data are almost 9 year old, which could be quite long for a topic like this and should be addressed. The research questions are clear and relevant. Results of such a study may have important implications of how CAM professions can build trust. I have several concerns, but most of these could be addressed I believe.

Major compulsory Revisions

My major concern is related to the wording of the 7 hypotheses, in particular the lack of clarity in the concepts and the language used.

1) H2 (Media Images) is related to media images, however exposure to media information is also used, as well as self-reported media attention (in the Discussion), which are all very different concepts. This hypothesis is only backed up by a small study that took place in Canada. This is a concern as issues related to media content are culturally determined. On this note, issues related to are not mentioned at all. What is used and thought to be credible in the Netherlands is different from other countries, which means that your results are culture-specific.

Authors’ response: We have made the concepts uniform. Also, we have added extra information on the hypothesis regarding media and public trust in CAM.

2) H3 (Network Knowledge) is about network knowledge. Again multiple terms are used to describe this issue and again it is not clear what exactly the intention of the hypothesis is. Knowledge and information are mentioned as well, as is experience, stories (p.15) – at least I think that the stories relate to ‘network knowledge’ – friends (in table 4).

Authors’ response: We have made the concepts as uniform as possible and have tried to be more clear on the exact intention of the hypothesis.

3) Conceptually, the way these hypotheses are described, seems to suggest that both H2 and H3 relate to actively conveying information. These factors as certainly impacting people’s perspectives on trust of the CAM profession and CAM practitioners, but it seems to me that these are context factors that more passively impact on people’s thoughts and beliefs. Having networks, reading the media one cannot escape being influenced by what is printed and by what network members do, say and believe, but it does not have to be a situation of active information exchange.

Authors’ response: H2 and H3 are not related to actively conveying information, but passively. With trust this is mostly passively done. However, there seems to be an attention effect in the sense that people who have experience with CAM report more often to have information from the media, compared to those who have no experience with CAM. This was added to the discussion.
4) H4 (Personal experiences with representatives of the health care system) relates to previous CAM use, but you do not address the multiple and profound differences between the various CAM approaches. People may in fact trust some CAM providers, but not others. This hypothesis clearly brings home how unwieldy the concept CAM is.

Authors’ response: We agree with the reviewer that this issue has to be addresses. Therefore, we added this issue to the discussion section.

6) H5 – H7 are very exploratory and based on very limited information, you may need to emphasize this.

Authors’ response: We are aware that these hypotheses are exploratory. As we noted in response to other reviewers we decided to leave out the hypothesis on philosophy of life. We agree that we would need a more proper measurement of this concept.

7) H5 (Advice of regular health care providers, notably GPs): I thought that it would be questionable whether many people would receive such advise, which is what you found as well. The question is also whether people asked for advice or whether the GP gave it unsolicited.

Authors’ response: We have elaborated on this topic regarding hypothesis 5 and also have raised this point in the discussion.

8) H6 (Philosophy of life): the operationalization of this hypothesis seems to be somewhat farfetched – how many Dutch people do not have a religious affiliation or one in name only?

Authors’ response: We have left out this hypothesis. This point was also mentioned by other reviewers.

9) - the terms ‘determinant’ and ‘influencing’ are commonly used, given the tentativeness of the hypotheses I think that it could be better to talk about correlates and associations - at least this should be addressed.

Authors’ response: We agree with the reviewer that this should be changed. Therefore, we adjusted this in the article.

10) - A concluding section on practical implication of the findings and its potential relationships to trust for CAM practitioners, would add substantially to this paper.

Authors’ response: we decided not to add a paragraph on practical implications. We have noted, however, that CAM providers indeed form professional associations and set up quality systems. This is in line with the results of this article about the relationship between institutional guarantees and public trust in CAM.

11) - The term regular is used for what could also be called medical, biomedical, conventional, mainstream…. You define regular (p. 12) as medical and physiotherapy). I’m not sure whether regular is the best and best understood denotation. You also speak about ‘regular education’, which is not clear.
Authors’ response: We agree that the term ‘regular’ as used in our article should be changed. ‘Regular’ health care is changed in conventional medicine. We also altered the term ‘regular education’ in the text.

Minor essential revisions

12) - The definition of trust on page 3 seems to suggest a dichotomy (winning or losing), however the way you describe trust it is a matter of level or amount (I would use degree)- in other words a spectrum.

Authors’ response: This part of the text is adjusted.

13) - In several places alternative and CAM are used interchangeably (p.4, 8, 10) and at the same time it hints at a difference, this could be clearer.

Authors’ response: We have changed this in the text.

14) - The term ‘previously developed model’ (p.4) is somewhat unclear – is it just a list of factors, a statistical model, a conceptual model? Please explain. Also, the last sentence on page 4 ends with…trust: in general? In conventional medicine? CAM?

Authors’ response: The model is a conceptual model. For reasons of clearness, we have added this model to the article and made the text regarding the model more explicit.

15) - The description of the questionnaire (p9-11) is somewhat tedious and not so easy to follow – could you just included the questions in an appendix or table? There don’t seem to be that many, so this would be feasible and quicker to grasp. Of course some narrative around this would be needed as well.

Authors’ response: we agree that the description of the questionnaire could be clearer. We have adjusted the text in order to make it easier to follow. We understand that it might be better to place the questionnaire in the appendix. However, the questionnaire is only available in Dutch and therefore it should be translated before it can be made available to an international audience. This is however rather costly.

Suggested edits

16) While the paper is fairly well written it should be very carefully reviewed for proper grammar, and in some places punctuation. I have listed some points below, but the list is not exhaustive. The beginning and the end of the paper need most change, the middle part (p.7 – 16) is clearer.

p.3:
- line 2: care as for
- line 5:...trust that their caregivers are
- line 6: what is a confidence good?
- line13:... people's general attitude
- line 14:... need should occur
- line 16: system and professions that are part of it.
- line 17: ...as 7 on a scale from 1(no trust) to 10 (high trust).
- line 20: population instead of people.

p. 4:
- line 4: ..convincing as CAM providers also include those who are not certified and whose educational requirements are unclear. In addition, many…
- line 7 – no new paragraph.
- line 8: Moreover, in the Netherlands CAM has been... than regular health care.
A case in point was the death...
- line 10: ... healers [9]. The ensuing negative media...
- line 12:...CAM is in the Netherlands and..
- line 19: ...elaborate on potential influencing factors..
- line 20:... second explanatory question:
Some other examples:

Line 13: review instead of inspectorate
p.7: reword last sentence – starting with Evidence..
p. 9: instead of ‘could mark etc. use: were asked to mark – or – marked... and
not could indicate but were asked to indicate..
line 4 from below : not ‘such as’ but including.
p. 11: line 6 from below: Relationships between ... and ... were first analyzed
using cross-sectional tables.
p.14: line 1:...had experience with CAM, a majority had a positive experience..

Authors’ response: we have corrected these minor mistakes in the article.