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Integrative medicine: A contested practice

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Abstract

In contemporary Western society, the healthcare arena has become increasingly technology-based, rationalised and specialised with alternative forms of medicine being taken up alongside orthodox medicine. This shifting healthcare terrain has brought forth challenges to practitioners' and patients' identity and to the practitioner-patient relationship. Today, the expertise and autonomy underpinning general practitioners' professional identity has been challenged. In parallel, patients have become reconceptualised from subjects in need of medical expertise, to 'informed' and 'active' health consumers. Within this fluid healthcare arena integrative medicine (IM) is emerging, a practice which amalgamates orthodox medicine with forms of alternative medicine. This emerging form of healthcare produces a number of paradoxes. These occur around the paradigm clash between treatment philosophies, issues of professionalism and the standardisation of treatments, power relationships and debates around dominance and subordination, and issues relating to patient autonomy and treatment responsibility. A discursive analysis of IM practitioners' and patients' talk reveals that the practice of IM gives rise to a number of contradictions and challenges for both IM practitioners and patients. Practitioners draw on discourses of holism, liberal humanism, spirituality and empowerment to construct IM as a healthcare model which maintains elements of both allopathic and alternative medicine in place, but also to legitimate practices inherent in IM. Through doing so, they reconstruct their medical professional identity. In conjunction, patients' draw on practitioners' extended knowledge-base and open-mindedness to construct IM practitioners as trustworthy professionals and to legitimate their own engagement in exploratory forms of treatment. This has implications for patients' and practitioners' subjectivity. Patients become individuals who deserve to be understood on a multitude of levels: psychologically, spiritually, emotionally and physically through which they gain recognition. Concurrently, practitioners' become placed in a paradoxical position with respect to their practice. They resolve this by resisting the position of biomedical expert and by incorporating a range of alternative medicine treatments to extend the healthcare they offer to patients. In conclusion, the practice of IM is shown to legitimate patients' engagement in self-reflexivity practices and to reproduce Cartesian dualism. Further, the research reveals how discourses of holism and empowerment, that are held to represent the fundamental difference between allopathic and alternative medicine, are drawn on by practitioners to legitimate a more in depth practice and a deeper level of

engagement with patients. Finally, the research questions whether IM constitutes a truly 'integrative' medicine.

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To Dad, with love

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Abbreviations

AIMA	Australasian Integrative Medicine Association
CAM	Complementary and alternative medicine
DHB	District health board
DTCA	Direct to consumer advertising
EBM	Evidence-based medicine
GP	General practitioner
HPCA	Health Practitioners Competence Assurance Act (2003)
IM	Integrative medicine
MACCAH	Ministerial Advisory Committee on Complementary and Alternative Health
PHO	Primary health organisation
RCT	Randomised clinical trials
SES	Socio-economic status

Terminology

A variety of terms are used interchangeably throughout this thesis to describe the healthcare practices referred to. These fall within three categories:

- 1) Allopathic medicine, orthodox medicine, conventional medicine or biomedicine
- 2) Alternative medicine, complementary medicine, complementary and alternative medicine (CAM), and non-orthodox medicine
- 3) Integrative medicine (IM)

These categories are outlined below. In each case the term that is most frequently referred to throughout the thesis is used as the descriptor for each category.

Allopathic medicine refers to treatment modalities conducted under the Western scientific paradigm. However, it should be noted that allopathic medicine is also practised in many non-Western societies. In New Zealand, allopathic medicine is the dominant model of healthcare practised and receives funding from the state (largely through taxation revenue). GPs in New Zealand operate as private businesses and set their own consultation fees. However, the government has recently injected more funding to ensure lower cost GP consultations for people enrolled in primary health organisations (PHOs), to which most GPs belong, and to encourage free GP consultations for children under six.

Alternative medicine is the term used to describe treatment modalities that fall outside the parameters of the Western scientific paradigm. However, it should be noted that what is considered 'alternative' medicine tends to shift over time. For example, through processes such as professionalisation, alternative medicine modalities may become understood differently and, in conjunction, individuals are likely to differ in their views about what is considered allopathic medicine and what is considered alternative medicine (Dew, 2003). In New Zealand, alternative medicine is considered marginal in comparison to allopathic medicine, largely because alternative therapies (and the training required to become proficient in such therapies) do not attract government subsidies.

Integrative medicine refers to healthcare which combines biomedicine with some form(s) of alternative medicine. The term integrative medicine is used in the current context to refer to treatment employed by medical doctors who combine the use of allopathic medicine and alternative medicine. In New Zealand, IM practitioners are not provided with government subsidies.

It should be noted that all participants understood the types of healthcare I referred to during the research. However, on a few occasions some clarification became necessary. In those instances, I clarified the meaning of the term used, and if the participant had a preference for using a specific term to describe that modality of healthcare, I attempted to use this myself so as to overcome any confusion.

Chapter 1

Healthcare in context

Introduction

Integrative medicine (IM) is an emerging form of healthcare in New Zealand and other Western countries. In order to understand its emergence it is important to consider the wider socio-cultural processes that impact on how healthcare is produced, practiced and consumed. This chapter discusses the social context in which IM is embedded.

The New Zealand public healthcare system has been restructured multiple times over the last thirty years. During the era spanning the mid-1980s to the mid-1990s healthcare policy was largely underpinned by neoliberalism. In this environment the government brought private providers into the market place with an aim to increase the range and efficiency of health services (Gauld & Derrett, 2000; Gauld, 2009). Management systems were introduced in order to improve service provision, and services were contracted out to stimulate competition. Financial incentives were also introduced to enhance performance and reduce costs. Since this era of major reform, health policy has shifted away from neoliberalism towards social democracy. Within this environment the government and citizens are represented by publicly elected candidates to area health boards who can be held to account for the management of regionally targeted health services (Gauld, 2009). In conjunction, humanitarian and egalitarian principles are enshrined through the

understanding that all citizens should have access to basic goods and services, along with the capacity to provide input into policy development (Gauld, 2009). If these rights are contravened the state will intervene, but to a limited degree so as not to circumscribe the individual freedom fostered. Social democracy could thus be said to represent a softened neoliberalism in that it includes both ‘society’ and ‘democracy’ (Gauld, 2009).

In parallel with this health policy shift towards social democracy, the boundary separating orthodox medicine from alternative medicine has become increasingly permeable. Healthcare practices that historically have been labelled as ‘quackery’, and rejected outright by orthodox medicine, are becoming progressively accepted as an alternative or complementary constituent of healthcare practice today. This shift, from an outright rejection of alternative or complementary medicine towards its selective incorporation, is posited as a major transformation to healthcare within the Western world (Clarke, Doel & Seagrott, 2004; Turner, 2004; Tovey, Easthope & Adams, 2004; Adams, 2007). In New Zealand, the shift towards a more pluralised healthcare landscape is evident through the increasing numbers of general practitioners (GPs) who incorporate forms of complementary and alternative medicine into their medical practice (Poynton, Dowell, Dew & Egan, 2006).

Within this pluralised healthcare environment, in which the boundaries between orthodox and alternative medicine have become increasingly blurred, IM is emerging as a new form of healthcare practice. Although hard to define precisely, IM may be considered as a healthcare practice that “selectively incorporates elements of complementary and alternative medicine into comprehensive treatment plans alongside solidly orthodox methods of diagnosis and treatment” (Rees & Weil, 2001, p. 119). In New Zealand, as in other Western countries, the emergence of IM is apparent. This is most evident in the increasing number of practitioners who claim to practice IM, or who incorporate forms of alternative medicine into their practice. Recent research indicates that 20 per cent of GPs in New Zealand practice at least one form of complementary and alternative medicine (Poynton et al., 2006). The expansion of IM is also evident in the number of health centres that promote their healthcare as being integrative and through the establishment of a New Zealand branch of the Australasian Integrative Medicine Association (AIMA). AIMA holds regular seminars and monthly meetings for members, a number of whom identify as IM practitioners.

There are two elements embedded within this fluctuating healthcare arena that are especially relevant to the current thesis and thus important to tease out. The first is that the medical profession is no longer fundamental to healthcare but instead is considered “one of many contributors to intersectoral public health action” (Gauld, 2009, p. 109). The second is that the healthcare sector has moved from being “expert dominated with some community involvement” to emphasising community participation and partnership (Gauld, 2009). This indicates that expertise has dispersed into a variety of forms, with conventional medical expertise being positioned as one form of expertise amongst others. In parallel, the health consumer is offered greater choice amongst a wide array of healthcare providers whereby a notion of ‘free choice’ comes to the fore. Further, some of the therapeutic practices on offer, and their underlying philosophies, resonate more closely with lay perspectives, particularly those concepts within alternative medicine which explore the body in non-medicalised ways (Sharma, 1996). This explains, in part, the revitalization of complementary and alternative medicine and the emergence of IM.

A variety of social processes contribute to the complexity of this continually shifting healthcare terrain. The most relevant to the current study are medicalization and pharmaceuticalisation, since these have a considerable impact on how healthcare is consumed and practiced, sometimes in paradoxical ways. One apparent paradox is that although medicocentrism has been challenged through the pluralisation of the healthcare market, this has not necessarily lessened medicalization. In fact, the multitude of complementary and alternative health practices and products now available to the public potentially extends medicalization, whilst also offering the healthcare consumer the opportunity to claim an enhanced degree of responsibility for health. The enhanced responsibility granted the consumer is often framed under the rubric of ‘empowerment’ or ‘expertise’ which, rhetorically at least, has granted the public a more prominent position when it comes to health policy.

Alongside the consumer gaining a more prominent position in healthcare, professional accountability has changed in form. Today medical professionals have become less accountable to their profession and more “accountable to the state, acting on the public’s behalf” (Timmons, 2011, p. 340). These shifts in medical professional accountability, along with tensions between the private and public sector have resulted in GPs’ professional

status being undermined. This challenge to GPs' professional identity has been augmented through the internal division and occupational solidarity that increasing specialisation within the healthcare system has brought (Turner, 2004), with general practice having become the gateway through which the public are channeled toward specific services. Increased corporate control over medical care and health reforms have also impacted on the autonomy of medical practitioners. These factors are posited as contributors to the widespread decline of public trust in orthodox medicine (Turner, 2004; Dent, 2006). However, although state intervention in the healthcare system has increased, and the hegemonic status of orthodox medicine challenged, it has been suggested that the State continues to persist in accommodating the medical profession over other types of healthcare professional (Allsop, Baggott & Jones, 2002).

From this discussion we are able to draw three conclusions. First, healthcare consumers' and healthcare providers' positioning in the practitioner-patient relationship has shifted, rhetorically at least, in accordance with changes in local healthcare policies (which, in turn, are shaped by wider social processes and discourses). Second, in that the provision of healthcare rests on a continually shifting terrain, medical professional identity is fluid rather than fixed. Third, this fragmented healthcare landscape provides a suitable environment for novel forms of healthcare to emerge. Such healthcare forms offer practitioners and patients potentially more pluralised positions.

IM epitomises the pluralisation that is evident in healthcare, but in a micro, hybridized form, thus blurring the boundaries between conventional medicine and alternative medicine. Integrative medicine is held to be a site of political and ideological contestation (Fries, 2008) and produces a number of paradoxes. These occur around the paradigm clash between treatment philosophies, issues of professionalism and standardization of treatments, power relationships and debates around dominance and subordination and issues relating to patient autonomy and treatment responsibility. The current thesis examines the paradoxes and contradictions that appear to be inherent in this emerging sphere of medicine and explores their implications for IM practitioners and patients.

The remainder of this first chapter discusses the context in which my research is located in more depth. First, it explores how the social processes of medicalization and pharmaceuticalisation impact on how health is consumed within contemporary society.

Next, it discusses how the healthcare practitioner and patient have been repositioned within the contemporary healthcare system. This section considers how health reforms challenge GPs' professional identity and how these challenges have been understood theoretically. It also considers how medical practitioners have been agentic in negotiating such challenges. The chapter then discusses patients' repositioning within the healthcare system. In particular, a focus is placed on how patients have been repositioned from inhabiting a 'sick role' to becoming 'active' and 'informed' health consumers. Finally, the chapter briefly explores the history of recent healthcare reform in New Zealand and how neoliberal and social democratic government policies have come to underpin the current healthcare system. This discussion then leads to a wider exploration of IM in Chapter 2.

The impact of medicalization and pharmaceuticalisation on society

Medicalization refers to the process of defining non-medical problems in medical terms and treating them with a medical intervention (Zola, 1972; Conrad & Schneider, 1980; Conrad, 1992), and is argued to be "one of the most potent transformations of the last half of the twentieth Century in the west" (Clarke et al., 2003, p. 101). Analysis of medicalization has brought a series of challenges to the scientific neutrality of the institution of medicine around the "production of medically suspect populations" whose members paradoxically participate in the construction of their own medicalised identities (Rosenfeld & Faircloth, 2006, p. 4). These medicalised identities are largely constituted through "passive medicalization" where consumers seek their own health solutions largely uncontrolled by the medical profession (Gabe & Lipschitz Phillips, 1984; Carpiano, 2001).

An increase in the direct marketing of pharmaceuticals to the public is thought to be one driver precipitating this process. New Zealand is one of only two developed countries to permit direct-to-consumer advertising (DTCA) of prescription medications to feature in print media and on national television. Research has found that and on average, an advertisement of this type is aired on television every 102 minutes, with increased frequency at certain times of day (Norris et al., 2005). Research has shown that DTCA has increased the prescribing of advertised products (Gilbody et al., 2005) and has reinforced gender divisions (Conrad, 2005), notions of biological dependence and inappropriate/appropriate aging (Triggle, 2005).

DTCA reflects the wider process of pharmaceuticalisation, a form of medicalization, which involves the “translation or transformation of human conditions, capabilities and capacities into opportunities for pharmaceutical intervention” (Williams, Martin & Gabe, 2011, p. 711). Pharmaceuticalisation brings two major consequences. First, it propagates the societal-wide understanding that ‘there’s a pill for every ill’. Second, it produces a different form of consumption which reaches beyond the medical (Conrad 2007) to include ‘healthy’ people who consume pharmaceuticals for the purpose of improving lifestyle (Williams et al., 2011) in addition to combating ill-health.

The growth of alternative medicine is also implicated in medicalization. Holism is considered to be a core value within CAM (Barrett et al., 2003). Taking up a notion of holistic health shifts the CAM practitioners’ focus away from symptomatology and disease to consider a wider domain such as spiritual wellbeing (Lowenberg & Davis, 1994). It is therefore suggested that holistic health denotes a ‘medicalization of lifestyle’ whereby everyday things like grief, stress and sociability have become correlated with health and illness (Lowenberg & Davis, 1994). Biomedicalization is said to extend the reach of medicalization further to include the control and transformation of inner nature (e.g., through genetic engineering) in addition to external nature (Conrad, 2005). It is therefore suggested that medicalization furthers the individualisation of social problems whereby the causes and solutions of health problems become located within the individual (Conrad & Schneider, 1980). Furthermore, individuals’ engagement in health-promoting activities becomes a means to display morality (Crawford, 1980; 2006). Thus medicalization perpetuates a victim-blaming culture because those groups who do not engage in health practices, most notably lower SES groups (Blaxter, 1997), become ascribed an immoral status.

A number of medical sociologists suggest that the growth of alternative healthcare indicates a shift away from medicalization to demedicalization (Ardell, 1977; Berliner & Salmon, 1980; Wiley, 1988). This is because holistic health, which conceptualises health as encompassing the mind, body and spirit of individuals, is thought to act as a counter-trend to medicalising practices and discourses. In contrast, it has been argued that holistic health represents both medicalization *and* demedicalization. Medicalization is evident in that the causality for illness is located within the patient. This perpetuates individualism, and omits the social context of people’s lives as being implicated in illness. Demedicalization in

holistic health is said to be apparent in the egalitarianism of the relationship between practitioner and patient, which counters medicalising practices (Lowenberg & Davis, 1994). However, the notion of an egalitarian practitioner-patient relationship is questionable due to the paradoxical ideology of the ‘empowered’ health consumer. After all, the health consumer has a *moral obligation* to enact health-promoting behaviours, which problematises the notion of free choice. Therefore the idea that demedicalization occurs in holistic health remains questionable.

These developments increase public understandings that medications are frequently used, commonplace and, moreover, that their consumption is a normal, everyday practice. Medicalization and pharmaceuticalisation also perpetuate the understanding that solutions for health concerns lay in the hands of the consumer to a larger degree. Further, such processes reinforce the notion that the pursuit of health is ubiquitous and that the emergence of novel forms of healthcare, such as IM, are a by-product of wider market forces, which open up more choice to consumers. However, as discussed previously, IM may represent more than ‘just another healthcare option’. Instead it is a site of contestation, containing a number of paradoxes which may have unforeseen consequences for health consumers’ subjecthood and for medical professionalism.

The fluidity of medical professionalism

The conceptualisation of medical professionalism has changed through the advent of managerial and entrepreneurial values, such as accountability, becoming connoted to professional conduct (Numerato, Salvatore & Fattore, 2011). Through the precedence of managerialism, and the emphasis on standardisation and rationalisation, the autonomy of medical professionals has been undermined and their occupational role and identity challenged (Dent, 2006; Numerato, et al., 2011). Identity in this sense refers to that of the profession, rather than individual professionals.

For general practice, professionalism has been defined by the provision of personal care to patients where attention is given to patients’ personal and social contexts alongside their medical concerns (Armstrong, 1979). In the past, patient-practitioner relationships were forged on a premise of trust and continuity of care. However, the field of primary medical care has become increasingly technology-based, specialised and regulated (Armstrong, 2002; McDonald, 2009). With the introduction of automated systems for patient recall and

the pressure on practitioners to meet targets for government funding, practitioner-patient consultations have become more time-limited. They have also become less about personalised care for patients, with clinical practice and consultations changing to “a more biomedical, disease-orientated” model of healthcare (Checkland et al., 2008, p. 795). GPs have come to be understood more as consultants or biomedical specialists than family doctors (Charles-Jones, Latimer & May, 2003). Thus notions of continuity of care and social medicine, which have been identified as central to traditional understandings of professional identity for GPs (Saultz & Lochner, 2005; Pickard, 2009), have been rendered problematic by these shifts, with implications for GPs’ vocational orientation and practice.

Several theories have attempted to encapsulate the changes and challenges that health professions have faced over the last few decades. These include deprofessionalisation (Haug, 1988), proletarianisation (McKinlay & Arches, 1985) and restratification (Freidson, 1994). Deprofessionalisation hinges on the idea that medical knowledge is becoming less opaque to the lay public, through, for example, the Internet and open-access online medical journals, and this has demystified medical knowledge and opened up a space for the emergence of ‘informed’ patients. This diffusion of medical expertise has undermined the notion of the medical professional as altruistic, resulting in a loss of public trust and respect. From a different perspective, proletarianisation refers to the loss of control an occupational group experiences over such things as membership criteria, training content, and autonomy over the terms and scope of work. In the medical profession, this is most notable in a bureaucratisation of medical care, where ‘good medicine’ is achieved through maximising efficiency and profitability (McKinlay & Arches, 1985). This has resulted in a narrowing of the technical base of medicine whereby medical rules and procedures have become increasingly codified and computerised, demystifying knowledge and giving less skilled health providers’ access to information, enabling them to undertake tasks traditionally overseen by doctors (Checkland et al., 2008). However, deprofessionalisation and proletarianisation have both been critiqued for their limited conceptual frameworks, which fail to incorporate the historic and dynamic challenges facing the medical profession (Light & Levine, 1988; Light, 2010).

More recently sociological theorists have argued that the medical domain is undergoing reprofessionalisation and restratification rather than decline, whereby medical dominance and autonomy is sustained “albeit in a new ‘risk aware’ best-evidenced standards-driven

form” (Chamberlain, 2010, p. 9). From this perspective an increase in accountability has led to performance appraisals, peer surveillance and review, and reflects the emergence of a new type of clinical autonomy (Pickard, 2009; Wallenburg et al., 2010). Reprofessionalisation is considered by some to be a consequence of wider “market-driven imperatives and an emphasis on consumerism” (Pickard, 2009, p. 252), and more likely to be imposed from above (e.g., Evetts, 2003) through policy initiatives which reconfigure the structure and responsibilities of the clinical workforce (Martin, Currie & Finn, 2009). Others have argued that reprofessionalisation also occurs within professional groups through processes of boundary negotiation (e.g., Mizrachi, Shuval & Gross, 2005). Within the medical profession, increasing specialisation and the growth of managerial roles have led to such boundary debates.

The diversity of conceptual frameworks used to describe the challenges to, and counter-challenges within, the medical profession points to the difficulty involved in fully encapsulating the shifting nature of medical professionalism in contemporary society. Not only did medical professionalism emerge through practices of monopolisation and subordination (Cant, 2009), but it is also evident that medical professionalism is continually challenged and contested by wider social processes (Marquand, 2000) and is in a constant state of flux. Consequently, medical professional identity can be considered to be more fluid than static, a “negotiated settlement ... always susceptible to new threats and challenges rather than a timeless category” (Dent, 2006, p. 40).

The fluidity that is granted practitioners may also open up new possibilities. Moving to new healthcare terrains, such as IM, arguably gives rise to “a powerful narrative ethic which allows professionals to re-story themselves” (Stronach et al., 2002, p. 130). The act of reconstructing their professional identity provides medical practitioners a means to resist and negotiate challenges to medical professionalism, allowing them to reassert their professional identity, and to find a way through ongoing health sector demands for accountability and governance (Gleeson & Knights, 2006).

Professionals have been shown to engage in various strategies to defend their professional terrain from such threats (e.g., Mizrachi et al., 2005). One important way in which GPs demonstrate agency in countering challenges to identity is through rhetorically emphasising holistic care as a cornerstone of practice. For example, the introduction of the “Quality and

outcomes framework” contract (National Institute for Health and Clinical Excellence, 2011) in the UK, which remunerates GPs for achieving quantifiable clinical and organisational targets, has been shown to affect GP identity and to move GP practice towards a more biomedicalised model of health and illness (Checkland et al., 2008). The introduction of automated patient recall systems has led to a depersonalising of care and has enhanced the construction of patients as passive, and the emphasis on patient consultation targets has led to an increased prescribing of medication. To counter these biomedicalising trends, GPs were shown to rhetorically emphasise holistic care, employing arguments to demonstrate their commitment to caring for the ‘whole’ patient even whilst engaging in antithetical work practices (Checkland et al., 2008). Another way in which GPs counter challenges to their professional identity is by rejecting some values inherent in traditional general practice and redefining the concept of professionalism. For example, Jones and Green (2006) found that early-career GPs rejected the notion of ‘vocation’, framing it negatively and suggesting it conveyed “old fashioned, over-burdened and dysfunctional approaches to primary care” (p. 948). Jones and Green (2006) discuss the shift to “new general practice” as rejecting many of the traditional values of primary care and as having potential to enable less paternalistic practitioner-client relations. This moves ‘good’ general practice away from sustaining continuity of care to being more about demonstrating commitment to the professional community (Jones & Green, 2006).

GPs use of such rhetorical strategies demonstrates a means by which challenges to professional identity are negotiated, and exemplifies how such rhetorical work acts to construct revised professional identities, and potentially, new practices of healthcare. This continually shifting and contested professionalism opens a space through which entirely new forms of professional medical identity are emerging. This has been noted in the case of physiotherapists. For example, Nicholls, Walton and Price (2009) found that one group of physiotherapists in Auckland have broadened their healthcare terrain by incorporating a “better breathing clinic”. This transforms the physiotherapy practice to being less orthodox in its orientation and reconstructs physiotherapist professional identity as autonomous and entrepreneurial.

This continually shifting healthcare terrain and the related professional restorying that is apparent elucidate the possibilities that have opened up to medical practitioners in terms of professional identity reconstruction. This discussion also sheds light on why the realm of

IM constitutes an interesting phenomenon. Through researching IM an opportunity is presented to explore the transformation of healthcare at a micro level. Currently, although there is a substantial literature at a macro level that points to how professionals defend their jurisdictional and epistemic boundaries, little research has been conducted at a micro level around how professionals combat specific managerial, technological or legislative threats and the ways in which they negotiate and defend their boundaries in light of these (Martin et al., 2009). Research into IM is particularly apt in this regard as IM is located at the epicenter of two diverse paradigms, that of biomedicine and alternative medicine, and thus constitutes a site where jurisdictional and epistemic boundary negotiation is likely to be played out.

The emergence of the healthcare consumer

Over the last few decades, there has also been a change in the ways that patients are constituted in healthcare. Patients have been recast from the 'sick role' to 'active' and 'informed' health consumers and are constructed as a partner within the practitioner-patient relationship, most notably under the rubric of concordance (Stevenson & Scrambler, 2005; Fejzic, Emmerton & Tett, 2010; Martin & Finn, 2011). Under this rubric, it is suggested that the healthcare consumer is provided with personal empowerment and freedom of choice. In this sense the power dynamic of the 'passive' patient and the 'expert' practitioner becomes problematised and new subject positions are opened up. However, it is suggested that "consumerism simply loosens the rules and expectations which constitute the traditional patient role" (Irvine, 2002, p. 43). Therefore the notion of the health consumer is understood to merely "reimpose hierarchical relations in the healthcare system" rather than bring about a democratization of healthcare per se (Irvine, 2002, p. 43). Research conducted on concordance within the doctor-patient relationship exemplifies this. Concordance refers to the consultation between doctors and patients based on an equitable relationship between the two parties (Pound et al., 2005). However, although concordance is said to denote an equitable practitioner-patient relationship (Pound et al., 2005), the term may actually be more of a rhetorical construction. Research conducted on doctor-patient communication around medication use revealed that although patients regarded the provision of information about risks of medications as essential, doctors tended to emphasise the benefits of treatment over possible risks (Stevenson, Cox, Britten & Dundar, 2004). Such incongruence between the information that is sought by patients and the information offered by practitioners reflects medicocentrism. Thus, in

Stevenson, et al.'s example, rather than elucidating a partnership, concordance functions at a rhetorical level to encourage patients to engage with practitioners' recommendations.

The 'partnership', 'empowerment' and 'free choice' granted to the health consumer are also constrained through the societal expectation that the consumer *should* uphold their moral duty to safeguard health. This consists of engaging in appropriate health practices such as seeking out information about health, consulting appropriate experts, avoiding risks, and adhering to the 'correct' medication regimes. In contrast, those who engage in 'risky' health practices become understood as deviant and thus implicated in working against the "greater good of society" (Lupton, 1993, p. 429). This moral imperative to pursue health reflects healthism. Healthism is considered to be "one of the more salient practices of contemporary life" (Crawford, 2006, p. 404). Through increased knowledge of health hazards, risks to health, medical breakthroughs and a plethora of products and services by which to maintain and enhance health, public health consciousness has increased exponentially. However, the sense of control that the pursuit of health promises to bring is elusive and instead propels a spiralling sense of anxiety around health concerns (Crawford, 2006). Cheek (2008) suggests that "we live in a state of heightened awareness and understanding of health but at the same time experience the feeling of never having enough of, or knowledge about health" (p. 976).

This moral imperative to engage in the pursuit of health is unrealistic. The health consumer is constructed simplistically, as a responsible individual who engages in rational behaviour, which does not take account of the social context of their lives. Not everyone has equal access to healthcare or health information. Marked differences are apparent in relation to ethnicity, SES and gender (Blaxter, 1997; Hodgetts, Bolam & Stephens, 2005). There also remains a question around whether the healthcare services provided or sold are what health consumers need and whether people actually understand themselves as consumers (Henderson & Petersen, 2002).

Another problem with the notion of the health consumer is that it represents an autonomous individual and fails to take account of the relational context of people's lives. This individualism is implicit within both allopathic and alternative healthcare practices and detracts from an emphasis being placed on community and collectivist approaches to healthcare. This in turn may problematise a population-based advancement of health and

wellbeing (Hogg, 1999). However, that is not to say that collectivist efforts do not occur. Consumer advocacy groups provide such an example. Through these groups, individuals foster identification with others who have a similar condition, achieving greater visibility and an acknowledgement of previously unrecognized or undiagnosed illness (Hess, 2004; Lee, 2006). However, consumer groups are forged on an individualistic basis and fit nicely within neoliberal ideology. This reflects the ‘double-edged’ character of consumerism. Although consumerism is characterized as a means by which collective identity can be forged, and through which disadvantaged groups can claim greater entitlement to health services, it also serves to regulate bodies and lifestyles and masks the need for social change (Henderson & Petersen, 2002). This process is bound up with the governance of populations whereby health becomes “idealized as self-governed lifestyle choice” (Bunton & Burrows 1995, p. 210).

The rhetoric of the health consumer may also serve as a means to allow the state to reposition itself in “relation to health professions in a process of micro-economic and managerial reform” (Irvine, 2002, p. 43). As discussed previously, this managerialist discourse has penetrated professional authority (Irvine, 2002). It is through this process that practitioner autonomy has become “responsibilised”, reflecting increased regulation over the medical profession in the form of audit and clinical governance (Dent, 2006, p. 461). Dent suggests that in Britain, “rather than the doctors effectively claiming to be the patients’ voice, it is now the state administration’s claim to have provided the patients with their own voice(s) and choices” (p. 461). Dent (2006) argues that patient choice discourse acts as a disciplinary technique in that it turns the ‘clinical gaze’ (Foucault, 1973) from the patient to that of the practitioner and in so doing challenges the dominance of medicine.

In New Zealand, the health consumer is certainly afforded choice within the increasingly pluralised system that constitutes contemporary healthcare. Rather than consulting their GP they may instead seek an alternative healthcare provider, such as a natural health store, in order to obtain a non-prescription medicine or remedy. It is at this level that the power dynamic in the patient-practitioner encounter has changed, largely because patients feel a greater sense of control through being able to deal with their health issues in the manner and timeframe they choose (Miskelly, 2006). The health consumer’s engagement with a diverse array of therapeutic products and services has been framed as bricolage (Broom, 2009). In the healthcare arena, bricolage describes a process where health consumers

actively explore and use different forms of healthcare. Bricolage also provides a means to subvert being positioned as inexpert in a medically dominated system (Broom, 2009).

However, individuals' ability to move into a more agentic position when it comes to healthcare may be possible for only some population groups. This is because alternative forms of healthcare are only available to certain individuals. There are structural barriers that prevent low SES groups gaining access to what are often expensive, non-publicly funded alternative medicine treatments. Therefore the emergence of forms of healthcare such as IM could perpetuate existing class divisions in society. This may therefore problematise lower SES groups' claims to moral citizenship, which is generally ascribed to those who actively pursue and display health.

Arguably, the 'partnership', 'empowerment' and 'choice' that are offered to the health consumer within allopathic medicine are rhetoric rather than reality. However, in the wider healthcare arena consumers' engagement in alternative forms of healthcare appears to ascribe them more 'empowerment' and 'choice'. This makes patients' positioning within the realm of IM particularly interesting because IM incorporates both paradigms of medicine.

Healthcare in contemporary New Zealand

Healthcare in New Zealand exemplifies the fluidity that is evident in healthcare today across Western societies. On-going health reforms and legislation introduced by the government constitute the wider structural factors that enable new healthcare forms to emerge, but also impinge on the subjecthood of those who engage in these.

In New Zealand, the emphasis placed on individuals to take responsibility for healthcare has shifted over the last few decades, in line with health policy reforms. From the mid 1980s to the late 1990s, in a similar pattern to Britain, New Zealand policy was heavily influenced by neoliberal ideas. The government's chief aim was to rationalise the delivery of health services with an aim to improve access, encourage efficiency and innovation, widen the choice of service; improve health professionals' working environment, and heighten the sensitivity of the system to changing health needs (Barnett & Barnett, 2005). The government therefore introduced competitive contracting for funding into the health sector, anticipating cost reductions and increases in efficiency. Within primary care, GPs

became grouped together into Independent Practitioner Associations so as to enhance their bargaining power with purchasers.

The reform to a more social democratic healthcare system came with a Labour government re-election in 2001 (Gauld, 2009). This reform emphasised the reduction of inequalities, the improvement of service for disadvantaged groups, and a reorientation of the health system towards collaboration and public health improvement. This came in the form of the Public Health and Disability Act 2000 and entailed the establishment of twenty-one district health boards (DHBs) who consult with their community to manage health services within their district using a population based allocation of funds (Barnett & Barnett, 2005). The provision of funds is preferentially channeled into public services with an aim to build public sector capacity. Governance is imposed in the form of sanctions for inadequate performance, which can result in even tighter governmental control and financial penalties. Thus, in reality, social democratic goals are countered by the application of neoliberal performance management tools (Gauld, 2009).

More recently, since 2003, Primary Health Organisations (PHOs) have been introduced. These necessitate a broader professional base and are community-oriented. DHBs provide funding for the 80 PHOs in New Zealand (Gauld, 2009). Each PHO is obligated to compile a list of formally-enrolled patients, on which funding is based, and to demonstrate that primary care services comprise other forms of healthcare providers, beyond GPs. The formation of PHOs is considered beneficial to some population groups because of the additional funding that has been channelled into these. For example, ‘care plus’ initiatives have been designed for people with chronic disease along with initiatives to improve access (Gauld & Mays, 2006).

However, as Gauld (2009) suggests, the New Zealand health system “remains in a state of flux”. Gauld (2009) discusses how DHBs are continually pressured to achieve greater coordination and, in conjunction, although government policy places an emphasis on primary care, the issues that are emerging are deemed to require attention. These include a multitude of PHOs having small patient lists and the conundrum that remains around how to develop “truly multidisciplinary organisations in an environment where funding favours GPs” (Gauld, 2009, p. 35)

In addition to the establishment of more ‘community-oriented’ approaches to healthcare, the government introduced initiatives which emphasise public safety. Today, the dangerous practitioner is identified as one who partakes in incompetent, irresponsible and unscrupulous practice, be it allopathic or alternative medicine (Dew, 2003; Wahlberg, 2007). Consequently, the New Zealand government has taken a managed care approach to regulate the medical profession. This has increased the level of surveillance over healthcare professionals. For example, the Health Practitioners Competence Assurance Act (HPCA) was introduced in 2003 with the purpose of protecting the health and safety of the public through the provision of “mechanisms to ensure the lifelong competence of health practitioners” (New Zealand Parliament, 2003). The HPCA extends the Medical Practitioners Act 1995, to cover all health professionals, thus increasing public safety by ensuring that health practitioners become registered in order to practice. Further, the Act ensures that practitioner competency is certified annually by a registration authority within the practitioners’ scope of practice. The Ministry of Health suggests that the HPCA is “very much about handing the authorities responsibility for and providing them with tools for ensuring that health practitioners are, and remain, competent and safe to practice” (New Zealand Parliament, 2003).

National concern around the safety and evidence-base of alternative forms of healthcare is also evident. The Ministry of Health established a Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH) in 2001 with an aim to provide practitioners and consumers advice and information on the benefits, risks and costs of complementary and alternative therapies. Traditional Māori healing was not included; being under the realm of the Ministry of Health’s Māori Health Directorate in line with the Māori Health Strategy.

MACCAH’s recommendations emphasised risk, protection and the optimisation of CAM consumers’ safety as key concerns. Further, although MACCAH acknowledged the possible complications inherent in bringing CAM and biomedicine together in healthcare, and the potential for an unequal partnership due to the dominance of biomedicine, they also suggested that funds be directed into research on CAM to establish “evidence for the efficacy and safety of CAM” (MACCAH, 2004, p. 6) and that evidence-based information on the efficacy and safety of CAM therapies be provided to consumers. These recommendations reveal the impetus towards creating a regulatory environment when it

comes to incorporating alternative medicine in healthcare. They also indicate how EBM has become concretised as the *only* means by which safety and efficacy can be established. This potentially problematises the practice of IM because EBM cannot easily be applied to alternative medicine practices and therapies.

Healthcare in New Zealand exemplifies the shifting terrain in which healthcare professionals are located. On-going reforms and changes in legislation have resulted in challenges to the integrity of both allopathic and alternative medicine practitioners' identity. These reforms also impact the health consumer. Directly, they appear to offer protection and choice to the consumer. However, indirectly, they may increase public distrust in healthcare, leaving the consumer in a space where existing forms of healthcare become questionable in terms of safety and efficacy. The scepticism that arises from this discursive entrenchment of 'risk' may in turn compel the public to seek out new avenues by which to safeguard health. IM could constitute one such avenue.

Conclusion

This chapter has discussed how the healthcare landscape has shifted over recent years. Wider socio-cultural processes have acted to transform how healthcare is produced, practiced and consumed. First, social processes such as medicalization and pharmaceuticalisation have heightened public health consciousness and have perpetuated the idea that 'there's a pill for every ill' and that the pursuit of health is a ubiquitous practice. Second, the practitioner-patient relationship has changed in form. Here, the expert status and professional identity of GPs has been challenged whilst the patient has been reconceptualised from: a naïve, compliant patient, in need of expert surveillance and advice, to an 'informed', 'active' and 'empowered' health consumer. In New Zealand, the healthcare terrain remains in a continual state of flux. This is evident through the number of health system reforms that have taken place over recent years and through the implementation of government legislation which prioritises public safety and in turn, heightens public awareness of potential risks to health.

These transformations to both the terrain of healthcare and the players that interact within the healthcare arena have the potential to perpetuate the healthism that is already evident in contemporary Western society. The public is 'offered' a greater degree of control over health through the consumption of an ever-increasing array of healthcare products. The

pluralisation of the healthcare arena acts to potentially extend medicalization and inadvertently perpetuates a need for alternative forms of therapeutic care. However, although new subjective possibilities may arise for both medical practitioners and health consumers through the emergence of novel forms of therapeutic care, there has been little research conducted at a micro level to explore this transformation in detail, and how it impacts the subjecthood of practitioners and patients in healthcare today.

Research into the realm of IM allows us to explore this transformation at a micro level. Further, IM is a particularly interesting form of healthcare because it is located at the crossroads of two paradigms that are philosophically diverse. However, paradoxically, the boundary between alternative medicine and allopathic medicine remains blurred with contestation around whether the emergence of IM constitutes a process of ‘mainstreaming’ (Coulter, 2004) rather than a partnership or merger between the two paradigms. A variety of concerns have been raised over this amalgamation, and a number of paradoxes are evident within IM. These paradoxes have implications for both healthcare patients and practitioners and will be explored in depth in the following chapter.

Chapter 2

The growth of alternative medicine; The emergence of integrative medicine

The fragmentation of the healthcare landscape, precipitated by the wider acceptance of alternative medicine creates a space for hybridised forms of healthcare to emerge. One such hybrid is IM which, rather than solely serving patients' or health consumers' needs, is held to be a site of political and ideological contestation (Fries, 2008). This chapter discusses the growth and increasing prevalence of alternative medicine in the contemporary developed world and explores the complexity and contestation surrounding the emergence of alternative forms of healthcare. For the health consumer, the realm of alternative medicine is held to be a location through which empowerment and wellbeing is reproduced, an important consideration in that notions of health in contemporary society represent not only the absence of illness, but also the presence of wellbeing and the maximising of one's potential (Sointu, 2006a, 2006c).

First, the chapter explores the growth of alternative medicine. It then examines the difficulty in defining IM and what existing research suggests IM represents. Next, it discusses how alternative medicine has moved from the premise of vitalism to the premise of holism and the implications of this shift for alternative medicine practitioners and patients. Finally, the chapter explores the implications of the emergence of IM for patients

and practitioners in terms of their positioning and subjectivities, and a discussion around the paradoxes that surround the practice. The chapter ends with the rationale for doing this research.

The growth of alternative medicine

During the early 19th Century various forms of healthcare were available to the public, with no particular approach dominating (Saks, 2003). Science had not yet been introduced to evaluate medicine and so a range of allopathic and alternative medicine practitioners, such as herbalists, homeopaths, and so on, practiced on an equal playing field. This was evident in New Zealand, where, during the 1870s, doctors comprised a diverse group of “itinerant street vendors, folk physicians and regular practitioners” (Belgrave, 1985, p. 3) with a proportion of the population regarding doctors as unnecessary due to their view of New Zealand as a ‘healthy country’ (Belgrave, 1985). However, the situation changed considerably in the late 19th Century when ‘germ theory’ was established, constituting the rise of an approach to treatment that rested on science. The media assisted in affording doctors a new-found respect (Dew, 2003) which was reinforced through New Zealanders’ increasing ability to pay for medical services, along with government legislation which marginalised non-orthodox medicine (Belgrave, 1985). For example, the Tohunga Suppression Act in 1907 restricted Māori from visiting traditional healers, and the Quackery Prevention Act in 1908 made it illegal for the makers of patent remedies to make false claims around curing, preventing or healing illness or physical defects (Belgrave, 1985).

During the same era, the medical profession gradually rose to prominence, especially following the introduction of the Medical Practitioners Act 1914, which legitimated orthodox practice whilst delegitimising other forms of medicine (Thomas, 2003). However, because medical legislation in New Zealand had been influenced by British legislation, which allowed homeopaths to continue their practice, a clause was introduced into New Zealand legislation which remains relatively intact. Today this states that “No person may be found guilty of a disciplinary offence under this Part merely because that person has adopted and practised any theory of medicine or healing if, in doing so, the person has acted honestly and in good faith” (New Zealand Parliament, 2003).

The marginalisation of alternative medicine was most evident in Britain, where by the mid 20th Century, alternative medicine practice was virtually non-existent (Saks, 2003). In contrast to the subjugation of alternative medicine, pharmaceutical companies enjoyed the benefits of increased regulation in that they faced no major obstacles in adhering to the regulations imposed (Saks, 2003). The commercial interests of ‘Big Pharma’ were pitched against consumer safety and, following a number of drug safety controversies, government agencies were set up to regulate the safety and effectiveness of medications. At this juncture, the health interests of patients were placed above consumer demand or desire. Nevertheless, due to public unawareness around the risks and benefits of medications, the ideology of the ‘false consciousness’ of patients arose which held that people were ignorant to the social forces that shaped their lives (Abraham, 2008). In effect, the ideology of ‘false consciousness’ granted the public a position of ‘dupe’ and a subjectivity of passivity and ignorance.

It was during the 1960s and 1970s, through the advent of the civil rights movement, the Māori renaissance and the second-wave of feminism, that traditional bastions of authority were challenged. This laid the ground for the emergence of a medical counterculture where demand for alternative medicine increased and indigenous perspectives around self-determination became recognised and legitimated. In New Zealand from the 1970s, Māori argued for changes to be made to health delivery which emphasised traditional medicine practice alongside Western biomedicine. The prominent Māori conceptualisation of health differs substantially from that of biomedicine as it incorporates the cultural, social, emotional and spiritual elements of individual community and land (Durie, 1985; Anderson, 1999; Dew & Carroll, 2007). These models are compatible with a humanistic approach to health that emphasizes the importance of interpersonal relations. Attention is given to the whole person in context. Interestingly, concepts of health and wellbeing which incorporate the wider social and spiritual domains remain “the most commonly held explanation of the cause of illness worldwide” (Grbich, 1999).

Today, alternative medicine and preventative healthcare practices operate in a wider cultural, political arena which emphasises self-determination and control over one’s identity and environment (Bakx, 1991). It is over the last three decades that the use of ‘complementary and alternative medicine’, or ‘non-orthodox medicine’, has risen substantially (Eisenberg et al., 1998; Ernst & White, 2000; Barnes, Powell-Griner, McFann

& Nahim, 2004; Tindle, Davis, Phillips & Eisenberg, 2005) as people seek alternatives to allopathic medicine (Saks, 1995; Furnham & Vincent, 1996; Foote-Ardah, 2003). This reflects a decline of trust in medical expertise and an expression of dissatisfaction with biomedicine (Saks, 1995), especially when biomedicine “is not producing desirable results” (Saks 2003, p. 113) which is particularly relevant for those who have a chronic illness or have received a terminal illness diagnosis.

The medical profession have also sought to incorporate alternative medicine rather than reject it outright (Saks, 2003). This shift is apparent in healthcare within contemporary New Zealand society, with 20 per cent of GPs practicing at least one form of CAM (Poynton et al., 2006). Chiropractic, osteopathy, acupuncture and hypnosis are the most utilized practices, with chronic pain and musculo-skeletal disorders the most commonly treated complaint (Dew, 2003). However, concerns have been raised about GP’s level of training in alternative medicine and the low number of referrals made (Dew, 2003). Currently, the medical curriculum does not incorporate complementary therapies to any significant degree. Further, recommendations to introduce non-orthodox treatment methodology has been problematised through claims that “medicine exists because it is based on science and not on the work of charlatans, and that acupuncture, osteopathy, chiropractic, naturopathy and homeopathy have nothing to do with scientific medicine” (Dew, 2003, p. 35). Others have pointed to the instrumentality of alternative medicine in bringing a convergence to the art and science of medicine in primary healthcare (Cairney, 1989).

However, alternative medicine is construed as treatment which reflects people’s health beliefs and can be used as a meaningful way to self-manage health and illness (Furnham & Vincent, 1996; Foote-Ardah, 2003). People’s engagement in alternative practices also relates to concerns about physical health having become conflated with a desire for looking and feeling good (Sointu, 2006a, 2011), whereby alternative medicine is not sought merely on the grounds of eradicating illness. For example, alternative medicine consultations are conceptualised as ‘treats’, given to another as a gift and thus signifying care (Thomas, Coleman & Nicholl, 2001). This reflects how the consumption of health practice goes beyond physiological functioning, and is also understood as a means through which people seek alternative subjectivities, such as a sense of wellbeing (Sointu, 2006a, 2006c).

Discourses of wellbeing in the context of CAM function to legitimate the subjecthood of individuals whose claims to health have been disrupted (Sointu, 2006a, 2006b, 2006c). Wellbeing is arguably more akin to lay knowledge, as it rests on an understanding of listening to one's inner wisdom and thus enables individuals to produce a self-derived sense of meaning around health and illness. Further, wellbeing allows for the land or environment, and a sense of spirituality to be incorporated. This is especially important to Māori who speak of the health-giving connection and interconnectedness with the bush, the land, streams and the sea. For Māori, living on the land, from the land and sea, and caring for the land, are seen as health-promoting and essential for wellbeing (Dew & Carroll, 2007). However, wellbeing is also “a possibility available for the choosing individual, and as such, conceptualisations of wellbeing play a role in producing subjects who are responsible for their own health” (Sointu, 2006c, p. 346). Therefore wellbeing dovetails nicely with neoliberal ideology.

This historical overview highlights how wider cultural and social processes have impacted both the growth of alternative medicine and public understandings of this form of healthcare. It also shows how the boundaries between allopathic and alternative medicine are permeable rather than fixed. Further, the discussion sheds light on the ongoing ideological contestation between these two realms of medicine. The increased use of CAM, by both healthcare professionals and the general public, has also added impetus to the professionalisation of alternative medicine.

The professionalisation of alternative medicine

Through professionalisation, alternative forms of healthcare can gain legislative recognition and traverse their marginalised status (Dew, 2003). However, the professionalisation of non-orthodox medicine brings both advantages and disadvantages to alternative medicine practitioners and for the therapies they practice. First, alternative medicine practitioners are granted a greater level of expertise, primarily through trainees completing courses and being awarded certificates and diplomas which increase their legitimacy. However, the greater legitimacy that training offers may also undermine the therapeutic base of the therapy in which practitioners engage. That is, through codifying the knowledge-base of different forms of non-orthodox medicine into training modalities, a unification of disparate modes of practice may occur (Cant, 2009). The introduction of codes of ethics, registration processes and disciplinary procedures for errant practitioners that are

embedded within the process of professionalisation may also act as a form of social closure (Cant, 2009). Further, the incorporation of biomedical science and methods into training modules as “a resource to prove and account for the effectiveness of their therapy” (Cant, 2009, p. 186) could be understood as a process of delegitimation. Finally, some CAM groups, such as chiropractic in New Zealand, have adjusted claims to the extent of their therapeutic reach which may constrain practice (Dew, 2003).

In recent years, evidence-based medicine (EBM) has become central within professionalisation discourse. EBM aims to assess the strength of the benefits and risks of treatment and practices, in order to establish efficacy, and to apply the best evidence in healthcare practice. The most compelling evidence is gained via randomised controlled trials (RCTs) (Jackson & Scrambler, 2007). RCTs have emerged through the primacy granted to scientific fact over medical opinion which reinforces and perpetuates a wider discursive shift from medicine being understood as an art to that of a science. From a policy perspective, EBM has been referred to as a means to justify the exclusion of non-orthodox practices from the healthcare arena (Broom & Tovey, 2007). However, non-orthodox practitioners and researchers are reluctant to adopt RCTs to investigate CAM. Not only are RCTs unsuitable to assess the effectiveness of non-scientific therapies, but they are incommensurate with the underlying philosophy of many non-orthodox therapies which do not reduce the body into organs, cells and molecules that can be treated separately. Instead these therapies attend to patients as unique in order to treat the ‘whole person’ (Keshet, 2009). For alternative medicine practitioners, the pragmatic trial is deemed more appropriate as it assesses whether treatment has a specific effect and thus addresses the issue of whether the therapy as a whole works, with the objective being to “discover the effect and outcome of the whole ‘package of treatment’” (Keshet, 2009, p.145).

In New Zealand, the identification of ‘dangerous’ practitioners is embedded within public health policy, and because alternative therapies lack a firm evidence base (in that the ‘gold standard’ RCTs are held to be inappropriate to assess the efficacy of alternative therapies) they are more susceptible to having their therapeutic claims undermined. This is exemplified in the professionalisation of chiropractic. In order to achieve a ‘workable’ relationship with the medical establishment, chiropractic redefined claims it made about what chiropractic therapy could do (Dew, 2003). Prior to professionalisation, chiropractic claimed it could successfully treat a number of ailments in addition to back problems,

including asthma, high blood pressure and diabetes. However, as a result of professionalisation, chiropractic became engendered to present itself as an association of musculoskeletal specialists. Therefore it revised claims about its therapeutic reach, alleging this only extended to back problems (Dew, 2003). This susceptibility to practice being labelled 'ineffective' is also apparent in Britain where, following an initiative by the Prince of Wales, which reported on national healthcare delivery (Coates & Jobst, 1998), a four-tiered taxonomy was introduced to the alternative healthcare system. The taxonomy created a hierarchy of non-orthodox healthcare services and produced a number of dividing practices within these therapies whereby some alternative practitioners seek regulation in order to avoid being outlawed as 'dangerous' practitioners (Wahlberg, 2007).

Cant (2009) suggests that the professionalisation of non-orthodox medicine has done little to enhance the status of alternative medicine in the larger hierarchy of medical practice, or conferred it with any special benefits or privileges. The regulatory measures introduced through professionalisation also bring challenges to the self-definition and autonomy of alternative therapies, and could be considered a way in which a co-optation of CAM practices by the mainstream system occurs.

The problem of defining integrative medicine

IM is a relative newcomer to the transforming healthcare landscape. The emergence of IM has led to a number of debates arising over its value and practice. It has been represented as a site of political and ideological struggle where boundary maintenance between allopathic and alternative medical practitioners is played out (Fries, 2008). It has also been argued to represent an "expansion of medical rationality into all domains of human life: biological, psychological, sociological and spiritual" (Fries, 2008, p. 354). However, there has been little agreement on how IM is defined and understood, with definitions varying considerably and some suggesting that the definition is still evolving (e.g., McCaffrey, Pugh & O'Connor, 2007).

The problem of definition goes beyond IM to its two constituents, biomedicine and CAM, with considerable debate occurring around how each is defined. The debate centres on biomedicine being defined in terms of what it is, whereas CAM is defined in terms of what it is not, and in the process becomes 'othered' (Baer, 2004; Coulter & Willis, 2004). The term CAM is also problematic as it encapsulates a vast array of techniques and underlying

traditions. Furthermore, attempts to categorise these shift over time. For example, in 2000 the National Center for Complementary and Alternative Medicine (NCCAM) pointed to five major domains: alternative medical systems; mind-body interventions; biologically-based treatments; manipulative and body-based methods; and energy therapies (NCCAM, 2000). In contrast, in 2008, NCCAM identified four major domains which included the latter four of the aforementioned, and an additional term: “whole medicine systems” which “cuts across the four domains” (NCCAM, 2008). This appears to have replaced the alternative medical system category.

NCCAM defines IM as “the combination of treatments from conventional medicine and CAM for which there is some high-quality evidence of safety and effectiveness” (NCCAM, 2008). This contrasts with the definition offered by the Consortium of Academic Health Centres for Integrative Medicine (CAHCIM) which defines IM as “the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing” (CAHCIM, 2008). The former definition focuses on treatment, evidence, safety and effectiveness whereas the latter points to multidisciplinary between practitioners, the centrality of the practitioner-patient relationship and incorporates the notion of therapy rather than treatment. The difference between these definitions may reflect a disparity in the worldviews held by a diverse array of practitioners and practices (Boon, Verhoef, O’Hara, Findlay & Majid, 2004).

It has been argued that “it is extremely difficult to practice, teach, research and formulate policy about such an elusive entity” (Boon et al., 2004, p. 48). From a review of 57 articles focused on the amalgamation of complementary and alternative medicine with conventional medical care, Boon et al. (2004) attempted to identify the key components that could define integrative healthcare. They suggest that four components were central – philosophy and values, structure, process, and outcome – but that these defined an ‘ideal’ rather than a realisable type of care. Under this definition, the relationship between patient and practitioner is constructed as a collaborative partnership in which both parties contribute knowledge and skills within a shared vision of health. The patient is treated holistically and constructed as a person with innate healing abilities. The practitioner is constructed as a facilitator of wellness, who combines conventional medicine and

alternative medicine synergistically to “exceed the collective effect of the individual practices” (Boon et al., 2004, p. 54). This conceptualisation reflects an egalitarian practitioner-patient relationship in which the patient is afforded agency in contributing to the healthcare enacted. However, as suggested by Boon et al. this definition is an ideal type. Therefore, it constitutes the *conceptual foundation* rather than the *actual practice* of its practitioners, much like the biomedical model (Gale, 2011). After all, not all GPs confine themselves within a biomedical orientation to practice. Some are far more holistic in their approach. Thus how to define IM is likely to remain problematic, particularly in that the form IM takes is likely to vary from practice to practice, regardless of the establishment of a commonly agreed set of underlying components.

One understanding that appears to be pervasive within understandings of both alternative medicine and IM is holism. Considerable debate surrounds this term. Coulter and Willis (2004) maintain that vitalism is *the* principal defining difference between orthodox medicine and CAM beyond the fact of CAM’s ‘otherness’ to biomedicine, which he suggests “leads to a different philosophy about health, healthcare and the role of the health provider” (p. 216). Vitalism, a vital force or spirit “which moves the body towards healing” (Evans, 2008, p. 2101), has been linked to superstition and anti-scientific attitudes (Greco, 2004). The discourse of vitalism has also constructed illness as a spiritual unease which can be countered by practitioners who enable the innate healing abilities of the body. This contrasts sharply with materialism where “disease is explained entirely in terms of materialistic factors (usually biological ones in the case of biomedicine)” (Coulter & Willis, 2004, p. 216). However, it is interesting to note that the usage of the term ‘vitalism’ is diminishing in alternative medicine literature. For example, in a recent review of 285 articles on herbal therapeutics in the Australian Journal of Medical Herbalism, Evans (2008) found that “an evidence-base for practice is increasingly apparent in descriptions of therapeutic interviews and reference to herbal philosophy and to vitalism are decreasing” (p. 2104). In fact, Evans claims that there have been “no references to vitalism in the last five years” (p. 2104).

It is suggested that holism has been taken up as a substitute for vitalism due to it being more acceptable to scientists (Greco, 2004). However, ‘holism’ is held to be vague and used to cover a vast array of therapies whose practices are non-reductionist (Kaptchuk, 1996). One theoretical perspective suggests that holism is a resistive construction to the

mind-body dualism inherent in biomedicine, offering patients a new belief system about health, illness, the body, and the healing process (Barry, 2006). A more critical view proposes that, within a niche where both non-orthodox medicine and biomedicine strive for dominance, complementary and alternative practitioners “use holism and ‘healing’ as a rhetoric strategy for gaining popularity” (Keshet, 2009, p. 148). In that holism is held to be used rhetorically by practitioners for political purposes rather than in line with the best interests of patients, an analysis of practitioners talk around this concept would be valuable.

The fact that IM varies in form is evident when considering the scope of IM practice and how it differs substantially from country to country, ranging from clinics which define themselves as offering IM or integrated care, to individual GPs who practice specific types of alternative medicine. For example, in the UK homeopathy has been the predominant type of CAM practiced by GPs (White, Resch & Ernst, 1997). In contrast, in New Zealand 20 per cent of GPs practice some form of CAM with 10 per cent practicing acupuncture, 5 per cent herbal medicine, 2 per cent osteopathy and 1 per cent chiropractic (Poynton et al., 2006).

However, although biomedical practitioners have opened themselves to integrating alternative therapies into their practice, many base their inclusion of CAM on the proviso of scientific validation within the EBM model (Parker, 2007). In the US, four CAM systems have risen to the fore in terms of legitimation: chiropractic, naturopathy, oriental medicine and acupuncture. Chiropractic care has been legitimised over other CAM practice. However, this is considered more of a semi-legitimation in that “heterodox practitioners are forced to comply with the structures, standards, and processes that are dominated by biomedicine” (Baer, 2004, p. 27).

Legitimizing the inclusion of alternative medicine alongside allopathic medicine through applying biomedical standards to alternative medicine arguably does not represent IM. Instead, it appears to reflect the hegemonic status of biomedicine and biomedical practitioners who are able to achieve a dominant status in relation to alternative medicine, largely because diagnosis and cure are legitimated over the pragmatic evidence base of alternative therapies (Mizrachi et al., 2005). Interestingly, in Germany the medical profession has been criticised for incorporating acupuncture in biomedical models (Saks, 1992, 1994) in that 50 per cent of medical acupuncturists using acupuncture explained its

efficacy scientifically rather than in the context of Traditional Chinese Medical theory. Therefore, as Cant (2009) suggests, integration may reflect a drive toward evidence based practice, is being carefully managed, minimally funded and is dominated by biomedicine's authority.

Problems around defining and conceptualising alternative medicine and IM reflect the impossibility of capturing the complexities of such a dynamic and evolving phenomenon within a single definition. After all, within the realm of alternative medicine, practitioners are said to engage in more personalised forms of treatment. Therefore their approach to practice is likely to change according to the needs of the unique individual they hold their patient to be, rather than constituting standardised treatment. In the current research IM is understood to reflect the practice of a medically qualified GP who incorporates one or more forms of alternative medicine into their practice and who describes their practice as integrative.

The paradoxes of integrative medicine

The contestation around a commonly agreed definition, an ill-defined scope of practice and power struggles, largely in the form of boundary maintenance, are aspects that make the site of IM an interesting phenomenon. Further, as eluded to previously, there are a number of paradoxes that become evident in the emergence of IM. First, the paradigms that constitute IM are held to be incommensurate. Second, the integration of CAM with biomedicine may enhance rather than counter the dominance of orthodox medicine. Third, the empowerment that is supposedly granted patients within CAM, through the breakdown of the expert-inexpert practitioner-patient relationship, is precarious. Fourth, the incorporation of CAM with mainstream healthcare in the form of IM may foster professionalisation and standardisation of practice which is antithetic to CAM practice. The following sections discuss each of these paradoxes in more detail.

The incommensurability of alternative medicine and allopathic medicine

Although the general consensus is that IM comprises allopathic medicine and some elements of CAM, it is difficult to assess how the two are merging, and indeed whether they are merging. Terms such as co-optation, assimilation, subordination, collaboration, synthesis, convergence, takeover, which can be found throughout the literature, point to very different forms of 'merger'. Synthesis, convergence and collaboration indicate an

equitable amalgamation of the two systems, whereas assimilation, co-optation, subordination and takeover connote a colonisation. Coulter (2004) suggests the term 'integrative' may "bear more relation euphemistically to the term 'takeover' in much the same way as in the business world, for there the term 'merger' conceals the reality or takeover between two companies (and on occasions a hostile takeover)" (p. 216).

The paradigmatic juxtapositioning of CAM and allopathic medicine within IM is held to be problematic on the basis that biomedicine and CAM are said to be incommensurable paradigms (Coulter, 2004). Disparate metaphysical systems are seen to underlie each: mechanism and reductionism underlie biomedicine; and holism underlies CAM (Coulter, 2004). Coulter raises the question as to how two "distinct philosophical foundations, distinct a priori assumptions and distinct metaphysical beliefs, can be unified within a single paradigm without doing great violence to at least one of the paradigms or totally transforming the other"? (Coulter, 2004, p. 110). Using the example of the transformation that took place in medicine in the late 19th Century, when the scientific method of investigation was introduced, Coulter points to the consequences of bringing disparate paradigms together. During that epoch medicine became transformed from an art to a science and illness was reconceptualised as disease, thus elevating the concept of biological determinism. Further, the increasing dependence of medicine on science and technology, led it to be practiced in institutions culminating in the "demise of the solo practitioner, the rise of the specialist and virtually the disappearance of care rendered at home" (Coulter, 2004, p. 111).

Therefore, as Coulter (2004) suggests, this adaptation transformed the notion of health and healthcare, the nature of medical practice, the therapeutic setting and shifted the focus from the individual and illness to biological structure and disease. Will the establishment of IM have an impact of similar magnitude, and, if so, in what form? The major concern being that IM may actually reproduce biomedical hegemony rather than offer the health consumer a *real* alternative realm of healthcare. If this is the case then the 'choice' that is said to be opened up to the health consumer through this more pluralised healthcare landscape becomes questionable.

The contradictions underlying holism and empowerment

There are a number of inherent contradictions within the concepts of holism and empowerment that CAM and IM may reproduce. First, holism, a principle that underlies alternative medicine, may serve as a means by which the co-optation of CAM practices occurs. Paradoxically, rather than holism offering an alternative to the reductionism of biomedicine, the notion of holism may actually be drawn on to unify disparate alternative practices. This reflects Baer's (2004) suggestion that holistic health is more of a biomedical construction which allows biomedicine to subordinate alternative therapies and therapists as adjuncts. Such rhetorical jostling may therefore constitute an ideological struggle for "dominance over the same niche" whereby while CAM practitioners "use holism and 'healing' as a rhetoric strategy for gaining popularity, biomedical discourse seeks to secure its dominant position by the discursive practice of boundary work" (Keshet, 2009, p. 148).

The notion of holism could also be held to actually strengthen biomedical hegemony in that it reifies and perpetuates an individualised healthcare model based on mind-body-spirit (Baer, 2004). The focus on holism within CAM stresses the importance of making lifestyle changes such as dietary modifications and managing stress, thus reinforcing the notion that it is the failure of the individual to achieve health. Holism therefore becomes bound up with morality. This is problematic in that failure to achieve or seek health becomes equated to "a failure to embrace life, an inability to master one's emotions or to appreciate the spiritual dimension of being" (Crawford, 2006, p. 411). Constructing ill-health as personal responsibility also brings victim-blaming which in turn downplays the role of poverty, unemployment, and so on, in disease aetiology (Baer, 2004).

Thus the integration of CAM with mainstream healthcare practice may increase rather than counter the dominance of orthodox medicine and thus limit the alternative subjectivities that become available within a more pluralised healthcare system. This is because alternative medicine becomes positioned as 'other' to mainstream medicine. Being 'other' to, rather than a 'counter system' has very different connotations. It suggests biomedical hegemony remains relatively unchallenged. Instead, mainstream medicine becomes reinforced as the 'standard' to which all other forms of medicine are compared (Cassidy, 2002). This is reflected by other researchers who suggest that the amalgamation of multiple alternative healthcare practices under the term 'CAM' is actually a means of co-opting these practices in order to bring this realm of medicine under control (Singer & Fisher, 2007).

This begs the question as to whether the practice of IM fosters the cooptation of CAM by mainstream medicine.

The notion of an ‘active’ and ‘informed’ health consumer suggests individuals have gained a degree of empowerment. However, this notion of empowerment is problematic. Although, empowerment promotes the notion of an agentic patient, and thus counters the passive patient construction within the allopathic patient-practitioner relationship, empowerment is underpinned by a number of contestable assumptions. These assumptions rest on the premise that patients actually want to become more informed about health and wish to take more responsibility for their own health and healthcare. Moreover, the notion of the empowered health consumer is a construction that fits with neoliberal ideology that the health consumer or patient *should* become empowered. One could argue that the encounter between a CAM practitioner and patient, where a joint exploration of the pathology occurs, provides the patient with a greater opportunity to become empowered. This is because the expert-inexpert dynamic is broken down. Further, CAM practices are shown to bring about the recognition of personal concerns which can be delegitimated within institutional settings. Thus CAM is understood to facilitate patients’ empowerment (Sointu, 2006). However, the emphasis placed on self-care and taking responsibility for one’s health may actually exacerbate anxiety due to the autonomy and individualism afforded the patient (Lupton, 1996). This potentially leaves the health consumer in a conflicted state in which “the demanding commitment of protecting and achieving health and battling every specific cause of death has brought death into a more or less continuous presence” (Crawford, 2006, p. 403). This creates a citizen who experiences less security about health. After all, as Crawford says, “the more important health becomes for us, the more insecure we feel” (Crawford, 2006, p. 403).

This brings us to the question of what happens in the relationship between the practitioner and the patient in the IM realm where “wellness and healing of the entire person, drawing on both conventional and CAM approaches” (Bell, 2002, et al., p. 133) occurs? Such a conceptualisation suggests that illness, diagnosis, treatment, the body, the relationship between the practitioner and patient may be constructed quite differently in the IM encounter as these factors differ markedly within each paradigm. This has implications for patients’ and practitioners’ subjectivities and in terms of how IM healthcare is practised and understood.

Professionalism, best practice and autonomy

As discussed previously, processes of professionalisation and regulation are strategies the state employs to ‘protect’ the public. Professions also engage in boundary work (Gieryn, 1983) to defend their territory by claiming expertise in specific areas. Medicine occupies a dominant position in this regard appealing to the laws of science and evidence as the norm (Larson, 1990; Martin, et al., 2009). Professionalisation and regulation therefore become significant when it comes to integrating allopathic and alternative medicine. As discussed previously, the process of professionalisation brings standardisation and ‘best practice’ which potentially challenges practitioner autonomy. In general, standardisation “aims to reinforce and regulate the distinct knowledge and skills base defining any given practice” whereby standardised training and assessment processes enable the detection of both qualified practitioners and incompetent, untrained individuals (Clarke, et al., 2004, p.334).

Ultimately, the contraction of practice that accompanies the professionalisation of non-orthodox medicine challenges the integrity of CAM (which rests on the principle of treating each patient as a unique individual rather than providing a standardised form of treatment) and has possible ramifications in terms of lessening non-orthodox medicine’s popularity (Cant & Sharma, 1996). CAM practitioners draw on diverse therapeutic techniques derived from multiple traditions whereby practice has been crafted through experience and entails a personalised approach to care, making CAM resistant to consensus and codification (Clarke, et al., 2004). Because IM has neither a mutually agreed upon or widely understood definition, along with a shifting scope of practice, this would make standardisation especially problematic.

Conclusion and implications

Today, the healthcare system consists of a multitude of diverse practices and incorporates non-orthodox medicine to a larger degree. Alternative forms of healthcare are understood to foster wellbeing and provide a means to self-manage health, offering personal autonomy and a greater degree of agency to the health consumer. For the healthcare consumer, the consumption of healthcare constitutes self-expression, denotes moral responsibility and symbolises social status and worthy citizenship (Clarke et al., 2003). For healthcare practitioners, taking up alternative therapies affords them a wider array of healthcare treatments to offer patients, and may act as a resistive strategy and a means to combat challenges to professional autonomy.

The incommensurability of the paradigms that constitute integrative medicine, along with further challenges surrounding the use of EBM (not easily applied to assessing the effectiveness of CAM or IM), and the impetus toward standardisation and professionalisation, in combination, have the potential to further transform healthcare practice. The emergence of IM blurs the ill-defined boundary of medical responsibility between patient and practitioner to a greater extent and potentially perpetuates an individualised healthcare model through its emphasis on mind-body-spirit connections, thus omitting the social context of health and illness (Baer, 2004).

The emergence of IM or integrated healthcare has wider implications than its relevance for practitioners' autonomy. Living with uncertainty characterises contemporary society and has enhanced reflexivity around health and illness whereby many people deliberate to a greater degree about which healthcare options to choose from the wide range available. Some researchers suggest that CAM functions as an ersatz religion, promising adherents salvation through individual effort, serving as a distorted response to the problems of loss of community and values (Alster, 1989). However, the IM model potentially represents an appropriation of alternative healthcare practices whereby patients' ability to escape their enmeshment in expert-based knowledge systems and relationships becomes problematised. The amalgamation of CAM and allopathic medicine potentially constrains health consumers' empowerment further as it may challenge those discourses that align more closely with lay understandings, such as wellbeing, and thus undermine the subject positions that such discourse gives rise to. What are the ramifications and implications for the patient, the practitioner and healthcare practice if practices that constitute legitimate means' of expressive self-hood are appropriated?

Ultimately, IM potentially represents a transformed healthcare model where alternative medicine is constructed as a bona fide arm of healthcare practice. Although CAM potentially challenges biomedical hegemony through its premise of holism, the individualised nature of CAM, and its philosophical fit with the biomedical model, may serve to perpetuate and reinforce the overarching idea that biomedicine, and the scientific method that underlies it, is the only legitimate means by which to treat illness and safeguard health. Moreover, it fortifies the construction of the rational neoliberal subject, and thus serves as a means of biopolitical control.

Research objectives

The conceptual contestation around what IM constitutes, represents and reproduces, warrants an investigation into IM practitioners' and patients' understandings of this emergent sphere of medicine. This study therefore explores how IM practitioners construct IM practice, how they position themselves and their patients in the practitioner-patient relationship, and how they resolve potential contradictions that separate the two modes of practice. The study also explores how patients understand the treatments they receive and how they position themselves and practitioners within the IM practitioner-patient relationship. The paradoxes discussed above have implications for how treatment is given and received, how health and illness are constructed and how the patient's body is understood, which in turn have implications for patients' and practitioners' subjectivities. The crux of each of these paradoxes provides the rationale for exploring five key areas within the realm of integrative medicine:

First, in that IM appears to attempt to combine elements of allopathic medicine and CAM, albeit in a new configuration, the question of how the paradigms that constitute IM are understood and whether and how these are integrated become of interest, particularly in that critical literature points to CAM being positioned as "other" in relation to mainstream healthcare practice. Therefore exploring how alternative medicine, biomedicine and IM are constructed, by both patients and practitioners, is of considerable interest.

Second, within the realm of alternative medicine the practitioner-patient relationship is represented as one in which practitioners assist patients to heal themselves. This suggests patients are empowered within the practitioner-patient relationship to some degree. Thus the IM practitioner-patient relationship is likely to differ from the doctor-patient relationship in general practice which is held to be more hierarchical in terms of expertise. An understanding of how this expertise-empowerment dynamic plays out within IM becomes important. In this vein, the study will also explore how participants' construct the IM practitioner-patient relationship and where responsibility for healthcare is understood to be located within IM practice.

Third, notions of an 'informed' patient and an 'active' health consumer, reflect people seeking healthcare as rational reflexive agents. This is a problematic concept as it reflects a conceptualisation of the patient as having a mind-body separation and therefore differs

markedly from the patient who is conceptualised holistically, where the mind, body and spirit are regarded as functioning in unity. Therefore, it becomes apposite to explore how the patient's body and subjecthood are constructed by both practitioners and patients within IM and whether this has implications for the subjectivities of either.

Fourth, to the extent that an individualised healthcare model underlies the practice of IM (Baer, 2004), it will tend to omit the social context of patients' lives. Therefore exploring how health and illness are constructed by those who provide and engage in IM healthcare becomes relevant. For example, is the social context of patients' lives taken into account in understandings of health and illness within the practice of IM?

Finally, because professionalisation and standardisation appear central to the 'mainstreaming' of alternative medicine, IM practitioners' adherence to best practice becomes a possibility. Engaging in best practice could limit practitioner autonomy and potentially undermine the practitioners' ability to treat patients as unique individuals, who are offered personalised treatment. It is thus important to explore whether the notion of best practice is taken up by practitioners and how it is constructed, and whether and how this problematises the positioning of the practitioner and patient.

Chapter 3

Methodology

This chapter discusses methodological issues and the methods used to investigate the aims of this research. The contestations and paradoxes that have been highlighted around the paradigmatic clash between IM treatment philosophies, issues of professionalism and the standardisation of treatments, power relationships, patient autonomy and treatment responsibility reflect the tensions and conflicts that are embedded within IM. The methodological approach taken incorporates an investigation of the participants' talk, but also attends to the broader discursive structures in which that talk is located. Such an approach enables an understanding of the discursive constructions that are drawn on and produced in relation to notions of patients, practitioners, the practitioner-patient relationship, illness, health, treatment, and the body, within the realm of IM. It also attends to the rhetoric that participants engage in and the positioning and subjectivities such rhetoric gives rise to.

The epistemological premise of this research rests on the principle that the world is constructed through the interactions that take place in the social sphere and therefore places an emphasis on language and its function. A number of assumptions underpin this epistemological position. First, language is understood as central to the production and reproduction of wider social structures rather than being understood as a means to convey

information. Second, meaning-making is embedded within socio-cultural processes that pertain to specific times and locations whereby understandings and meanings of events differ across situations (Lock & Strong, 2010). Third, meanings and understandings develop through social interaction, in which shared agreements are reached. Fourth, individuals' action and interaction within the socio-cultural milieu, and the sense-making that occurs in relation to this, "produce the discourses within which people construe themselves" (Lock & Strong, 2010, p. 7). Fifth, discursive structures are viewed as constitutive of reality and thus reflect and produce social, political and economic forces (Parker, 1992). The subject is therefore situated within interconnected regimes of knowledge, giving rise to a fluid subject who may engage in contradictory practices. Two theoretical strands underpin the analytic approach taken; Foucauldian theory and positioning theory (Harré & van Langenhove, 1999). In the following section these are discussed in relation to how they inform my study.

Theoretical underpinnings

According to Foucault, the world is divided up into spheres of meanings and practices which constitute regimes of knowledge. Foucauldian theory is relevant to the current thesis because the research investigates a form of healthcare that is underpinned by two disparate paradigms of knowledge. The interconnectedness of these paradigms at the site of IM arguably generates a novel mode of practice. The participants' location within this realm of healthcare therefore gives rise to new subjective possibilities and practices that may be contradictory.

A key premise which informs the methodology of this research is that discourses constitute the world in particular ways, with people 'taking up' the subject positions that are produced through these discursive structures (Foucault, 1973). Positioning refers to how we are addressed in discourses as particular types of subject and what rights we have to speak, controlling what we can say from particular positions. A myriad of possible subject positions are available for us to inhabit as social actors. However, these fluctuate in accordance with the varying social contexts within which we find ourselves (Harré & van Langenhove, 1999, p. 4) and rather than people becoming passively locked into a discursive structure, subjectivities are understood to be formed through an active negotiation of discursive constraints. Therefore, the subject emerges as the result of a dynamic process of reconstitution through which they reinterpret and refashion themselves through the

discursive practices in which they engage. In light of this shifting multiple-selfhood, individuals are apt to experience contradiction in the discursive practices that are afforded. Harré and van Langenhove (1999) suggest that as language constructs the person as a unitary knowable identity, and thus prescribes that individuals act rationally, in the face of such contradictions attempts are made to remedy, resolve, ignore or transcend them.

For Foucault, regimes of knowledge are bound up with power. Foucault conceptualised power as circulating through negotiated social practices rather than it being a uni-directional, top-down force. Therefore power is not solely a privilege afforded those who hold positions of authority. This conceptualisation fits well with the current thesis. Within the healthcare terrain, wider discourses of expertise and empowerment circulate and construct healthcare consumers and providers in certain ways, which has consequences for patients' and practitioners' positioning, and power relations, both within and beyond the healthcare encounter. This dynamic implicates responsibility for health and healthcare, and in particular *who* becomes granted responsibility for health and healthcare, which is one area of exploration undertaken by the current study. However, although patients and practitioners are bound up within the circulation of prevailing discursive norms, according to Foucault, individuals resist and negotiate discursive norms in order to overcome the contradictory positioning that may result (Foucault, 1980). These multiple points of resistance are understood to enable particular kinds of subjecthood to form. Further, such resistance can work to acknowledge and reinforce that which is resisted (Wetherell & Potter, 1992), thus concretising dominant understandings. This is particularly relevant to the current study because the overarching aim is to explore whether and how the two paradigms within IM integrate and what this gives rise to in terms of challenges to either of the paradigms, along with the positioning and subjectivities of the individuals involved.

Subjectification is a further theoretical premise that has application for the current study. Subjectification is understood by Foucault as the process through which individuals become defined as a subject in accordance with prevailing discursive norms. For example, through scientific classification the 'psy complex' has emerged (Rose, 1985). The 'psy complex' refers to how psychiatric and psychological knowledge and practice, such as diagnoses and therapy, have brought about a classification of what is deemed 'normal' or 'abnormal' subjecthood. In turn, individuals take up these ideas and practices to establish 'identities', engaging in a reflexive understanding of themselves as certain kinds of subjects. In healthcare, as alluded to in previous chapters, the subjecthood of both medical

practitioners and patients is constantly in flux, thus a theoretical perspective that allows for individual agency and how this is implicated in the construction of subjecthood becomes important. Such an understanding incorporates a notion of self-policing where “the self itself acts to turn itself into a subject, rather than suffering passively at the behest of external impositions” (Lock & Strong, 2010, p. 249).

It is through the use of narratives that the possibility of becoming coherent selves is opened up. Thus how people speak of things; and the rhetoric they employ conveys the notion that a conversation is “not merely the construction of some object in language and thought, but also the act of accomplishing or performing something” (Arribas-Ayllon & Walkerdine, 2009, p. 102). Speech acts are therefore understood as productive. People engage in rhetorical practices to produce dominant constructions of people and social phenomena. Thus speech acts achieve specific purposes such as challenging or countering a prevailing norm, producing dominant constructions or presenting oneself in certain ways. For example, Guerin (2003) proposes that people attain status within their social groups “by risking the use of prohibited conversational material” (p. 35) such as making racist remarks. This theoretical understanding thus accounts for the inconsistencies and variability inherent in talk, and is able to take account of individual agency.

An investigation of the ways in which the participant’s talk is discursively produced allows an understanding of the actions and functions of talk, such as whether it legitimises or delegitimises certain practices, as well as the wider patterns of meaning and implications for power relations (Parker, 1992). Understanding how participants position themselves and each other in the current study is important because IM is held as having a number of inherent contradictions, which are likely to promote resistive discursive strategies. Focusing on how resistance occurs is therefore important. Such an approach allows for an analysis which is contextualised, taking account of broader discursive formations, but also elucidating the discursive work in which people engage in order to resist, enact and reproduce certain discursive objects and subject positionings. After all, the individual is continually enmeshed in dialogue whereby thinking itself contains the “words of others” which “bear the marks of their social contexts of use and historical struggles over meaning” (Wetherell, 2007, p. 664). Meaning is thus derived from a negotiation of competing possibilities (Billig, 1991; 1996).

As a researcher, it is important to recognize that our own epistemological and ontological positioning, and our methodological and theoretical orientation to the research, is bound up with the wider socio-political, institutional and interpersonal world in which we are embedded (Mauthner & Doucet, 2003). It is thus important to note that three social locations converge in this research. The first is the healthcare professional whose construction of health and illness is in part shaped by their training and on-going registration requirements as biomedical practitioners. The second is the patient, who as a lay person is exposed to myriad ways through which to understand and safeguard health. Third, there is my own position which straddles multiple social locations: that of researcher, health consumer, and at various times during my life, patient. My understandings are also shaped by my positioning as a middle-aged, middle-class, English-born Pakeha woman. Within this position I have gained the financial means to consult various alternative medicine practitioners in addition to allopathic practitioners during my lifetime. This reflects how research is a “joint product of the participants, the researcher, and their relationship: It is co-constituted” (Finlay, 2002, p. 531).

My own understandings of alternative and allopathic medicine have shifted over the duration of this PhD research. At the initial stages of the research, my view of alternative medicine was that it afforded lay people and patients a non-biomedicalised way of understanding health and thus functioned to counter medicocentrism and to offer a means by which individuals could resist the position of a biomedical subject. However, as the research progressed my own understandings changed. This shift was largely due to my engagement with a critical literature regarding CAM and IM. In particular, my attention was drawn to a critique of the holism that is held to underpin CAM and the empowerment that is said to be granted to health consumers through their engagement with CAM. Prior to having read this literature I had not held notions of holism or empowerment up to an intense level of critical scrutiny. However, from this newly acquired vantage point I came to recognise CAM and IM as far more complex and contradictory than I had originally assumed. I also began to understand more about the social context surrounding these emerging forms of healthcare. I came to recognize that within New Zealand discourses of individualism, collectivism and neoliberalism shape our social world and that healthcare reforms and policies reflect neoliberal and social democratic ideologies. These work to position individuals as particular kinds of healthcare subjects: the healthcare professional who is under increasing surveillance by, and more accountable to, the State; and an active

and informed healthcare consumer who is expected to take individual responsibility for health. Furthermore, with regard to the latter, I came to understand how ones positioning as an ‘active’ and ‘informed’ health consumer is morally laden whereby engaging in health-promoting behaviours in a key means through which to achieve worthy citizenship.

Since my mother’s death from lung cancer 18 years ago, I have become increasingly health-conscious and recognise that I am positioned by healthism discourses. Over the years I have sought multiple alternative treatments, in the form of osteopathy, homeopathic medicine, acupuncture and aromatherapy massage. These have been personally beneficial due to their effectiveness in easing a number of muscular-skeletal health problems I have periodically suffered. The relationship I forged with these practitioners also contributed to my positive experience of the care I received during these consultations. I viewed these relationships as markedly different to that of my relationship with allopathic practitioners, most notably because the alternative medicine practitioners were, in the majority of cases, interested in my emotional wellbeing as well as my physical health. I felt valued as a person rather than merely a medical case. However, I also acknowledged that because of my continual relocation from one city, and indeed from one country to another, I had never had the opportunity to develop an ongoing relationship with one specific GP.

As a consequence of my engagement in this research, I began to question the ramifications of occupying the position of a health-conscious middle-aged woman. Questions such as: What are the repercussions of a preoccupation with health in my own, and other women’s, everyday lives? Does IM reproduce the preoccupation that women are already prone to experience about their bodies, particularly as this is bound up with achieving an ideal level of physical attractiveness? From research I had previously conducted, I had come to realise that health and beauty were conflated and that being slim and exhibiting health connotes women worthy citizenship and the socially prescribed attainment of the elusive ‘feminine beauty ideal’.

It was from this vantage point that the conceptual framing of my research emerged. This framing was also bound up with my identification of a number of paradoxes surrounding CAM and IM that had become apparent during my reading of the critical literature (as discussed at the end of chapter two). One particular publication was pertinent to my decision to analyse patients and practitioners talk discursively. This was Checkland et al’s

(2004) study which found that even though doctors had moved to a more biomedical model of care, they continued to make claims to holistic practice. Checkland et al. held that it was through constructing their practice as holistic that the doctors were able to bolster claims to medical professionalism. This indicated two things to me. Firstly, that holism is drawn on discursively by individuals to achieve specific purposes. And secondly, that the holism and empowerment, which I had understood to represent the key points of difference between allopathic and alternative medicine, were likely being drawn on by practitioners for multiple purposes. And what about patients? How were they positioned in light of this? And what discursive work were they engaged in? I believed that an analysis of the discourses surrounding IM, how they are taken up by both IM practitioners and patients, and the constructions and positioning these gave rise to would provide a means by which to more effectively understand the realm of IM, thus extending existing research.

An initial foray into the field of integrative medicine

My initial awareness of integrative medicine came through a conversation with a pharmacist. She talked of her membership with the New Zealand branch of the AIMA and explained how this form of healthcare combined alternative medicine with allopathic medicine. This was the first time I had heard the term, but recognised the possible contradiction inherent in combining two disparate modes of healthcare. From an inquisitive standpoint, I searched the internet and found the AIMA website. The website contained information about the philosophy, background and aims of the association. It also featured past and forthcoming seminars and conferences being organised, and listed a number of medically qualified practitioners who worked within the IM realm. During my search of the website I became aware of a two-day AIMA seminar entitled “Integrative medicine: Obesity and diabetes” that was due to be held. I contacted the secretary of the NZ branch and made arrangements to attend.

Prior to the start of the seminar, I was provided with a conference bag which included a booklet outlining the seminar schedule, a copy of an AIMA journal, and a number of pamphlets from members exhibiting alternative treatments and medications in the main foyer of the conference venue. Over the course of the seminar I also became acquainted with a number of AIMA members. The seminar itself consisted of a series of presentations featuring topics such as: “Complementary therapies and diabetes – perfect partners or dangerous liaisons?” and “Draining the damp – a traditional Chinese medicine dietary

therapy perspective on diabetes and obesity”. During the seminar I paid close attention to the language used by the presenters, all of whom were healthcare practitioners. Phrases used, such as “I don’t talk about disease I talk about people”, “when we connect we achieve outcomes, when we don’t connect nothing changes” and “a synergy of wellbeing” proved insightful into gaining an understanding of the philosophical orientation of the association. I also became aware of a number of commonly held values. These included ‘compassion and humanity in healthcare’, ‘improving health’, with an emphasis on illness prevention rather than cure, and ‘individual responsibility for health’.

A philosophical orientation of compassion and humanity in healthcare was apparent in statements practitioners made about their engagement with patients. Practitioners described the patient-practitioner encounter as “person-to-person” rather than expert-client based. Further, effective practice appeared to be about “serving patients” and providing them with a “personal service” rather than “helping” or “fixing” them. Terms such as “mindfulness” and “active listening” and the importance of practitioners’ “presence” in the healthcare relationship also came through in the talk. The manner and presence of the practitioner appeared to be construed as equally important to therapeutic efficacy as the interventions employed. The practitioners’ engagement in “inner work” was also promoted as a means to enhance the practitioner-patient relationship and the effectiveness of practice. This suggested, rhetorically at least, that IM practitioners took up a more fluid position in relation to patients in the healthcare relationship.

The “service” practitioners spoke of also appeared to rest on assisting patients to take responsibility for “their own health and happiness”. This was epitomised by one practitioner who described her practice as providing “healing and lasting change that only patients can do for themselves”. “Self healing” appeared to be construed as intrinsic to people’s make-up and this was bound up with the practitioner helping the patient find the “root cause” of illness. For example, one presenter said: “each individual will have their own root cause for the conditions of obesity and diabetes”. Such talk indicated an understanding of treatment as highly individualised.

Overall, the content of the presentations indicated that orthodox and non-orthodox medicine philosophies and practices were being integrated to some degree. Moreover, my attendance at the seminar enhanced my awareness of the inherent contradictions that

attempts to combine disparate treatment philosophies raised. However, even though presentations drew on scientific evidence and statistics to substantiate knowledge claims, in parallel they emphasised individuals' lifestyles and the linkages between mind and body as implicated in illness.

Participants

I decided to recruit both IM practitioners and patients as participants for the research. I also deemed it important to recruit patients who visited practitioners who claimed to practice IM, rather than those who engaged in general practice with alternative medicine as an add-on, as that could be considered to constitute a different mode of practice. Therefore I decided to recruit patients through the IM practitioners who had chosen to participate in the study. This ensured that patients' references to the practitioner-patient relationship, the treatment they engaged in, and so on, were pertaining to understandings of IM rather than to practice which had a more allopathic orientation or that which featured alternative medicine solely.

Following ethical review and approval through the New Zealand Health and Disability Northern X Regional Ethics Committee (see Appendix F), the first stage of participant recruitment consisted of identifying practitioners who practiced some form of IM. Fortunately, through attending the AIMA seminar I was able to make contact with a number of IM practitioners. I had also identified some additional practitioners on the AIMA website who fitted the criteria for participation. The criteria for inclusion were that the practitioner was a medically qualified GP who incorporated one or more forms of alternative medicine into their practice, were affiliated with AIMA and who described their practice as integrative. From the original list of practitioners I had compiled, I ensured that this comprised practitioners who incorporated different forms of alternative medicine in their practice. I believed such heterogeneity would allow for a richer corpus of data. However, I was also aware of the multiplicity of understandings that was likely to arise from such a diverse array of practice, from both practitioners and patients. This raised a concern about the difficulties a large collection of nuanced understandings could bring to analysis. However, I concluded that accruing a wider range of understandings would allow for an enhanced understanding of IM practice, and thus add to the richness of the findings.

I forwarded an information sheet (Appendix A) to those practitioners I had identified as possible participants. I followed this up with a telephone call, reiterating the background to my research and asking if they would be interested to participate. I made an appointment to interview each of the practitioners who agreed to participate in the study. Because the location where healthcare took place was deemed a “locality organisation”, that is “an organisation through which substantial study recruitment or conduct” takes place (Health Research Council of New Zealand, 2005), during the interview process I asked practitioners to complete a Locality Assessment Form (Appendix C). The locality assessment form features questions related to the researcher and the research environment being deemed suitable for such a study, along with any issues practitioners’ foresaw arising in relation to the local community. Initially, I identified twelve medically trained practitioners who practiced in the field of IM in Auckland. Six of these agreed to participate.

Patient recruitment was through information sheets (Appendix B) which were placed on the reception desk of the practitioners’ place of practice. I received a number of enquiries from patients who were interested to participate. I talked with these patients about the study over the telephone and answered any questions or concerns they raised. From these initial enquiries, 11 patients, nine women and two men, agreed to participate in the study. The numbers of patients from each practice, and pseudonyms for all participants, are identified in the table below. Four patients were being treated by Jenny, three patients were being treated by Clive, one by Sarah, two by James, one by Sandra. Unfortunately, no patients from Doug’s practice enquired about participation. The patients ranged from 29 to 71 years of age and all were NZ European.

The table below lists the practitioners, the alternative medicine practices in which they engage and relative number of years’ experience. The table also lists the patients I subsequently interviewed from each practice. All participants’ names are pseudonyms.

Practitioner	Alternative practices incorporated	Years practiced	Patients treated
Jenny	Traditional Chinese medicine Acupuncture	13	Nigel, Gloria, Cath, Beverly
Clive	Acupuncture, Chinese medicine Mind-body healing	20	Bill, Jan, Jo
Doug	Environmental medicine	25	-
Carole	Herbal medicine Natural Fertility Management Mind-body medicine	15	Sarah
James	Naturopathy Chelation therapy	10	Diane, Jill
Sandra	Holistic and integrated medicine Longevity medicine	8	Kim

Table 1. Practitioners' sphere of alternative medicine practice, duration of experience and patient participants treated

Method

Because I had identified general topic areas that I wished to explore with participants, the semi-structured interview was deemed the most appropriate method of data collection. There are a number of additional reasons as to why I deemed this approach suitable. First, semi-structured interviews allow interviewees to respond to issues openly, from their own vantage point, using their own words and language. Moreover, because of the conversational nature of semi-structured interviews, they provide an opportunity to “collect and rigorously examine narrative accounts of social worlds” (Miller & Glassner, 2011, p. 144). Through eliciting such accounts I believed I would be provided a means to more fully explore the context in which participant’s accounts are located and the ways in which people rhetorically position themselves, others, and the social world around them. Thus not only would this provide a deeper insight into the “cultural frames people use to make sense of these experiences” (Miller & Glassner, 2011, p. 145), but would also allow an investigation into how the participants use rhetorical strategies in their accounts to achieve particular effects (Byrne, 2004).

Second, this style of interview enables rapport to be established and developed because it allows for flexibility in terms of how the interview flows (Longhurst, 2010). I felt this was

important as, from my previous experiences of interviewing participants, I realised that this relatively open style of interviewing fostered an empathic engagement between myself and participants. I believed that developing empathy within the research relationship would not only enhance the interaction between researcher and participant, but would also enhance the depth of the narrative that participants shared. Further, I was aware that establishing a good rapport with participants may encourage greater self-reflexivity on their part. Other researchers have noted how this can lead to an enhanced revelation of understandings and feelings, and in particular, can give rise to those that “contradict or conflict with what everyone thinks”, thus reflecting the “anxiety, ambivalence, and uncertainty that lie behind respondents’ conformity” (Kleinman, Stenross & McMahon, 1994, p. 43). Through encouraging participants’ self-reflexivity, I therefore hoped to gain a greater insight into contradictory and conflicting positionings and subjectivities.

Prior to the interviews taking place I constructed an interview guide, which listed specific topic areas to explore during the interviews. The interview guide consisted of open-ended questions (e.g., “how would you describe the treatment you receive?” – see Appendices D and E for details) and provided me with reassurance that, in the event of conversation drying up, I had questions ready to hand. The approach I took was to ask a general question (e.g., “how long have you been seeing Jenny [the practitioner]?”) at the beginning of the interview, so as to allow participants time to become accustomed to being interviewed, leaving the more thought-provoking questions until later in the interview. I hoped this would help participants to feel more comfortable, and would enable them to expand on issues they raised. This technique is recommended as it allows participants to ‘warm up’ (Longhurst, 2010).

During the interview I was mindful of my body language and other non-verbal cues, as I was aware that through such subtle mannerisms rapport is built. I was also mindful of actively listening and fully acknowledging participants accounts, so as to encourage participants to elaborate on certain aspects of their talk. Further, through asking follow-up questions, and allowing pauses for reflection on questions asked, I showed an active attentiveness to participants which helped me to guide the interviews more effectively.

Following each interview I wrote field notes. I looked upon these as an early stage of data analysis (Longhurst, 2010). The field notes incorporated commentary on the general flow

and tone of the interviews, along with a record of themes that had come to the fore. I also noted those moments when I became particularly conscious of my own position and responses in relation to participants.

Although semi-structured interviews were a suitable medium for the exploration of the meanings and understandings of participants, I was also aware that they remain a partial account (Charmaz, 1995). Furthermore, the accounts generated do not remain intact but are further fractured through the analysis and interpretation that follows (Miller & Glassner, 2011). Miller and Glassner (2011) suggest that “numerous levels of representation occur from the moment of “primary experience” to the reading of researchers’ textual presentation of findings, including the level of attending to the experience, telling it to the researcher, transcribing and analyzing what is told, and the reading” (p. 134). However, a partial understanding is all that can ever be gained because what is given to us by our respondents is only “a trace of other things, not the thing – lived experience – itself” (Denzin, 1991, p. 68). This is because meaning-making is embedded within socio-cultural processes that differ across situations and events, an assumption that underpins social constructionist epistemology.

Practitioner interviews ranged from 48 to 92 minutes duration and were conducted at the site of practice, apart from one interview which took place at a nearby quiet café at the request of the participant. Patient interviews ranged from 49 to 73 minutes duration and took place either in the participant’s home or in a private room at Massey University. Both practitioners and patients were provided with an information sheet prior to the interview. This featured an overview of the study, what was required of participants, their rights, and the assurance of confidentiality and anonymity. All participants consented to discussions being digitally recorded and used for my PhD thesis and for academic publications and presentations that flowed out of this. In addition, patients were informed that in cases where concerns were raised regarding practitioner conduct or about serious untreated health issues they would be advised to contact their practitioner and/or the Health and Disability Commissioner’s Office. Patients also completed a brief data sheet featuring age, gender and ethnicity. Being aware of patients’ ethnicity was important so as to ensure cultural sensitivity, particularly around Māori cultural concepts. However, as it turned out none of the participants identified themselves as Māori. Patients were given \$20 to cover any parking and travelling expenses incurred. All recorded interviews were transcribed

verbatim and pseudonyms were used on the transcripts to ensure anonymity. Interview transcripts were made available to only myself and my PhD supervisors, and electronic copies were password protected to ensure no unauthorised access could occur.

Reflections on the interview process

My background and personal understandings of healthcare shape how I am positioned in relation to this study. My tendency to advocate for the underdog and my critical stance toward taken-for-granted understandings are likely to have some bearing on the research process and the data gathered. I recognised that when empathising with participants concerns, particularly the ambivalence they occasionally exhibited towards biomedicine, I may have come across as somewhat sympathetic, mainly because I considered alternative medicine to be the marginalised paradigm within IM. I acknowledge that taking up such a stance could have influenced the degree to which participants expanded on certain issues, encouraging elaboration during instances when I became a more ‘sympathetic listener’, although I tried at all times to maintain a neutral stance. For example, when Carole talked negatively about the depersonalisation that occurs in conventional medicine, pointing to it as failing to capture the multifaceted dimensions of what constitutes a human being, I may have engaged more empathically with her line of thinking thus eliciting more talk from her in these instances. This reaction stems in part from my own experiences of allopathic and alternative medicine and through my exposure to academic literature that I had read during the initial part of my PhD research. For example, one question raised in the literature was how biomedicine, and the inherent reductionism of the body within this model, could adequately capture a person’s experience of illness? At times, I also found it challenging to maintain a neutral stance, especially in cases where I found the participants’ rhetoric persuasive. For example, during my interview with James, I demonstrated like-mindedness to his critique of pharmaceutical companies’ actions and found myself agreeing with the principles he espoused. After all, I had read some damning reports, books and articles about the unscrupulous practices of the pharmaceutical industry. During such interviews, I questioned my own ethical position, in that I may have contradicted the critical stance I was taking to the data collected.

I found the experience of interviewing patients and practitioners to be dissimilar in terms of the content of the conversations that unfolded. Consequently, at times, the manner in which I responded to participants’ talk shifted in accordance with how they verbally engaged with the topics raised. This may have influenced what participants revealed during

the interviews. For example, patients often spoke of distressing events related to their own ill-health which elicited a deeper level of emotional engagement and responsiveness on my part. In contrast, practitioners spoke from the position of a professional and thus from a less emotionally-affected position warranting a different kind of response. With practitioners, I experienced a sense of them being the 'knower' and found myself taking up a 'non-expert' position in relation to them. This contrasted to the 'counsellor' stance I found myself taking up with some of the patients at times.

Most of the patients interviewed experienced health problems; in some instances these were current and in other instances historic or episodic. In such cases, patients tended to explain the nature of their health concerns in a detailed narrative form, particularly those with chronic illness or with multiple illnesses. I recognised a need to be open to listening to these narratives, particularly those which recounted traumatic experiences. I felt that interruptions to patients' illness narratives would be disrespectful or devalue their experiences and instead I felt it important to fully acknowledge and offer validation for the experiences they conveyed. I also felt that displaying a deeper level of empathy in these instances allowed a greater rapport to develop between myself and the patient interviewed. This enriched the interaction between us and also enhanced the depth of the talk. My tendency was to let the patients' narratives flow. In some instances I became concerned that the topic areas I had identified as being of importance may not be covered adequately, due to interview time constraints. However, this concern did not materialise. Even in those cases where I drew participants' attention to the time that had elapsed (because it differed from the duration suggested in the information sheet), participants expressed a desire to continue with the interviews.

At times I was particularly mindful of the fragility of some patients' health. For example, when I had stopped the recorder at the end of the interview with Sarah, she declared she would have to stop for a while afterwards "to get her breath back". Sarah indicated that she had found the interview taxing in terms of her energy levels. This was a situation I had not anticipated and I wondered if I should have been more mindful of such possibilities in advance. Fortunately in this instance, after a couple of minutes of general conversation, Sarah said she was fine and that she had enough energy to continue her afternoon as planned. At times I was also less directive when interviewing Sarah in comparison to other participants. Her talk about life or death situations related to her fluctuating health elicited

a concerned, more attentive response on my part, and a desire to meet Sarah's emotional needs which, on occasion, outweighed the emphasis placed on what I personally hoped to achieve from the interview.

The setting where the interviews took place also potentially impacted on the interview process. Private settings such as participants' homes or practitioners' consulting rooms seemed to be more conducive to eliciting greater rapport. Such settings may have promoted feelings of familiarity and relaxedness on the part of participants. These locations also served to minimise distractions, which enhanced the flow of the conversation. One interview in particular, emphasised how the environment in which the interview took place could influence the discussion that ensued. This was the interview with Sandra, which, at her request, took place in a café. In this instance the act of eating food whilst interviewing (which the practitioner insisted upon) was somewhat intrusive. It was difficult to put my interview guide in an unobtrusive place due to the size of our table, causing me to rely on memory about which topics to cover.

During some of the interviews with practitioners, I also found myself becoming conscious of my own bodily health and became interested in practitioners' comments in relation to this. At times, personal interest interfered with my position as 'researcher' in that I became conscious of wanting to ask questions myself, from the position of a person who is mindful of health and who wanted to probe these experts' knowledge for my own reasons. During such moments I became aware of a tension between my position as 'health consumer' and that of 'researcher'. However, despite these tensions the interviews proceeded well and provided rich data for analysis.

Data analysis

I conducted a Foucauldian discourse analysis on the interview texts. The analysis was undertaken with a view to finding out how discursive formations of 'the social' are taken up as 'the personal' and what implications these have for practitioners and patients in the IM realm. From the earlier field notes I had taken, and the subsequent transcription process, I became familiar with the broader patterns of talk. I then identified those excerpts that related to the conceptual and theoretical paradoxes I had identified as being of specific importance. This constituted a five-stage process:

First, because of the apparent contradiction inherent in combining somewhat disparate modes of medicine, I was interested in how the practice of IM was constructed. For example, I was interested to explore whether understandings of the ‘whole’ person versus a more reductionist view were problematic and, if so, how these were negotiated. I therefore searched the texts for those excerpts where alternative medicine, allopathic medicine and IM were constructed, along with constructions of patients, treatment, and the body.

Second, I focused on talk about the practitioner-patient relationship, and responsibility for health and healthcare. I paid particular attention to those excerpts of text that related to expertise and empowerment in that the second objective of my study was to understand more about how the expertise-empowerment dynamic played out, and the rhetorical strategies in which participants engaged to negotiate any inherent contradictions that arose.

Third, because the ‘informed’ and ‘active’ health consumer is constructed as a rational reflexive agent, thus reflecting a conceptualisation of the patient as having a mind-body separation, which differs markedly from the patient who is conceptualised holistically, where the ‘whole person’ is taken into account, I searched the text for those accounts referring to patients. I was particularly interested to understand how the body and the patient as subject were constructed by both practitioners and patients, and whether holism was taken up, and the implications this had for patients’ subjectivities.

Fourth, I searched the text for how the healthcare model was described, along with how participants constructed health and illness. This was with a view to understanding whether the IM model is constructed as individualistic and the degree to which the social context of health and illness is accounted for, particularly in terms of practitioners’ understandings.

Finally, because wider social processes are implicated in challenges to traditional notions of medical professionalism, I identified those excerpts of text in which the practitioners accounted for themselves as healthcare professionals. Specifically, in that GPs have been shown to demonstrate agency through rhetorically resisting challenges to their professional identity, I sought to investigate whether and how IM practitioners engaged in a reconstruction of themselves as a healthcare professional and the implications this gave rise to for the subjecthood of both patients and practitioners.

At each stage of the analysis I copied extracts related to these sub-sections into specific data files. I then conducted a closer reading of these sub-sets of talk, paying particular attention to the variable ways in which the items of interest had been constructed, and the work the talk appeared to perform. I examined the texts with an eye to understand potential patterns in the talk, especially for similarities, dissimilarities and contradictions in the talk in order to identify the discourses that were operating. From the larger patterns I discerned, I sought to explore the positioning and repositioning that became apparent. I checked the patterns that were emerging within and across interviews, and provisional interpretations were developed through a process of cross-checking extracts for coherence and constancy.

Initially, I conducted my analysis and structured the findings around the paradoxes that I had identified as points of contradiction within IM. However, I realised that this read more like a thematic analysis. I therefore worked to identify the major discourses that are drawn on by practitioners and patients within IM, and how these intersect with the paradoxes I had discerned. As a result of re-orientating my analysis to explicate these discourses, I was able to more adequately elucidate the complex and contradictory positions offered up by the discursive web that surrounds IM.

The findings I obtained through this analytic process drew my awareness to a number of contradictions both within individual accounts, and across accounts. These contradictions featured most prominently when comparing practitioners' accounts with patients' accounts. One of the most interesting findings was that although the objects constructed by both practitioners and patients were similar, the ensuing rhetoric that both patients and practitioners engaged in worked to position patients and/or practitioners in particular, and sometimes problematic, ways. This became most apparent in terms of how practitioners constructed IM patients. For example, through drawing on an empowerment discourse practitioners positioned patients as responsible and educated through their engagement in IM. However, this positioning was only afforded patients if they were shown to actively strive for 'optimal health' which was constructed as achievable through the guidance and support of the IM practitioner. If patients failed to take up the understandings of the practitioner, they became positioned as uneducated and prone to faulty thinking. However, it was also through such discursive work that practitioners were able to reconstruct their medical professional identity. In doing so, the practitioners were able to claim a heightened

degree of expertise, beyond that of GPs or those practitioners who practiced alternative medicine solely. This discursive positioning also functioned to reproduce a hierarchical practitioner-patient relationship. It was because of the extent to which the practitioners' rhetoric had implications for patients' subjectivities that I decided to devote an entire chapter to this area of my findings.

The structure of the findings falls into three separate chapters. The first chapter explores the practitioners' talk, discussing the discourses the practitioners draw on and the discursive constructions and positioning this gives rise to. It also explores the various ways in which practitioners go about reconstructing their medical professional identity, and how in doing so they are able to claim an enhanced 'expertise'. The second of the findings chapters examines how the practitioners construct and position patients. This chapter also explores how the practitioners' talk functions to create a specific kind of IM patient. Finally, the third of the findings chapters explores how patients construct themselves, IM practitioners, the IM practitioner-relationship, treatment, health and illness. This chapter also examines the functions of the patients' talk. In particular it discusses the practices and ways of being that the patients' talk enables and constrains.

Chapter 4

Practitioners' talk: Reconstructing medical professional identity

This chapter discusses how the IM practitioners draw on discourses of holism, liberal humanism, spirituality and empowerment to construct IM as a healthcare model which maintains elements of both allopathic medicine and alternative medicine in place, but also functions to construct it in a way that legitimates practices inherent to IM. First, practitioners draw on a discourse of holism to construct the healthcare model they employ as focused on the 'whole person' which incorporates the spiritual, psychological and emotional aspects of patients, in addition to their physical body. They also dichotomise medicine as either 'good' or 'bad' and, in doing so, construct the holistically-oriented practice of IM as 'good medicine'. Second, practitioners draw on liberal humanism and spirituality discourses to construct their practice as patient-centred. IM is constructed as a form of healthcare that treats the person rather than the disease and is focused on attending to patients' spiritual and psychological malaise, in addition to treating their physical ailments. Within this discursive framework IM treatment is constructed as an ongoing journey through which a notion of healing becomes legitimated. Through their engagement in such discursive work, the practitioners reject a biomedical understanding of the body and instead construct it as an interconnected system which is bound up with the external environment. Third, the practitioners draw on a discourse of empowerment to

position themselves as educators. They also construct IM as constituting ‘best practice’ and ‘good doctoring’. Through the notion of ‘best practice’, IM becomes a better form of healthcare practice than that offered by GPs, and through the notion of ‘good doctoring’ the practitioners position themselves as other to and better than a biomedical expert. In doing so, they claim a form of expertise in which their practice becomes about responsabilising patients. Through engaging in this discursive work the IM practitioners are able to reconstruct their medical professional identity and to reclaim the integrity they suggest has been lost in the allopathic medicine sphere. This is discussed in more detail below.

A holistic practice and “a whole different philosophy”

Holism is a key discourse taken up by these practitioners. In drawing on a discourse of holism they construct the patient as a ‘whole person’ with psychological, spiritual and corporeal dimensions that need to be kept in balance. The patient’s body becomes understood as one aspect of the interconnected mind-body-spirit and it is through an extensive exploration of these interlinked dimensions of the patient that practitioners are able to locate the “root cause” of patients’ illnesses. Finding the “root cause” of illness is constructed as a key aspect of effective treatment. In addition, through constructing patients as having multiple dimensions the practitioners warrant the use of a wider array of healthcare practices with patients. Consequently, the practitioners position themselves as healthcare professionals who can offer patients more than allopathic or alternative medicine. They also legitimate their engagement in the more investigative and exploratory approach they take to their practice. The following excerpts illustrate how holism is taken up by the IM practitioners to construct their practice:

Jenny The model that I work in is a Chinese medical model which is a holistic model and which is very different to a Western medicine model. So I’m interested in the jigsaw in people’s lives. I’m interested in all of their lives, from before they were born until now and that’s the physical, the physiological, the personal and the spiritual

Carole So it’s a bit different than a regular practice but it’s much more of a sort of holistic, integrative approach

James I mean I call it holistic medicine I guess. So holistic means mind, body, soul. So mind is obvious, body is obvious, the allopathic medicine is purely, really concerned with the body and a little bit to do with the mind but still using chemicals to control the end points, pharmaceuticals and no attempt made to get underneath that and what’s the root cause

The practitioners frame IM practice as an “integrative approach” which explores the “jigsaw in people’s lives” in order to find the “root cause”. Their talk of IM practice therefore dovetails nicely with wider projects of the self which focus on personal discovery and the pursuit of authenticity and fulfilment (Sointu & Woodhead, 2008). The practitioners construct IM as providing a toolkit, which although varying from practitioner to practitioner, comprises multiple modes of alternative treatments alongside Western medicine. So in addition to offering patients traditional Chinese medicine, nutritional medicine, homeopathy, anti-aging and regenerative medicine, IM practice also consists of “blood tests and lots of other tests”, “knowledge about food and herbs and supplements” “herbal medicines”, “diet” and “mind-body medicine”. The practitioners refer to combining an array of therapies, or as Carole suggests, “pull from the best of all the different modalities and offer people a combination of things”. The practitioners also describe IM in terms of what it is not: “it’s not short consultations”, and point to how “there’s a lot of things we don’t do here that a GP practice does, like immunisations and routine things”. They refer to the differences between IM and general practice and talk of how “time is a huge difference, having more time with people” and refer to providing “a listening service” and “a more in-depth assessment and treatment programme”. In general, the practitioners claim that “the whole philosophy is different”. This is evident in talk which constructs IM practice as “facilitating healing”. This consists of “not just treating the symptom or what the person comes in with, but really trying to look at what might be underlying that” and how “along the way we often discover meaning”. Through such claims the practitioners work to construct themselves as a very different type of healthcare professional to a GP.

However, constructing their healthcare as holistic also places the practitioners in a contradictory position at times, because the holistic philosophy they take up problematises some of the allopathic practices in which they engage. The practitioners overcome this contradiction by dichotomising medicine into ‘good’ and ‘bad’ categories. ‘Good medicine’ is constructed as a form of healthcare practice that is founded on a wider knowledge-base and one that takes account of the contextual factors of patients’ lives. ‘Good medicine’ is also constructed as pluralistic and highly complex, offering patients a bigger picture of health and illness. It also incorporates preventative medicine. In contrast, ‘bad medicine’ is constructed as a superficial practice which consists of using drugs to alleviate symptoms. ‘Bad medicine’ is also constructed as being that which fails to explore the whole, yet

complex person that the patient becomes through the holism discourse and as that which lacks integrity. And it is general practice, and the over-use of pharmaceuticals in particular, that is held to exemplify this lack. This construction frames “all-powerful” pharmaceutical companies as the primary reason for EBM having a stronghold within medicine in terms of proof of effectiveness. In making such claims, the practitioners problematise the ‘gold standard’ status of EBM and RCTs and instead construct these as “science for the drug companies”.

The following commentary from Clive, a practitioner who incorporates acupuncture and mind-body medicine in his practice, illustrates the discursive dichotomisation of ‘good’ and ‘bad’ medicine:

- Clive To me the ideal is that people are still very rational, they don't discard Western medicine. But you find people seem to be able to do it, people that come here, they know when to call on it, particularly with their children. But the overuse of antibiotics, indiscriminate use, has been pretty awful because it's contributed to all the resistant bugs and things that are around. So that hasn't been good. You've got to be selective with your antibiotics. So to me, it's all pointing in the right direction
- Helen About minimising use of
- Clive Yeah, yeah. Good medicine doesn't mean throwing drugs at people
- Helen No
- Clive It means being selective. But you know, you still, as a doctor, if somebody comes in and hasn't been diagnosed, I have to do that, I will do that. And if somebody comes in and during the process they'll say “look I've been through all these doctors and I've had all these X-rays but I still doubt that they found something”. There's no way that we can go into this because that worry is diagnosis. So I said “Look do you want me to attend to that? Do you want me to make sure that that diagnosis is correct or they haven't missed anything?” So my role can be that as well. And if they say “yes”, I say “well I've got to do that first”. And we have to do that because we have to be comfortable that we're not missing anything there. If you're worried you've got leukaemia or cancer then the role is, if that hasn't been attended to yet, it's terribly important that happens

In the above excerpt, Clive talks of Western medicine as eliciting an overuse of pharmaceutical medications and refers to how this has increased health-related problems in society rather than solving them. He talks about the prescribing of medications in a derogatory way, equating this practice to anything other than “good medicine”. Although diagnosis is known to confer doctors an elevated status in relation to patients (Freidson, 1972), Clive undermines the power of diagnosis in the allopathic system through claiming that a key part of his practice is to reassure patients that nothing has been missed through the diagnostic process within the allopathic medicine realm. Clive is thus able to position

himself as achieving an expertise and a vantage point from which he can see beyond the limited and limiting gaze of the purely allopathic practitioner. Through this repositioning, Clive is granted licence to assess patients' conditions in a more in-depth manner. The assessment he refers to positions him as a practitioner who is able to give patients a final opinion, over and above the diagnostic opinions that have already been proffered to the patient by the GP. Further, through reference to such double-checking activity as a necessity, or as a "terribly important" part of treatment, Clive undermines allopathic medicine whilst granting primacy to IM practice. It has been noted elsewhere that practitioners who work with multiple therapeutic modalities offer patients who are dissatisfied with biomedical treatment, often through non-diagnosis, other healing options and thus a means to traverse the void that such uncertainty brings (Adams, 2003; Miskelly, 2006).

The excerpts below also exemplify how medicine is dichotomised as either 'good' or 'bad'.

Sandra Some of them will actually verbalise their frustration with the family doctor. Either the limited time they get with their family doctor or the family doctor's lack of knowledge about some of the things that I've got knowledge of. I just think that integrated medicine really is the right way to do it. It's real medicine. It's the real way it should be. It's correct. It's fundamentally correct. It's doing what the person needs through understanding their physiology and their biochemistry and the way they think. So, but the doctor's really been directed by influential people in their training and in their career who have steered them towards the current Western model without any attention to the physiology and the biochemistry. And they don't know any different. Although I've noticed doctors are more open these days. But I don't know how open they are

Doug We've got to get real and I think that's where a lot of the problems have come from. There's this sort of wishful, magical thinking that we've engaged in that's allowed medicine I think to become a shadow of what it could be, or healthcare to become a shadow of what it could be. And we really aren't getting anything like the kind of service that we could have and the fact that our hospitals are over-flowing, that the health publics are exploding is totally predictable given the reality. But everyone puts their hands up and then says "well this is happening", it's many reasons why it's happening

In these instances Doug, who brings nutritional medicine into his practice alongside allopathy, implies that mainstream medicine today is lacking, invoking a notion of risk through constructing the public health service as inadequate and unable to meet patients' needs. Similarly Sandra, who describes herself as specialising in a range of practices

including longevity medicine and illness prevention, draws on a discourse of holism to construct IM as “real” and “correct” medicine and in doing so implies that other types of medicine are not good enough.

Practitioners also discredit the effectiveness of allopathic medicine and the integrity of biomedical practitioners. For example, in the following, James, who practices naturopathy and chelation therapy, draws on statistics to denigrate chemotherapy’s efficacy. In doing so, he positions allopathic doctors as having little to offer patients:

I feel sorry for those doctors [referring to orthodox medicine practitioners] because they have to work like that where there is no hope. Because they actually, they don’t believe that what they do makes any difference. Because you know chemo actually can make you worse. Chemo has about a three per cent improvement of five years survival on average. It almost does nothing. It probably actually makes things worse

And here, Carole, whose practice incorporates naturopathy and mind-body medicine, works to undermine the evidence-base of conventional medicine:

Well there was a really good paper in, I think it was the British Medical Journal, a couple of years ago, which looked at conventional medicines and how many of those were truly evidence-based and it was about sixteen per cent of what we do conventionally actually has that sort of solid evidence base. So I thought that was really interesting. And I think there’s a place and a value in that evidence-based medicine, but it’s also limited

Further, in the following excerpt, Jenny, who practices traditional Chinese medicine alongside allopathic medicine, constructs the science of randomised controlled clinical trials as pseudo-science and draws on the reliability and replicability that comes from observing phenomena over years to construct Chinese medicine as pure science:

You don’t have a written history of two and a half to three thousand years of observational wisdom without something that you’ve observed being able to be demonstrated again and again and again, reliably and replicably, to make a difference. It’s the pure definition of science. Western medicine says science is this double-blind randomised controlled clinical trial. That’s science for the drug companies. In actual fact, pure empirical wisdom, if you read the intellectual definitions of science, Cant and Kuhn and all the rest of them, Chinese medicine is pure science. It’s the observation of phenomena over time and knowing that when you do something the response is reliable and replicable and that’s science

Biomedicine is also denigrated on the basis that it invalidates one entire branch of medicine; environmental medicine. In the following, Doug constructs the expertise and the

knowledge of the body within nutritional and environmental medicine as more scientific than “drug based medicine” and works to debunk the notion that alternative medicine is not scientific:

Now there's a whole area of science in there. It's a highly complex biochemistry and toxicology which conventional medicine has totally ignored. Not because it's not valid, not because it's scientific, it's actually much more scientific than prescribing a drug that you don't really understand how it works, but because you've been told that that's the drug you should prescribe for this condition. And so it's often doctors who are working in this area of nutritional and environmental medicine are painted as being somehow unscientific and strange as well. Whereas, in actual fact, to work in that area they actually have to have a far greater understanding of biochemistry and endocrinology than their colleagues who are working with primarily drug based medicine

Such claims act to break down the dichotomy between allopathic medicine as scientific and alternative medicine as holistic and work to lend credence to the notion of IM, which becomes a means by which to bridge the gap between allopathic medicine and alternative medicine. In doing so, the practitioners legitimate the practice of IM. However, allopathic medicine is not dismissed altogether by these practitioners as it constitutes a key component of their therapeutic toolkit. In the following, Doug is shown to counter the dismissal of allopathic medicine by blurring the boundaries of holism and science. Here, he suggests that surgeons, who are perceived to be very scientifically oriented, are far less scientifically-oriented than imagined and are instead ‘holistic’ in their approach:

And so surgeons have a different attitude and they're much more, ironically, they're much more holistic in their thinking than physicians. Not because that's the work they do, because they're surgeons by definition, involved in very active interventional procedures, but they're not as caught up in the mythology of being scientific because they know they're very dependent on, um, they can't do those sorts of trials

Furthermore, alternative medicine is constructed as having a valuable role to play in medicine. Doug alludes to how the Hippocratic Oath of ‘first do no harm’ cannot be truly upheld if GPs continue to have ignorance of the value of alternative medicines:

And I think, by nature, most doctors really are intrinsically people who have a sense of understanding of the intangible aspects. And anybody who's actually worked with a patient facing a life-threatening illness is drawn to a certain extent into their world. And in that situation, yes the person needs your scientific and professional knowledge and understanding, but they also need your compassion as a human being and your understanding. You know, a compassion for the spiritual journey they're on. I don't think the spirituality side of medicine has been openly talked about

or shared or has been as much a part of the teaching curriculum or the research curriculum as it should be. And I think that the public out there have been wanting access to health interventions which are not just medications and surgery, but to homeopathy, to acupuncture, to musculo-skeletal medicine, to nutritional approaches which has almost, I think, has driven medicine more and more into a reaction. And I think a lot of it's been deliberate by industry because it serves industry for doctors not to be very knowledgeable about areas where, particularly in the drug-based area, there are alternatives to medication...Unfortunately, I think though that this mythology about everything having to be scientific was basically purely about biochemistry and then about, once we get into clinical use, about double-blind controlled trials. I think there was almost a paranoia, a very unbalanced perspective. I guess it's almost like the McCarthy era when you were afraid to be a communist. I think there's this real sense that if you're a medical practitioner you're afraid to be classified as flaky

Doug problematises the practice of allopathic medicine through highlighting how the 'whole patient' needs to be taken into account. Doug also draws on a spiritual discourse to suggest that practice needs to incorporate the "intangible aspects" of patients and a "compassion for the spiritual journey" of the patient. Doug points to allopathy being tantamount to a pawn in a larger power game in which the pharmaceutical industry is all-powerful. He also points to a conundrum around how the widespread practice of EBM in the larger healthcare framework has made GPs fearful of being labelled 'flaky' if they engage in alternative practices.

In contrast to allopathic medicine, to which the practitioners implicitly attribute a morally dubious status, IM is constructed as epitomising the practice of 'good medicine'. The practitioners refer to IM as providing them with a wider knowledge-base; one which places an emphasis on taking account of the contextual factors of patient's lives, such as their environment and lifestyle. This enables the practitioners to focus on a wider array of risk factors and how they may be implicated in patients' ill-health. In the following excerpt, I ask Carole: "How is the patient treated in the IM realm, in comparison to the alternative medicine realm and the biomedical realm?" Carole, in response, paints allopathic medicine as "superficial" in comparison to IM and implicitly suggests that the latter represents better treatment and a means by which people can be fully assessed, largely in order to understand "what's going on underneath":

If you look at the relationship as the key thing, there is a relationship of trust and openness and respect. So that may not be that different in those different areas, but what's offered is different. And the philosophy behind it is different. So, in the complementary and alternative world, that's where the

practitioner's coming from, working holistically with the person. So looking at the whole picture and what might be contributing to their health issues – environment, diet, life style and offering whatever particular skill they offer. Integrative medicine, as I believe it, is really offering the patient the best of conventional and complementary. So it's drawing from both of those areas and again more fully assessing people. Looking at what's going on underneath. And conventional medicine, the tools are very different that are offered and I see conventional medicine as quite superficial and symptom-oriented. So if the person's got a symptom or a pain, that is what is treated. So they give them something for that and that's sort of the end of it. That's not true always. Some doctors are much more holistic in the way they operate, but the whole philosophy behind conventional medicine is more, in my mind, sort of symptom-oriented and if it's prevention, it's prevention in terms of using drugs to stop something down the track, so treating blood pressure with medication or treating cholesterol with medication rather than the sort of bigger picture of prevention

By constructing the holistic practice they take up as 'better' practice the practitioners work to legitimate IM because this form of healthcare offers a wider knowledge-base and more treatment options than the biomedical sphere alone can offer. Treatment becomes bound up with looking at a "bigger picture", one that is able to more fully take account of the patient as a complex subject who is understood to have corporeal, psychological, spiritual and emotional dimensions that are interrelated and which work in complex ways to bring about health and illness. By constructing IM healthcare in this way, the practitioners legitimate the use of a holistically-oriented mode of healthcare which they claim, unlike biomedicine, does not split the patient into separate parts of mind and body. Instead, the practitioners claim that the holistic model dovetails nicely with IM practice which is about looking after human beings. Jenny alludes to this:

I didn't have to split the mind and body as the Western model did. I didn't have to just treat cause and effect. I didn't have to just look down the microscope and reduce everything to the smallest possible parts. I could still look after human beings. And in the Chinese model there's no division

Through constructing the mind-body-spirit of patients as complexly interconnected, the practitioners necessitate the use of a more extensive range of treatment options and thus legitimate a more exploratory approach be taken within IM practice. In constructing IM as unlike other healthcare practice, they also position themselves as a new kind of healthcare professional.

Patient-centred medicine: The provision of personalised care and compassion

Another means by which these practitioners construct their medical professionalism is through claims to the practice of patient-centred medicine. Discourses of liberal humanism and spirituality are drawn on by the practitioners to construct IM practice as patient-centred. The liberal humanism discourse constructs the patient as a unique individual who has a right to self-fulfilment and happiness. This discourse also produces an individual who is entitled to make their own decisions within a healthcare relationship which is more egalitarian. This dovetails neatly with a spirituality discourse which the practitioners draw on to construct patients' meaning of life as an important consideration within the IM treatment regime. Through this discursive framework, patients within IM are understood to embark on an individualised journey through which meaning, purpose, transcendence and healing can occur. Such patients are also constructed as individuals who are entitled to hope and connectedness. It is through drawing on these discourses that the practitioners construct IM as strongly patient-centred. Patient-centred medicine invokes the notion of treatment as an ongoing journey which involves an acknowledgement of the contextual circumstances of patients' lives and is bound up with healing patients, a practice that becomes warranted over cure. Constructing IM practice in this way warrants the practitioners to develop an ongoing, more personalised level of engagement with patients, and consequently allows them to legitimate a new form of medical professionalism. In doing so, they are able to reclaim the continuity of care that has been lost to GPs through challenges to medical professional identity (Saultz & Lochner, 2005; Pickard, 2009).

Through this discursive work the practitioners also open up a subject position that the 'curing' inherent in biomedicine does not afford them; in effect they become facilitators of healing. However, promoting healing over cure could minimise the importance of curing patients and, moreover, could lessen the emphasis placed on the therapeutic efficacy of care, whilst increasing the emphasis on helping patients' to find meaning in their symptoms. This ethos comes through in the IM practitioners talk. They claim that assisting patients' to find meaning in their illness is *central* to the care provided. One route by which meaning can be sought is through helping patients' to identify lifestyle and personal factors that could be contributing to illness, such as faulty thinking. Such an exploration is implicit within the practitioners' quest to find the "root cause" of patients' illness. For example in the following excerpt James, a practitioner who incorporates nutritional medicine in his

practice, talks about the array of risk factors that have to be considered, and the complexity involved, in order to find the “root cause” of illness:

- James A lot of it's all related to the same root causes and diet has a huge part to play in that, the correct diet. A lot of our diseases are dietary-related, as well as toxicity. And stress-related. So the mind-body connection is huge too. So you have to put all that together. You don't want to just stick with the physical. You've got to look at the mind as well and that becomes a bigger picture. But not a lot of doctors put all that together, it gets to be too much
- Helen Yeah
- James And I'm trying to do that. But I can't say I've got it sussed. But I'm having a go at it, trying to work it all out

Here the body is shown to fade into the background whilst a diverse array of risk factors caused by lifestyle choices, come to the fore. Further, because the practitioners come to anticipate personal change as being part of the patients' healing process, an emphasis on changing the patient becomes “understood as both means and ends rather than just a means to an end” (Hughes, 2004, p. 34). For example, Hughes (2004) notes that in touch therapies such as reflexology “treating and touching the patient is both treatment and further diagnosis” (p. 34). Furthermore, when healing is promoted over cure, gaining a status of ‘healthy enough’ becomes accepted and ‘healthy’ comes to constitute the patient being “engaged healthily in their life context” which takes the emphasis away from the practitioner curing the condition (Hughes, 2004). This precipitates the promotion of individual behaviour change and moves the locus of control from individual practitioners to the wider health education arena (Scott, 1999). Through constructing IM treatment as enabling change and precipitating healing, the IM practitioners are also able to differentiate themselves from GPs. This is because unlike GPs, whose gaze tends to rest on patients' bodies, the practitioners construct themselves as discerning of patients' wellbeing on multiple levels, with an insight into how the mind becomes implicated in healing.

Successful healing is premised on a *certain kind* of relationship developing between practitioner and patient. Carole alludes to this:

What I've come to over the years is one of the key things in the whole health or healing modalities is the relationship side of things and that goes across any sort of modality. So, I guess that's a similarity with GP practice. If there's a really trusting, respectful relationship between the patient and the practitioner, I think that goes a long way, no matter what tools or how the practitioner's working. And I know GPs who really foster that relationship and really value that and that's a big part of the healing process I believe...And I think without that relationship in a healing setting, whatever the practitioner does is going to be less effective, less

helpful, is my belief. If that trust isn't there and that openness and confidence

In this excerpt, Carole draws on a discourse of liberal humanism to construct effective treatment as a healing process in which the practitioner-patient relationship itself becomes essential for successful healing to occur. The relationship is constructed as mutually respectful and trusting, but within this there is an implicit requirement for the patient to open up and confide in the practitioner. Delving deeper into understanding the person and building the relationship become key aspects of effective treatment. Without a certain kind of relationship having been established treatment is rendered less effective. Interestingly, Carole's talk indicates a contradictory rhetoric which is evident throughout the IM practitioners talk. The notion of 'healing' that is taken up by practitioners connotes that 'the power to heal' actually resides within the practitioner. However, the healing can *only* take place if the patient opens up enough. Thus, in effect, the patient rather than the practitioner is constructed as the one who enables healing. Such understandings can be problematic for patients. Sered and Agigan (2008), in a study of CAM practitioners' understandings of practice, found that through failing to adopt the 'correct' attitude patients could be held accountable for healing not being successful. In the current study, the rhetoric employed by the practitioners suggests that patients are required to reveal an extensive amount of personal information to the practitioner. If the patient does not open up to the degree deemed necessary then they potentially become culpable or, at least, partially responsible for the treatment's ineffectiveness. The use of such rhetoric reinforces the importance of establishing and maintaining a different kind of practitioner-patient relationship than that offered by GPs, and is another means by which the practitioners differentiate themselves from other healthcare professionals.

Constructing IM practice as patient-centred also legitimates practitioners taking a holistic approach, as notions of holism are about treating the person rather than the disease. Following on from Jenny's previous comments, in the excerpt below she draws on her own anecdotal evidence to suggest that allopathic medicine is antithetical to the ideal of looking after people. Instead, she constructs it as about looking after people's "parts". In comparison, the Chinese medicine model is "compassionate" and allows her to identify with the suffering of others. Being somewhat scathing of Western medicine and embracing Chinese medicine warrants Jenny's engagement in a very different mode of practice:

Jenny Because it's actually about taking the time and having the patience to listen to somebody tell you their life story and then with that

person, working out how you're going to change something that is causing them some distress

Helen Yeah

Jenny So that's what practice is for me. It's people stuff. It's sort of up close and personal because the Chinese model is a very personal model and it's a very individual model and it's about the person, not about the disease. The disease is part of the person, but I have to treat the person

Helen Yeah, yeah. So you talked about how you don't aim to fix the person as such. Do you think that's a difference in terms of what Western medicine aims to do?

Jenny It depends how you want to define Western medicine...And let's be really clear, I'm not decrying my Western training. I wish to be western trained. I loved my nursing training. I did have some intellectual conflict in the middle of my medical degree because I had gone from nursing, where I delivered babies and laid out the dead, to actually looking after heart attacks and asthma sitting in the bed, and emphysema. And somehow the management of people went to other people. All I seemed to do was make a diagnosis, give hoards of Western drugs or whatever, and other people assisted the patient to go home or organised for the family to have relief. And I was no longer looking after people as I was when I was nursing, I was looking after the parts. And Western medicine is a Cartesian philosophy, thanks to Rene Descartes, or a Cartesian philosophy, which divides the mind and body. And so here I was at med school thinking "jeeppers I've swapped this sort of holistic, compassionate, caring medical model I had when I was nursing for looking after bits of people". And you know we didn't even have the courtesy in ward rounds to often address the patient in the bed. So there was a lot about my medical training I had issues with"

Jenny talks about how taking the time to listen and attending to the person rather than the disease is essential. She refers to engaging with the whole person rather than looking after their parts. This talk reflects a frustration which is shared by the other IM practitioners interviewed; around general practice largely being about diagnosis and the prescription of drugs. Jenny's talk nicely encapsulates the challenges to medical professional identity and the loss of the tacit understanding of patients. Tacit knowledge describes practical knowledge which rests on intuitive understanding of what forms of treatment to offer and enacting this through hands-on-experience (Polanyi, 1966).

However, it is interesting that Jenny claims to have no conflict in combining the use of allopathic medicine and traditional Chinese medicine, even though she overtly refers to the contradictory underlying philosophies of the Western and Chinese medicine models:

I don't need to be schizophrenic about it and be Western this minute and Chinese the next, because people come as human beings. And when you give people permission to speak they tell you about themselves. They may say, "I'm here because I've got a

sore foot”. However, when you give them a safe space to tell you about their lives, you suddenly find that the foot is part of a sprained soul, not just a sprained foot. And so you give people permission to speak too. They actually talk about it. Because one, there’s time, and two, it’s a safe space where they know it doesn’t go anywhere else

Jenny’s talk typifies the frequent emphasis the IM practitioners place on patients’ needs and how these are a primary consideration within the healthcare they practice. In the above excerpt, Jenny constructs the patient’s soul as central to their malaise, granting it a superior status in relation to the body. In doing so, she challenges the biomedical construction of illness as having a biological origin. Jenny also transcends the dichotomy of being “Western this minute and Chinese the next” by constructing patients as human beings above all else. Furthermore, Jenny constructs the practitioner-patient relationship as confessional in nature; patients’ *need* to be given time and attention, to be listened to and provided with a safe place in which to speak. Through such talk Jenny grants license to exploring the ‘whole patient’ at a deeper level, in order to ascertain whether physical symptoms are merely a manifestation of some deeper pathology. Jenny’s rhetoric thus acts to lessen the importance ascribed to the *type* of healthcare practiced and to blur the boundaries between Western and traditional Chinese medicine. This typifies the IM practitioners, and works to legitimise their professionalism.

The IM practitioners speak of ‘tacit knowledge’ as being fundamental to IM practice, particularly the healing work they engage in, which is about facilitating the positive transformation of environmental elements. The environment referred to encompasses elements that rest both within and outside the patient’s body. Creating the “right environment” is associated with a chemical change in the body; a change which works to reduce the need for allopathic medicine. Clive encapsulates this in the following excerpt:

You’re creating an environment rather than sort of imposing a chemical change in the allopathic way but by doing that you’re reducing the need for all that [allopathy] as well

By drawing on a discourse of holism the practitioners are able to reject the mind-body dualism inherent in biomedicine, and resist being positioned as biomedical experts. The practitioners also discredit EBM and reject understandings of the body in biomedical, reductionist terms. Instead, by drawing on discourses of holism and spirituality the patient’s body becomes part of an interconnected system, whereby the external environment can be inscribed on the body. Thus a lack or loss of separation between external environment and

internal environment becomes evident. This understanding is echoed by Miskelly (2006) who suggests that through holism “the body becomes a site for personal and social inscription” (p. 195). Holism is also held to underpin an understanding of the body as a site through which pain or illness is symptomatic of psychosocial conflict (Lupton, 1994; Scott, 1999; Sered & Agigan, 2008). However, through opening up an understanding that multiple societal and environmental factors could contribute to the aetiology of illness through chemical changes, the interconnected body is constructed as more complex. This complexity legitimates an expert interpretation to be made, but not necessarily in the form of a medical diagnosis. Other research has noted how such interpretative methods may actually prove harmful to patients because the practitioner is granted authority to interpret patients’ bodily experience (Scott 1998, 1999), which may undermine patients’ subjective feeling of their bodily states.

Unlike other healthcare options, IM offers multiple forms of treatment with which to support the interconnected system that the patients’ body becomes, a system which *needs* support in the form of IM. This is also suggested by Carole:

So if someone has chemotherapy, for instance, which is a very powerful form of treatment, they [integrative practitioners] bring in the other things to really support their system through that. That to me is really the best way, the best way forward

Thus the interconnected body that is constructed becomes ‘at risk’ when exposed to (mainstream) healthcare that cannot provide adequate care or healing for the ‘whole person’. The body-self that becomes constructed within IM invokes the notion that patients are exposed to risk within the wider healthcare system because “their system” is not adequately supported. Sointu (2006b) suggests that a notion of the interconnected body allows us to understand the body-self as being protected by “complex interior systems capable of fending off danger through constantly adapting” (p. 208). Because IM reproduces a notion of the body as interconnected and needing to adapt in order to achieve balance, flexibility and adaptation become understood as inherently beneficial. Thus the philosophy taken up by these practitioners may reinforce the importance of flexibility which is understood as a powerful and highly valued commodity, particularly as it fits with the interconnected, globalised world that contemporary society has become (Sointu, 2006b). As Sointu (2006b) suggests:

“Healing the body, the mind and even the spirit involves the appropriately self responsible person regaining a ‘natural’ sense of

flexibility that is also conceptualised as affording this person a sense of authorship and agency – primarily through inner reflection. Furthermore, noting bodily changes, tensions and experiences becomes an important means of keeping emotions that are seen as intertwined with the physical in check” (p. 208)

Conceptualising the body as a system reproduces societal values around what is considered acceptable or unacceptable personhood (Martin, 1994). Within the IM practitioner-patient relationship, patients’ flexibility and adaptability, within the mind, body and spirit, come to underpin the likelihood of successful treatment, and therefore become integral to the wellbeing of the IM patient. In conjunction, the IM practitioners’ ability to enhance the positive subjective experience of patients, through bringing patients to a state of balance, becomes constructed as essential to effective IM practice. This in turn legitimates the more personal approach that the practitioners invoke as being a hallmark of IM, and the cornerstone of their IM professional identity. However, the positioning this gives rise to may also inadvertently promulgate the construction of some patients as being ‘stuck’ or not flexible enough (Martin, 1994; Sointu, 2006b).

Reconstructing expertise and facilitating patient education through ‘best practice’ and ‘good doctoring’

IM practitioners draw on a discourse of empowerment to construct themselves as a healthcare professional ‘other’ than a biomedical expert. Unlike the authoritative position the practitioners ascribe to GPs who they construct as “telling the patient what to do”, the IM practitioners claim a less authoritarian position in relation to patients. Instead, the practitioners position themselves as educators, working to facilitate patient empowerment. Through the empowerment discourse the practitioners are able to negotiate issues of where responsibility in healthcare lies because through this discourse taking personal control over one’s own life and environment is constructed as inherently beneficial. And it is through patients becoming more involved in their healthcare and making choices about the options available to them that patient’s participation and control can be ensured. Through taking up this discourse the practitioners construct patients’ feelings of control and self-efficacy as integral to patients’ health and wellbeing.

The practitioners talk of educating patients. The education they refer to consists of advising patients of practical ways in which they can increase their knowledge about how to enhance and safeguard their health. The practitioners also claim to educate patients through

broadening patients' understandings of the philosophy underpinning the treatments engaged in, and through facilitating patients' learning around how aspects of their lifestyle could be contributing to the onset of illness. Practitioners also talk of providing patients with relevant reading material to take home with them and of encouraging patients to explore additional information resources, such as the internet, in order to consolidate their knowledge:

- Sandra However, the reason I give people a lot of information by email, which they can read at home, is because in order for them to participate and do what I want them to do I need buy in. And if they can read why I'm doing it and I am explaining it as I go as well, then they'll understand, you know, then they're more likely to do it
- Jenny And I give them a lot of information in a written form, because it's very hard to remember what was said three hours ago, really. So we have an extensive library that we lend people, I have extensive hand outs and information for people. I encourage people to get informed because knowledge is power really
- Clive But a part of it is also an understanding and education, that this is an ongoing education process and they're willing for that to happen. And have possibly been a bit more empowered

It is through claims of effectively selecting the most appropriate and effective treatments from the extensive IM toolkit that the practitioners again position themselves as an expert unlike that of a GP. The IM toolkit is constructed as a means by which far more treatment options can be provided to patients, in comparison to allopathic medicine, which is construed as more superficial in comparison. And practitioners claim that it takes a particular form of expertise to navigate these options effectively. This can be seen in the following excerpt from Carole. Carole points to the limitations of conventional medicine and the relative ineffectiveness of GPs who do not have the wider IM toolkit available to them:

- Carole And some people will come with a clear diagnosis already and say "I've got this and I want some help". And quite a lot of people come because they haven't been able to find what's going on with them. And they might have had a lot of tests and seen specialists and they're coming to try and find something to help them feel better. And then I also do a whole process of assessment and testing and combine the Western and the more and I suppose holistic or naturopathic diagnosis tools to, you know things like adrenal fatigue which isn't conventional or accepted conventionally as a diagnosis but is very much accepted in the naturopathic world. So I might look at some of the naturopathic diagnoses and how they fit with the Western and try and come up with some sort of greater understanding of what's going on for a person

- Helen And so having then practiced that for quite some time, would you see that, I mean you must obviously, like things become apparent that wouldn't if you were just dealing with one side of the equation?
- Carole Oh yeah, definitely. I mean GPs would see people with what a naturopath would call adrenal fatigue. They'd see them all the time, I mean it's quite a common thing. But they'd have their own interpretation, chronic tiredness or stress or whatever and there's not really anything conventional medicine offers for that. So a GP often finds that sort of scenario quite difficult because the tests are all normal, the person has these chronic symptoms and they don't know what to do with it. So that's the great thing I found about having these other tools or skills is that there is something to offer people

Practitioners' implementation of multiple theoretical frameworks and the wider array of 'tools' or therapeutic modalities that become available to them can actually work to create a therapeutic philosophy within practice which in turn reinforces and perpetuates practitioners taking an investigative attitude and experimental approach to treatment (Salkeld, 2005). In the current study, it is arguably the case that claims to the use of multiple tools and skills are essential to the practitioners claiming a particular type of expertise. Moreover, the notion that a more pluralised treatment toolkit should be available to patients becomes essentialised and embedded in the practitioners' philosophic orientation and thus entrenched as an important element of the practice in which they engage. Further, it is through claims to a different type of expertise and through constructing IM as encompassing a "whole different philosophy" that the practitioners are able to reconstruct their medical professional identity.

'Best practice'

In the current study, the empowerment discourse is drawn on by practitioners' to construct IM as 'best practice'. 'Best practice' is largely about educating patients on the contents of the IM toolkit. This is achieved through informing patients about the different treatment options available to them and also through pointing out the benefits, inherent risks or side effects of particular treatment regimes. The practitioners construct such practice as a means of enabling patients to make informed decisions about the 'best medicine' or treatment options in which to engage. This approach to practice seems very much like that taken by GPs. However, 'best practice' is also constructed by these practitioners as about encouraging patients to take up elements or tools from the IM toolkit for themselves. The toolkit, and the knowledge the patients become privy to through its use, is thus constructed as an essential means by which to empower patients and is framed as an entitlement. In the

following excerpts, the practitioners point to the benefits patients can reap through having knowledge about the extensive range of treatment that IM practice offers:

Jenny It's a matter of being able to offer what is the most effective medicine. See my Hippocratic Oath says "do no harm" and as a Western trained doctor, I have a responsibility to inform my patients of what is the best medicine for the issues that they bring into practice. So if you come in with an Achilles tendonitis, technically I should inform you about best practice and evidence-based medicine. So I should tell you about anti-inflammatories for your Achilles tendonitis and I should also inform you of what the risks are with anti-inflammatories. I should also tell you about the international studies with glucosamine and chondroitin and what sorts of Achilles tendonitis you could use these products for. I should also inform you about whether osteopathy, physiotherapy, acupuncture, manual therapies will be beneficial. As a person, or a consumer, coming for a service you are entitled to know what is best practice and, you know, many of my colleagues haven't got a clue what best practice is. Coz if you're purely in one way of thinking and you're busy, busy, busy and you know most doctors are incredibly busy, how do you find the time to grow and to go and actually embrace some other ways of looking at problems?

Clive So my practice has really evolved into an in-depth process which is first of all helping them, because there's a lot to take on to begin with. Although I'm lucky, most people are ready for it because they've heard about me. And then to give them the tools to carry on...So the idea is that they go away with some power, some tools, some power to start owning what's happening, not being a victim to what's happening

Helen OK, so owning rather than being a victim?

Clive Absolutely. I mean I suppose what we're talking about is you can change your environment, you can use your choice to change your environment in your life. You can't change your genetic structure very easily, but you can change how those genes are expressed which is the whole idea of epi-genetics, that's the focus. To a greater or lesser extent I do that with everybody

Within a discourse of empowerment the notion of patients "owning what's happening" is promoted as the means by which patients can reposition themselves from being victims. Making effective choices about lifestyle and taking more responsibility for health are constructed as the means to achieve this and become framed as commonsense. Furthermore, 'choice' is framed as a means by which patients can change the way their genes are expressed. The use of such rhetoric challenges biomedical discourse as it promotes the idea that even if a patient's biological or genetic structure is deficient or faulty, through engaging in IM the patient is provided with the means to change this. Consequently, the onus remains on the patient to engage fully in the educational process

and to make the ‘correct’ lifestyle choices. However, previous research shows that patients do not always wish to take responsibility for finding information and enacting it themselves or may not have sufficient knowledge or information literacy to gather the information needed and to employ it effectively (Henwood, Wyatt, Hart & Smith, 2003). Therefore although the concept of ‘information for choice’ is promoted through an empowerment discourse, the actual choice granted to patients may be constrained, thus problematising the notion of the empowered and informed patient or health consumer (Henwood et al., 2003).

Practitioners also construct ‘best practice’ as first and foremost about practice or treatment that keeps patients safe. In general, natural therapies are constructed as safer than pharmaceutical medications and become categorised as low risk, thus invoking the understanding that natural therapies are ‘good medicine’. In the following excerpt, Sandra alludes to there being a treatment hierarchy in which pharmaceutical medication becomes the least preferred mode of treatment:

Sandra So you know what works and how it works. You know fundamentally what’s going on and you know that there are different ways that you can address that. You know that to fix the migraine you’ve got to get her sleeping, so you need to give her melatonin. You know that you have to sort out her diet, her thyroid and her progesterone. Otherwise you could give her migraine drugs or put her on the pill, depending on when she gets the migraine. So there are lots of different ways

Helen So you have to tailor it to the individual really?

Sandra Yeah

Helen In terms of how they’re presenting?

Sandra But most people accept what I advise. Very few of them tell me that they don’t want this or they don’t want that. If it’s a drug they’ll say they don’t want a drug. So I’m sort of preaching to the converted. Not that I was seeking out people who had any particular mindset, but these people tend to be averse to drugs and tend to be more interested in natural therapies. And so, because I prefer natural therapies before I give a drug, I suppose that’s why they do what I suggest

Thus the notion of ‘best practice’ is used rhetorically to categorise allopathic medicine and alternative forms of healthcare within a hierarchy which acts to privilege natural, non-pharmaceutical-based remedies and treatments. This dovetails nicely with lay understandings of CAM as natural and safe, and pharmaceuticals as harmful due to iatrogenic effects (Cartright & Torr, 2005).

'Good doctoring'

The practitioners' also draw on liberal humanism and spirituality discourses to construct IM as 'good doctoring'. Through constructing practice in this way they position themselves as a healthcare professional who offers a more compassionate and humane form of healthcare to patients. The practitioners talk of providing a personal service to patients, through offering them longer consultations, and by spending more time with patients. In addition, they talk of identifying with patients suffering. 'Good doctoring' is also bound up with healing patients, which is not necessarily about effecting physiological changes in patients' bodies. Instead 'good doctoring' is constructed as making patients 'feel better' which is brought about through reassuring patients and bringing them to a place of faith in terms of the practitioner's ability to heal. In conjunction, the practitioners place an emphasis on how a patient feels subjectively rather than on the physical manifestation of illness. In this way, the facilitation of a placebo response can constitute effective practice. Such rhetoric works to trouble the idea that an evidence-base is necessary to effect improvement in patients' health, and at the same time grants legitimacy to the importance of a more in-depth practitioner-patient relationship being established. In the following excerpt, James indicates that a good doctor can facilitate a placebo response in the patient through effectively utilising their skills:

So you use the power of your own personality and your presence to help people with problems. So there's a whole placebo response going on in medicine depending on the skill of the practitioner. That creates the difference between a good doctor and a bad doctor. And the drugs are sort of almost in between that. So I think I had a high success because I realised that who I was was the big part of the healing of the person, and the reassurance that you could give them. Or it was just the words you use, you know the language you use is really important

James talks of his personality, presence and skill-base as integral to affecting the placebo response. And moreover, draws on the practitioner's ability to create a placebo effect as a key factor to the healing that IM is able to promote. Thus the placebo effect becomes a demonstrable outcome of the practitioners' power to heal. Through engaging in such rhetoric the practitioners challenge the hegemony of biomedical discourse and the inherent notion that the practice of EBM is the only means by which to establish treatment efficacy.

Practitioners draw on a discourse of empowerment to emphasise the benefits that IM practice provides patients over and above mainstream healthcare. Practitioners construct patients within the mainstream healthcare system as disempowered through being pushed

around and treated less humanely, and through not being provided a personal service. In contrast, the practitioners claim that IM fosters empowerment through the wider array of treatment options available to patients, the knowledge they become privy to, and through the compassion and respect they are shown. In this way, the practitioners' position themselves as unlike conventional medical professionals who fail to offer patients a personalised, patient-centred approach. This in turn acts to bolster and strengthen the practitioners' claims to a different form of expertise. The following excerpt from Carole exemplifies this:

In the hospital system often they tell me they feel more like a number or that that personal service is not always there. So that can be quite disempowering, that sense of being moved through and not really treated as an individual. Whereas in complementary and alternative and integrative, more time is spent. So there's not that sense of rushing through, being pushed through

Through this discursive work practitioners reinforce the notion of 'partnership' or 'participation' being inherently beneficial to patients. The development of a mutually trusting and respectful IM practitioner-patient relationship is also deemed a pre-cursor to efficacious treatment. Thus the need for a different form of practitioner-patient relationship becomes legitimated.

The practitioners construct the IM practitioner-patient relationship as one in which they walk alongside the patient rather than take up a dominant position in relation to them. The relationship is thus constructed as egalitarian and is said to offer patients a means by which to become a participant rather than a recipient of care. In the following, Sandra talks about how important it is to get patients to participate in treatment:

I know that their budget is important so I try and get it all done in the first visit on purpose and as a result it does save a lot of money. The downside to that is that you give them a lot of information while you're there and some of them are overwhelmed by it. However, the reason I give people a lot of information by email, which they can read at home, is *because in order for them to participate and do what I want them to do, I need buy in*. And if they can read why I'm doing it and I am explaining it as I go as well, then they'll understand, you know, then *they're more likely to do it*. The other reason I do it all in the first visit is because they need to see results. If I were to do it in some sort of a traditional way which is detoxify them first, alter their diet, then do other things, they won't see any quick results, they'll become despondent and disengage (emphasis added)

In this relationship, the expertise the IM practitioners lay claim to morphs from an authoritative stance of *telling* the patient what to do, to *guiding* the patient to wellness. In the following excerpt, Jenny alludes to how practice is not about *fixing* the patient, but about working with them as an *equal*:

I'm not here to fix them, but I am here to be on their journey and to basically have a conversation. I mean it's about conversations between equals....And it's not about me playing the expert and telling them what to do. It's about me assisting them to learn about their lives, about their disease, if that's what you want to call it, about their imbalances and about what life does to them, and how they might change it for themselves. So practice for me isn't easy

Jenny positions herself as facilitating patients' education rather than taking a dominant stance within the practitioner-patient relationship:

So I get people to think, to read, to Google, to go on-line to get themselves educated about this so-called blood pressure that other people consider to be a diagnosis that's going on in their bodies. I also talk to them about how Chinese medicine sees their imbalance and what it's about and what the practical things are that they can do in changing their lives, to change the reasons why they have blood pressure. Coz if you think about it – what is blood pressure? It's pressure in the blood system. And who puts ninety per cent of the pressure in the system? We do. So, often it's a combination. If I need to use Western medication because somebody's blood pressure is dangerously high and it does pose a risk to rupturing a vessel in their head then I will use Western medication alongside Chinese medicine, alongside dietary advice, alongside exercise advice, alongside whatever the person feels comfortable to do, to change what they've got. So I will use all of the skills I have really. It's not a matter of ignoring the fact that I'm registered by the Medical Council

However, a power imbalance is implicit in the relationship and manifests in subtle ways through Jenny's talk. She constructs patients as *needing* “to learn”, as being “imbalanced” in some way and as ultimately *needing* to effect change. Thus although Jenny frames the patient's journey within a discourse of empowerment, the actual power granted to the patient, and thus their ability to maintain an equal position in relation to the practitioner becomes precarious, undermined by an underlying assumption on the part of the practitioner that the patient does not currently know enough about themselves or about the ‘correct’ way to live their life. Further, Jenny implies that it is only by uncovering the ‘truth’ of what the patient is doing wrong that patients can find a path to healing. Thus, it remains questionable as to what ‘participation’ really means.

In drawing on a discourse of empowerment, the notion of patient choice becomes promulgated by these practitioners and is constructed as a fundamental principal underpinning the practitioner-patient relationship. The practitioners construct the advice disseminated and the array of treatment options offered through the extended IM toolkit as options that the patient is free to take up or reject. In conjunction, notions of participation and partnership suggest that the patient has equal access to gaining an understanding of the ‘imbalances’ that could be precipitating ill-health and are therefore able to work with the practitioner to establish how these ‘imbalances’ could be rectified. In this way, the practitioners position patients as having ‘choice’ over treatment options. This can be seen in the following excerpt in which Carole conveys a clear vision of how an integrative medicine centre provides this:

So an integrative medicine centre, I would see more as really a team working with the patient in the centre and the team working for the best sort of outcome for the patient. And then I also talk about the integrative health system on the wider sense where complementary and conventional medicines are both valued and funded and supported and the patient gets some choice about which one they go to and get supported in that choice

However, the idea that choice is granted to the patient is somewhat undermined by the prescriptive role that the patient is expected to perform. The practitioners’ talk suggests that patients’ become obligated to make the appropriate changes, if not they remain at risk of jeopardising their health. This problematises the notion that egalitarianism is inherent within the IM healthcare encounter.

Alongside ‘choice’ being handed to the patient, health becomes constructed as something that can be ‘owned’ by patients. ‘Owning health’ is about patients becoming suitably responsible for health. In the following excerpt, Jenny refers explicitly to “empowering people to take ownership of their own health” and in doing so works to renegotiate her position as expert, by maligning the kind of expertise that is about “fixing” people:

So it’s actually about the in-word, the buzz word, it’s actually about empowering people to take ownership of their own health. It’s not about me as a so-called expert, fixing it or telling them what to do. It’s about a partnership. It’s actually about a medical partnership of mutual respect

Similarly, in the following excerpt, Clive responds to a comment I make about the differing level of responsibility granted to patients within the IM practitioner-patient relationship, in comparison to that within the allopathic GP-patient relationship. Here, Clive states that in

the realm of IM total responsibility for health is afforded the patient under the rubric of “health ownership”:

- Helen So it sounds like there’s a different kind of responsibility for healthcare in that model
- Clive Totally. About health ownership. The buzzword to me is them owning health. Now at the same instance that doesn’t mean you don’t use your services properly. You need a diagnosis. So somebody comes in and you have an irregular pulse or whatever, that needs to be sorted out. So within this requires a degree of education about ownership, assertiveness, taking responsibility but also seeking help when it’s needed. I think hopefully we’re going to evolve into that

To these practitioners, “health ownership” is largely about patients taking responsibility for health and seeking help when it is needed. The practitioners also implicitly suggest that patients need some education from their practitioner to do this effectively.

The notion of “health ownership” suggests that an individual is granted control over their health and has the power to shape it in the way they choose. However, paradoxically, constructing health as something that can be ‘owned’ acts to reify health. In its reification health becomes something that can be manipulated and worked upon, thus warranting these IM practitioners to define good health and to mould it into shape for patients. This problematises notions of egalitarianism and operates to reproduce expertise, albeit in a less explicit form. IM practitioners’ expertise is masked under the guise of facilitating patients’ healing and empowerment which are derived through encouraging patients to take up a heightened degree of responsibility, and through guiding patients to take ownership of healthcare. In related literature, this notion of ownership on the part of patients has been shown to extend to illness whereby subjective notions of illness become manifestations of personal identity and can lead to feelings of responsibility and self-blame for illness occurring (Sontag, 1991; McClean, 2005; Baarts & Pedersen, 2009).

The discourse of empowerment that is drawn on by these practitioners reinforces the commonly held view that increasing patients’ knowledge and enabling patients to exert more control over their illness, their behaviour and treatment is inherently beneficial. However, this understanding perpetuates and reproduces the construction of empowerment as an outcome and, in addition, rests on the assumption that patients *wish* to exert more control over decisions about treatment. Such an understanding may overlook other influential factors that could impede patients’ agency, such as the enforced changes

to lifestyle and the uncertainty and vulnerability that illness can bring. Further, it fails to take account of the full context of patients' lives. The onset of illness can bring limitations to bodily control and patients may not understand or take on board the knowledge they have become privy to, thus predisposing patients to feelings of powerlessness (Aujoulat, Marcolongo, Bonadiman & Deccache, 2008). In the current study, through the practitioners talk, empowerment is reproduced as a fixed outcome rather than a fluid process that people engage in *at times*, the latter being an understanding which acknowledges peoples vulnerability and thus how they may *want* to depend on an expert sometimes, and seek empowerment at others (O'Caithan et al., 2005). Therefore in the present study, patients' engagement in the IM practitioner-patient relationship may enhance patients' "buy in" to the practitioners' empowerment framework but paradoxically may also give rise to conflictual subjectivities for patients (this will be discussed in Chapter 6).

Conclusion

The findings in this chapter have discussed how these IM practitioners draw on discourses of holism, liberal humanism, empowerment and spirituality to construct their practice, the treatment they provide, and the IM healthcare relationship in a number of ways. In doing so, the practitioners work to position themselves and their patients. The rhetoric employed by the practitioners works to legitimate the IM practice in which they engage and enables them to reconstruct their professional identity. This identity incorporates aspects of the medical professional identity that has been challenged through the managerialism and bureaucratisation of general practice.

First, through drawing on a discourse of holism the practitioners are warranted a deeper insight into patients' subjectivities. This is because effective practice becomes constructed as that which can adequately treat the 'whole person' and bound up with ascertaining the "root cause" of patients' illness. However, drawing on a discourse of holism is also shown to place the practitioners in a contradictory position at times, because the philosophy they take up problematises some of the allopathic practices in which they engage, such as the prescribing of pharmaceutical medication. It is through the discursive production of "good" and "bad" medicine that the practitioners work to negotiate this contradiction, largely by rendering allopathic medicine as less humane and as falling outside of what is considered 'good medicine'. In the process they contest the basis of biomedical science and the integrity of allopathic medicine practitioners. Further, through reconstructing what

‘good’ medicine *should* be, they legitimise the more holistically-oriented integrative practice in which they engage.

Second, practitioners draw on liberal humanism and spirituality discourses to construct IM as a form of healthcare that treats the person rather than the disease. Through constructing their practice as patient-centred the practitioners legitimate the therapeutic endeavour of attending to patients’ spiritual and psychological malaise, in addition to treating their physical ailments. Through drawing on the more extensive range of treatment options that IM provides, and the more holistic understanding of patients as complex entities with mind, body and spirit, practitioners reinforce the need to explore beyond patients bodies, in order to find the “root cause” of illness. Claims to ‘patient-centred’ medicine are also used by practitioners to reject understandings of the body in biomedical terms. In dismissing biomedicine as limited in its ability to adequately explore patients’ maladies, the practitioners are further warranting the more in-depth practice in which they engage. Through this rhetoric practitioners are able to forge a reconceptualised continuity of care, a mode of care in which treatment equates to a journey, and where a notion of healing over cure becomes legitimated. This understanding also perpetuates a construction of the patient as flexible and malleable, and thus open to ongoing treatment and care.

Third, the practitioners draw on a discourse of empowerment to position themselves as educators. Within this discursive framework they construct ‘best practice’ as largely about providing patients with information regarding the extended range of treatments that IM affords them, beyond that which allopathy or alternative medicine alone can offer. This range of treatments is referred to as a “toolkit” which patients are given access to and encouraged to take up elements from for themselves. The notion of a “toolkit” works to responsabilise patients. And the egalitarianism said to be fostered in the IM practitioner-patient relationship is promulgated as enabling this. Through drawing on empowerment and spirituality discourses the practitioners also make claims to ‘good doctoring’ which is bound up with educating and healing patients. In making such claims they position themselves as other than a biomedical expert. As healers they become granted the right to accompany patients on their healing journeys and to help patients feel better on multiple dimensions; spiritually, psychologically, emotionally and physically. And as educators they work to increase patients’ knowledge. Within this framework, ‘choice’ is also offered to the patient along with a notion of ‘health ownership’. Furthermore, it becomes commonsense

for patients to take up elements of the “toolkit”, and to learn from the practitioners about each treatment’s benefits and risks because they become empowered in the process. This is constructed as sensible practice and discursively ties in with wider health promotion discourses that rest on the assumption that it is through increasing consumer knowledge that public health can be ensured.

However, the self-responsibility that becomes granted to patients may also constrain their choices. Patients’ ability to balance their own health maintenance endeavours with “seeking help when it’s needed” is constructed as a necessity. This positions the patient as being in need of education from the practitioner in order to maintain health effectively. Further, the IM practitioners reproduce a hierarchical therapeutic relationship in which they are granted a diffused level of expertise which rests on empowering patients. However, this notion of empowerment can be problematic. Other research has suggested that the notion of the empowered patient is a fallacy and is understood as an aspirational ideal (Salmon & Hall, 2003), self-serving political rhetoric (Sinding et al., 2010; Henwood et al., 2003) and a professional construction (Aujoulat et al., 2008) which some patients are reluctant to take up, or actively resist. Patients’ healthcare needs shift in accordance with the ebb and flow of the changing context of their lives and the fluctuating nature of illness. Therefore their desire to depend on an expert is more likely to occur when they are feeling particularly sick and vulnerable. Patient empowerment is also said to rest on an unevenly balanced power relationship between the lay patient and health professional which overlooks the idea of power as shifting and fluid (Lhussier & Carr, 2008). Understanding empowerment as an outcome shrouds the processual nature of empowerment; a process that has a one-way direction in which the practitioner holds the power and grants it to the disempowered patient (Lhussier & Carr, 2008). Taking up a notion of empowerment as more fluid and shifting may work to lessen the implicit individualism of empowerment. In the current study, the empowerment discourse taken up by these practitioners’ constructs patients’ increased involvement and responsibility for healthcare as inherently beneficial, thus reproducing empowerment as highly individualised.

Through drawing on empowerment and spirituality discourses, the practitioners position themselves as healers and educators and warrant the possibility of forging an ongoing relationship with patients, and thus forge a reconstituted continuity of care. Within this form of healthcare, patients’ bodies become less biomedicalised, and therapeutic

endeavours come to incorporate the psychological, spiritual and contextual aspects of patients' lives. Through drawing on discourses of holism and spirituality, practitioners also construct their effectiveness as bound up with taking account of the 'whole person' which incorporates the "underlying intangible aspects" of the patient, through which they warrant a more personalised level of engagement with patients and the necessity for them to tap into a wider knowledge-base which calls for empathy and intuitive understanding. For the practitioner, enacting a deeper level of engagement with patients allows them to use 'tacit knowledge' which requires an intuitive awareness of the body. I would suggest that the practice of IM offers practitioners a means to reclaim and enact the 'tacit' and experiential knowledge that has been undermined through challenges to medical professional identity.

In effect, the IM practitioners engage in a process of reprofessionalisation. As an IM professional, the practitioners position themselves as facilitators of healing and as educators; in which the practice of teaching patients how to help themselves becomes legitimated. Treatment becomes framed as a journey of discovery for both the patient and practitioner. Miller and Crabtree (2005) talk of healing as "a deeply personal experience that emerges from a suitably fertile, relational, social, biological and cultural ecology" (p. 42). They coin the phrase "healing landscape" in which healing is forged in a wider context than that of the patient-practitioner encounter or within a specific type of healthcare setting. Instead, the patient is conceptualised as having four different faces. This understanding takes account of patients' uniqueness, their familial connections and wider social context. In this sense, the patient is envisaged as a shifting and multi-dimensional subject, positioned within a web of external relationships and a shifting terrain of places and social contexts through which the patient "co-evolves". Moreover, the environment is considered as contributory to the patients' malaise, thus externalising the aetiology of illness. This idea bears relevance to how the IM practitioners construct their practice in the present study. However, although the IM practitioners construct patients as needing to address the environmental and contextual issues in their lives, as a precursor or in conjunction with them treating the symptoms of illness that are evident in the mind-body-spirit of the patient, ultimately the aetiology of illness remains embedded within the individual. Therefore even though contextual factors are understood to play a role in the patients' illness, thus moving away from an objective pathologisation of the body, the pathologisation may become rendered in the psychological, emotional or spiritual sphere of patients whereby their belief system becomes subject to scrutiny.

Sointu (2006b) suggests that responsibility and agency are being reconceptualised through the practice of holistic healthcare, and moreover that life becomes “conceptualised through the notion of interconnectedness” whereby “what is wrong with one’s body can be perceived as related to personal unhelpful attitudes that result in a person being stuck or rather, not being flexible enough” (p. 207-208). Through claims to the use of a wider therapeutic toolkit that the practice of IM affords, the practitioners are granted licence to explore the life-world of the patient to ever-increasing degrees. In effect, IM practice represents a means by which the doctor can work, not only on the health of patients, but also their subjecthood. It is however, in pointing to the limitations of allopathic medicine and constructing IM as providing a more extensive and effective toolkit with which to treat patients, that the practitioners’ methods and practice becomes constructed as altruistic, and a more humane means to help patients resume their former health status and safeguard health. This acts to reinforce the practice of IM as inherently beneficial to patients over and above other healthcare options.

Chapter 5

Practitioners' talk: Reconstructing the patient

The discursive framework drawn on by these practitioners' and central to their reprofessionalisation, not only fosters a repositioning of the practitioner, but also serves to reposition the IM patient as a particular kind of subject. This chapter explores how the IM practitioners' talk has implications for patients' positioning and subjectivities within and beyond the IM practitioner-patient relationship. As discussed in the previous chapter, practitioners draw on a discourse of holism to construct IM patients as individuals who deserve to be understood on multiple levels: psychologically, spiritually, emotionally and physically. In conjunction, the practitioners draw on discourses of liberal humanism, empowerment and spirituality to position patients as being on a pathway of discovery through which the patient can learn how to manage their health effectively. This is based on patients avoiding risks, most notably through changing faulty beliefs or thinking and unhealthy behaviours and lifestyles. Patients become positioned as empowered and aware if they can understand illness as a transformative process and are willing to strive for "optimal health". Through discourses of spirituality and healthism, striving for optimal health becomes a necessity for patients' successful treatment journey. This journey is constructed as a pathway through which patients are able to discover more about

themselves and their illness. In contrast, patients' lack of understanding becomes implicated in the development and progression of illness.

The patient's treatment pathway: A perpetual journey

As discussed in the previous chapter, through drawing on liberal humanism and spirituality discourses these practitioners construct IM practice as a journey in which the IM healthcare offered to patients continues over time. A journey alludes to there being a starting point and a destination. The IM treatment journey is antithetical to the notion of a 'quick fix' and instead is constructed as a pathway through which discoveries become possible, and expected, along the way. For the duration of their treatment journey IM patients are offered a raft of treatments in order to improve their health and/or to prevent further illness from occurring. In parallel, a healthism discourse is invoked in that patients' pursuit of health becomes constructed as a moral imperative, whereby the destination of "optimal health" becomes the psycho-physiological state that patients' are urged to strive for. In conjunction, patients' commitment to the treatment journey becomes constructed as essential in order for them to receive the optimum benefits of IM.

In the following, Clive draws on a spirituality discourse to construct the treatment journey as a transformative process through which changes in patients' level of health manifest at an energy level. In this way, the patient's body is constructed as an energy system which provides Clive with "feedback" in the form of "lightness":

I'm more and more keen on the people who are committed to this journey. But for some, just bringing the subject up may be enough at the moment. They'll give you every reason why they won't go there at the moment, but as the years go by, they'll attend to it. Because it brings some challenges. It may bring in challenges to relationships. They may have to change relationships, move. They may do all sorts of things that are particularly difficult. So there are real practical reasons. But the answer is yeah, the transformation, what you look for is little changes. Just days where they begin to feel a sense of lightness and connectedness to the environment, that they may have recognised a bit in their lives before, but not much. Or they may just harp back to a happy time. So usually, the body gives you feedback and it's usually one of lightness and light heartedness

The excerpt above exemplifies how the patient's journey is constructed as a route through which transformation is likely to occur. Clive talks about subtle changes being detectable in the body at an energy level. Here the patients' body becomes other than a corporeal object. However, understanding the body at an energy level is not necessarily a construction that

patients share as it is embedded in a relatively unfamiliar conceptual framework. Further, in that changes to health become manifest at a level that may not be easily detectable by patients they arguably become impelled to defer to the practitioner, who guides them in understanding the subtleties of these changes. This positions patients as having less understanding of their bodies relative to the practitioner and therefore problematises the notion of the practitioner-patient relationship as a partnership. Further, patients become positioned as needing to take on board the conceptual and philosophical framework offered by the practitioner in order to understand the psycho-physiological transformation that occurs. If not, they become positioned as at risk. This is because patients' lack of awareness and a failure to achieve mindfulness is constructed by the practitioners as an obstruction in attaining the health-giving benefits of a mind-body-spirit in balance. Within this discursive framework the practitioners are granted the right to monitor the patient closely.

Because patients are constructed as lacking awareness of their psycho-physiological state in relation to the practitioner, patients become positioned as in need of education. This is exemplified in the following excerpt in which Jenny explicitly states that her role is to enhance patients' understanding of themselves and to educate them about the mind-body link:

I'm having a Chinese experience and adding in a bit of Western medicine if I need to. But the person actually goes on a journey of discovery about themselves. I mean I'm trying to educate people to understand what their body is about and what their health is about and what causes changes in their body that they don't like, and the fact that there is no distinction between mind and body

Taking up a position of knowing more about the patient's body than the patient him or herself knows, arguably gives Jenny the right to interpret and guide patients' experience of their bodies. This works to undermine patients' self-understanding, whilst, at the same time, legitimates practitioners becoming co-constructors of patients' illness narratives.

Within a spirituality discourse the IM practitioners also position themselves as visionaries who can see patients' illness trajectories ahead of time. The patient's illness trajectory is framed as potentially hazardous to patients' because of the risk to health that it signifies. Therefore the patient is constructed as being continually at risk, unless they take the practitioners' understandings onboard and become suitably educated and aware. IM treatment therefore comes to represent a possibility through which the illness trajectory can

be avoided. This in turn, concretises the necessity for patients to remain on their IM treatment journey.

The following excerpt from Sandra exemplifies the construction of the patients' illness trajectory as hazardous. Sandra talks of 'metabolic syndrome' as a widespread illness issue. Sandra constructs this issue as a severe problem by labelling the syndrome 'an epidemic'. However, 'metabolic syndrome' is an esoteric term that may not be easily understood by patients:

Now you know that this woman's on the road to getting all the problems that her mother had. Now metabolic syndrome is an epidemic problem that we have in our Western society. Big tummy, can't lose weight, blood pressure, cholesterol and diabetes. So eventually she'll get, she's got the blood pressure, she's got the cholesterol, she can't lose weight and she'll end up like her mother with diabetes, gout and probably kidney failure as well because that tends to go with the gout and the hypertension. So how can you stop her going there? Because at the moment you can see that happening, but all you can do is give her a drug for her blood pressure, a drug for her cholesterol and tell her to lose weight. And she does all she can, but she can't lose weight because it's her metabolism. Now what I would do there is give her the nutritional support to lose weight. Get all the insulin improving vitamins into her

Such talk acts to reinforce the notion that risks to health are common and pervasive but not easily detected. Further, Sandra's talk of 'an epidemic' becomes a powerful rhetoric which reinforces the need for an effective intervention that falls beyond the scope of allopathic medicine. Therefore it is the IM practitioners' expertise, which is demonstrable through their use of the wider IM therapeutic toolkit, along with their ongoing monitoring of the patient that is required to prevent patients from becoming ill or to bring them to an optimum state of health. That the patients' health trajectory is constructed as hazardous creates an impetus for patients to act in line with the practitioner's instructions and recommendations. Thus a preventative treatment approach becomes construed as commonsense and necessary in order to safeguard health and wellbeing, reinforcing the need for preventative measures to be taken. Framing preventative measures as necessary acts to warrant treatment that is on-going, and possibly never-ending. Further, it is through health and illness being constructed as points on a projected health/illness trajectory that the notion of the "chronic illnesses of aging" becomes a taken for granted notion, as alluded to by Sandra:

And you give her progesterone and you give her what she's lacking and then she stops going down that road. Otherwise you then give

her gout drugs, more cholesterol drugs, more hypertension drugs and other things happen. Do you see what I mean? All you're doing is giving another drug as she progresses through these chronic illnesses of aging. You're not preventing the illnesses of aging. And this is a big issue because we've got a very large, we're set to have a very large proportion of people who are going to be elderly in our community and we know that fifty per cent of people over eighty have Alzheimer's disease, and we know that the average lifespan is now about eighty-six. So we're going to have all these dependent people if we don't do something about it

In this sense, the development of chronic illness becomes part and parcel of the aging process. Thus patients' natural aging process becomes reified as a risk factor and one which patients are urged to mitigate. Such understandings reinforce the nebulous nature of risks to health but at the same time perpetuate the understanding that risks are continually present. This works to create a precarious subjectivity for patients as, unable to circumvent the natural aging process, they become positioned as at greater risk of illness as they age. This widens the pathological sphere in terms of extending the array of risks to health. Moreover, it may predispose the patient to be ever-vigilant of potential risks to health which in turn is likely to perpetuate anxiety and, consequently, render it necessary for patients to take action in order to safeguard health. In conjunction, IM becomes understood as a suitable healthcare option in which to engage as it offers a wider range of treatment options to combat such possibilities.

This finding echoes that of Salkeld's (2005) study which explored IM doctor-patient communications in the United States. Salkeld found that doctors were educating patients through the notion of risk. Practitioners gave prescriptive advice to patients through framing the etiology of disease under the rubric of risk. However, rather than taking up an epidemiological understanding of risk, the practitioners incorporated a notion of risk as inherent in certain everyday behaviours and focused on the individual as instrumental to risk reduction (Salkeld, 2005). Through drawing on discourses of risk, trust and personal responsibility for health the practitioners produced a dichotomous and limiting positioning for patients. Patients could either gain control through becoming educated and discerning, largely by avoiding risky behaviours or, if they failed to take adequate responsibility for their health, they risked becoming victims of capitalist greed (Salkeld, 2005). This demonstrates how the discursive work practitioners engage in can narrow patients' subjective possibilities and potentially reproduce healthism, in that responsibility for health becomes prescribed as the only sensible course of action to take. The philosophy espoused

by the practitioners in the current study may have similar repercussions for patients' subjectivities. The dichotomisation of medicine into 'good' and 'bad' categories constructs allopathic medicine as inadequate and holds safety assurance techniques, such as EBM, as questionable. This has repercussions for patients' subjectivities because it is through the education offered by practitioners about IM practice, constructed as "a whole different philosophy", that patients can discover "meaning". In promoting such a philosophy, the IM practitioners may further problematise patients' trust in allopathic medicine. This is because allopathy is constructed as limited and potentially inadequate due to its inability to explore patients' psycho-physiology fully. This in turn, may cause patients to question taken-for-granted allopathic-based practices, such as taking pharmaceutical medications, thus exacerbating patients' uncertainty about how to safe-guard health effectively.

However, there are specific ways in which IM patients are construed as being able to mitigate risk. One way is through patients reaching a heightened state of awareness. Patients are positioned as having the potential to become enlightened through their engagement in IM; a state in which they become able to more easily discern risks to health. This is framed as beneficial to patients. For example, in the following, Clive suggests that administering acupuncture to a patient can actually aid patients' awareness of environmental risks that could lead to ill-health:

I think in general my work is to create that environment inside and outside the body because we're connected, that is, that healing is maximised. Simple as that. So we're not actually forcing a change with an outside subject or substance. Acupuncture connects you to the outside so you actually become more connected to the outside. So we're just, so this is very much about them learning to create that environment. Now that can be releasing old emotions, self-forgiveness, you know the internal environment is very important, avoiding toxic relationships as well. So it's very much based on that. And there are other doctors who'd be looking at industrial toxicity and things. And in fact I will refer them to those people if there's some sort of, an obvious problem. But for mine, it's really their emotional health as well as their physical health because there's really, to me, total integration of that. There's no separation, OK. But they can do things about it, so they can do things about their environment, but they do have to challenge their restricted beliefs about "I can't do this"

Through drawing on a spirituality discourse, the IM practitioners' construct patients who engage in IM as having the opportunity to develop enhanced mindfulness. This increases their ability to discern environmental influences that may be detrimental to health. Consequently, IM treatment becomes a route through which patients can seek greater

protection from illness. However, in order for patients' mindfulness to be enhanced it becomes important for patients to get their bodies into an optimal state. This understanding works in conjunction with a healthism discourse which constructs health as a moral imperative and which works to reinforce the patient's goal for "optimal health" as sensible and reasonable. And, on the flipside, if patients do not engage in such practice it renders them potentially culpable for illness occurring. This works to construct uneducated patients as more susceptible to risk, and as immoral, and in parallel makes re-education seem a reasonable and necessary pursuit.

Patients' re-education becomes possible through the practitioner assisting them to alter their faulty beliefs and thinking. In this sense, practitioners become granted the right to provide patients with certain rules about how they should think and behave. This is exemplified in the following excerpt, in which Jenny talks of a need to correct the language of the patient in order to bring about a positive change:

But if they want to say "aargh, it's just been such a dreadful day and I feel so terrible", I'm not interested in that emotive kind of description of themselves because it's a put down and they're busy listening to them put themselves down. So it's about "hang on, back up the bus, let's just stop and have a factual statement about how you're feeling. Let's take out all the emotional overlay and let's learn to say 'this is a rainy day, I'm actually struggling today. You can use that word if that describes how you are, but let's language it with some sort of honesty and integrity for you, rather than making it some great emotive exercise". So we do language-changing, because language is powerful and the Chinese understood that you could use language to change reality. So we do a lot of that sort of stuff – teaching people to look at things differently, to understand their bodies in other ways

Such talk constructs the patient's language as less than factual, and as lacking in honesty and integrity. This construction also works to delegitimize patient's engagement in emotive language during treatment. In contrast, patients' ability to convey a more factual account, through the practitioner assisting them "to look at things differently" is constructed as essential to successful treatment. And it is through constructing such practice as a necessity that patients' re-education becomes warranted:

I realised that I had to motivate people to change their lives because they would tell me that they didn't have enough time to walk around the block or to eat broccoli or to do the right things for their health. So I started learning about helping them with life management, time management, how to think. Really cognitive behaviour therapy, but I'm not trained - positive psychology

IM practitioners frame IM as a means of protecting patients from risk and thus as inherently beneficial. Furthermore, enacting the ‘correct’ healthcare practices becomes central to patients reaping the rewards of good health from the treatment they receive, which perpetuates the notion of health as a moral imperative. In drawing on a discourse of empowerment, practitioners construct patients’ ability to understand their bodies and to learn more about themselves as essential in order to manage their own health effectively. However, being granted an uneducated position within the practitioner-patient relationship reinforces the need for patients to understand the philosophy espoused by practitioners. This essentialises the need for practitioners to infiltrate the inner world of patients in terms of their thoughts and beliefs, in order for effective education to occur.

Fisher (2008) problematises the empowerment that the virtuous, authentic, reflexive citizen is expected to achieve, pointing to how this is constructed in line with hegemonic neoliberal citizenship. She argues that discourses that draw on ‘achievement’ and ‘normality’ to construct the virtuous citizen problematise one’s positioning as an empowered individual. Fisher’s study, which focuses on the talk of parents with disabled babies, found that whilst parents reflexively engage in empowering discursive construction at home, this is not publicly facilitated. Neoliberal and biomedical discourses espoused by health and social care organisations operate to grant the parents and children “deficient identities” which limits claims to empowerment (p. 583). Sinding et al. (2010) discuss how a discourse of patient empowerment is tantamount to a political strategy whereby granting the patient control over treatment options increases patients’ responsibility for monitoring and avoiding the possible harm that comes with the likes of prescription errors and non-compliance. These findings bear relevance to the present study, whereby a discourse of empowerment is drawn on by the IM practitioners to position IM patients as active rather than passive and as able to take more control over their own health and treatment options. However, the agency that is purportedly granted patients is questionable. This will be explored through an analysis of the IM patients’ talk, the focus of Chapter 6.

The patient: A complexly interconnected “whole person”

As discussed in the previous chapter, through drawing on a discourse of holism the practitioners construct IM practice as comprising a range of treatments with which to treat the ‘whole person’ rather than the separate parts of the person. This works to create a need for psychological and emotional dimensions of the patient to be considered and explored

in addition to the patient's body. The patient's psyche is constructed as being of particular significance because it is held to encompass the patient's belief system which is constructed as central to patients' ability to reach and maintain a state of 'balance'. In the following excerpt, Carole constructs the patient's mind, body and spirit as interwoven and claims that in order to keep the emotional, physical and mental factors in harmony and functioning well, it is essential to keep patients in balance:

Whereas more integrative or complementary approaches would see the body, mind, spirit as really not separate from each other and any parts of those out of balance would impact on the other parts. And it really honours the sort of interconnectedness of the whole body itself and the body-mind, those different areas much more so. So there's no separating out. If something is happening physically in the body then that's impacting and contributed to by lots of other factors physically, mentally, emotionally

However, this understanding seems paradoxical. Although, Carole constructs the patient's mind, body and spirit as an interconnected 'whole' she continues to break the 'whole' down into emotional, mental and physical parts that need to be considered separately, as these are constructed as impacting each other to bring about illness. Further, in that the mind, body and spirit of patients are constructed as interconnected, but not necessarily in an easily discernable way, practitioners' need to explore each and every facet of the patient to a greater degree becomes legitimised. The deeper levels of malaise that become apparent through such a lens again offers patients an altered understanding of themselves because the 'whole person' they become in IM consists of a complexly interconnected system which requires multiple modes of treatment or maintenance in order to function effectively. This may work to problematise patient's own self-understanding, and position them in need of further education from their practitioner.

Hughes (2004) discusses how constructing the 'body' and the 'individual' as separate, but in communication works to position patients as in need of re-education. In Hughes' study treatment consisted of helping patients to make physical changes in their lives, but also to alter their perception of pain. Such constructions are potentially problematic. In patients being positioned as uneducated they are vulnerable to having their experience of illness being interpreted for them by the IM practitioner. This may be problematic for patients because patients' illness narratives, rather than merely reflecting their experience of illness, provide a means to restory identity in the face of illness (Kleinman, 1988; Frank, 1995; Badone, 2008). Therefore, if patients' illness narratives become opened up to interpretation by another, their ability to reconstruct their biographical identity could be undermined.

Furthermore, through the discourse of holism, patients' corporeal illness becomes linked to their psyche, whereby maintaining a mind-body balance becomes constructed as essential to good health. This understanding may operate to reproduce Cartesian dualism.

However, patients' education is constructed by the IM practitioners as inherently beneficial. Through drawing on a spirituality discourse, effective treatment becomes constructed as more about patients' "getting something out of their process" or "if they learn something spiritual about themselves" rather than returning to health per se. In the following excerpt, James talks about miracles being commonplace in his practice. However, his talk conveys a notion of miracles occurring at a spiritual level rather than physically:

But miracles always happen. You know I always come from that angle. I don't care how bad things are, but miracles always occur. And the miracle may be they actually turn around and survive or they end up dying happy. Whatever the miracle is, is sort of the angle I'm taking now. Hope is the thing. That's the main thing, offer hope to patients, to people

Miracles are also drawn on by practitioners to frame the patients' return to health as extraordinary. However, the miracles alluded to are talked about in relation to the patient making changes in line with the practitioners' recommendations. This is exemplified in the following excerpt from Jenny:

You've taken a lifetime to grow this imbalance. We don't necessarily have another lifetime to change it. However, let's get your medication down to as low as possible so we minimise side-effects and we have you feeling well. And so miracles happen, often (laughter) which always kind of surprises me. And people suddenly get into meditation, and they come back two weeks later and their blood pressure's dramatically different and you say "what have you been doing?" and they say "well, I went off and I've been monitoring my blood pressure and I've been able to identify that these things in my life are what caused my blood pressure to rise and I've checked it with the monitor". And so they change their lives and I stand really humbled by what people do for themselves really

Therefore the notion of a miracle is not necessarily understood to symbolise a patient being cured, but can also reflect a patient developing hope or "dying happy". Through constructing patients as having a spiritual dimension, a multitude of subjective possibilities are therefore opened up to patients as acceptable, such as a state of wellbeing. Such subjective states incorporate outcomes outside those based on science and the evidence-base that constitutes successful treatment in the allopathic sphere, and thus successful treatment outcomes become decoupled from returning to physical health. This is

potentially problematic for patients because in shifting the emphasis of treatment as being about curing patients, the position of being ‘healthy enough’ becomes legitimated, thus reinforcing the notion that a subjective sense of wellbeing is more important than physical health.

In drawing on a discourse of spirituality, patients’ health problems also become constructed as having a spiritual basis, whereby the practitioners are warranted a need to understand the spiritual aspect of patients. In tandem, talk of “miracles occurring”, of “aha moments” and “your belief system can change your bodily function” become commonplace notions that the patient becomes exposed to. The patient’s ability to achieve this balanced, receptive state is constructed as essential. In the following, Clive refers to how reaching this “balanced receptive mode” is almost a prerequisite for change to occur:

Now the realisation of this stuff is enhanced if you’re in a receptive mind. So you know, the balanced receptive mode comes from harmony, through talking, through nodding and laughing together and that’s a big part of it. You can enhance it if you’re doing something like acupuncture, your body, you create total physiological balance, OK. And if you add in breathing exercises then these messages become much more easy to receive, because the person’s in a receiving mode....So all I really try and do is to allow them to become at one in a receiving mode, which is a big change for them. So they need help for that. They actually need a friend or a help, or me or someone to help them get into that mode so we get the ball rolling. And then it’s to teach people to do this themselves

Clive therefore constructs patients as being unable to achieve this balance without guidance, support, and thus in effect, a re-education. Patients’ inability to understand the multitude of risks to health and the way they can fully engage in fighting against these, positions the patient as at risk. In the following excerpt, James implicitly suggests there is a *need* for people to take action and seek alternative healthcare options:

- James But I still have a great sense of responsibility. Because of the knowledge I’ve got, I have to make sure this carries on. I have to spread it as much as I, that’s what I mean by the responsibility for me. I’ve gotta make sure this gets out there and we make the change required to bring good health to this planet
- Helen Yeah
- James Yeah and that’s on the environmental level as well, you know, because the environment’s totally toxic. So yeah, you can’t separate any of those things out
- Helen So you’re imparting knowledge to the patient or the person that comes to see you and you’re
- James Yeah. I’m recruiting them, they’re my foot soldiers for the battle
(laughter)
- Helen (laughter)

James You sign them up, you get them thinking like me, make them realise, this is what's going on. Now you can do something here and they can talk to ten other people and tell them this. It works like that. It's a numbers game. People always have the power, it's just they don't realise it. Look what happened in India, you know half a billion people were controlled by a hundred thousand British soldiers. And one day the Indian's went "hold on, we totally outnumber these guys" and the British were out of there like that. They'd have all been killed if they'd stayed there any longer

Through invoking a spirituality discourse, James' likens his practice to a crusade whereby his role is constructed as bound up with 'spreading the word' and bringing "good health to the planet". In effect, patients are actually positioned as assisting him to bring about new understandings to the masses. Such talk indicates a preference towards fostering a new way of thinking. This is tantamount to people needing to be converted which rests, in the first instance, on patients themselves moving away from pharmaceutically-based healthcare interventions to the wider range of healthcare options that become possible through IM. Such a perspective is echoed by Sandra who says she is already "preaching to the converted":

But most people accept what I advise. Very few of them tell me that they don't want this or they don't want that. If it's a drug they'll say they don't want a drug. So I'm sort of preaching to the converted. Not that I was seeking out people who had any particular mindset, but these people tend to be averse to drugs and tend to be more interested in natural therapies. And so because I prefer natural therapies before I give a drug, I suppose that's why they do what I suggest

Such talk further problematises the notion of the IM practitioner-patient relationship being a 'partnership' and may act to perpetuate a heightened self-awareness on the part of the patient, predisposing them to foster a recognition of 'self' that comprises deeper levels that need consideration and work. It also grants the patient yet another facet of selfhood that they may not have understood themselves as having or being, prior to their treatment journey. In conjunction, the practitioner becomes an expert and an educator with a knowledge-base that straddles *two* spheres of medicine. Thus rather than IM producing a practitioner-patient relationship of greater equity it perpetuates the expert practitioner/non-expert patient dynamic found within the allopathic sphere. And such a relationship dynamic allows practitioner narratives to dominate within the practitioner-patient relationship (Freidson, 1970; Sered & Agigan, 2008).

These findings reflect how wider discourses of holism, spirituality and empowerment work to position patients as being in need of education. Such a position is reflected in contemporary public health which invokes a discourse of empowerment to construct the 'expert patient'. This construction is derived through the patient having attained a certain amount of knowledge in relation to their own illness and through taking increased responsibility for their own health maintenance. However, the present study echoes the suggestion that 'lay expertise' is a fallacy (Prior, 2003). As Prior (2003) suggests such a construction is problematic on the basis that patients' knowledge, in comparison to practitioners, is incomplete and restricted. Patients do not have training or knowledge of technical matters in areas such as risk assessment or in epidemiological data analysis and are thus ill-equipped to comprehend the "technical complexities" of disease aetiology (Prior, 2003, p. 53) or, in the present study, to ascertain the "root cause" of illness and how it manifested. In effect, IM patients are provided with a script in which understandings of health and illness become voiced in a vocabulary where "patient choice reflects the medical ideology that the doctor knows best" (Dent, 2006, p. 464). This opens up the possibility that patients themselves draw on an empowerment discourse in order to position themselves as more informed and thus more able to engage in an open and equitable dialogue with practitioners. However, this dialogue is arguably a co-construction in which patients become "proto-professionals" and take up the "fundamental stances and the basic concepts of the particular profession with which they are closely interacting" (de Swaan, 1990, p. 100). Consequently, these IM patients may come to redefine not only what constitutes effective treatment and outcomes, but also their own states of health and illness in line with the practitioners' understandings.

'Optimal health' and 'ultimate healing'

Practitioners draw on discourses of holism and spirituality to construct the patient's body as having a natural tendency or movement towards healing and wholeness. In turn, patients' health is constructed as being more about the learning patients take from their ill-health rather than overcoming illness or eradicating symptoms. This is exemplified in the following by Carole:

I think the other difference with holistic medicine is that the body has this natural movement towards healing and wholeness, so that is a base of a lot of those modalities. So with that as a base you then are finding ways to really nudge or support or help the person to move towards where they naturally, that they naturally will be moving. And more removing blocks to that. Whereas I think conventional medicine has such powerful tools at its

disposal that it's often more, it feels like more of a bit of a control and taking over and doing to, than really supporting

Carole, in talking about the differences between holistic and conventional treatments, suggests that her aim is to get patients into “a state of optimal health”:

Some doctors are much more sort of holistic in the way they operate, but the whole philosophy behind conventional medicine is more, in my mind, sort of symptom-oriented and if it's prevention, it's prevention in terms of using drugs to stop something down the track. So treating blood pressure with medication or treating cholesterol with medication rather than the sort of bigger picture of prevention. Getting someone more into a state of optimal health with diet and lifestyle and emotional support

“Wellness” is another term taken up by the practitioners to allude to the possibility of patients becoming more than healthy. For example, in the following Jenny claims that traditional Chinese medicine returns patients to “wellness”, and goes on to suggest that this state of “wellness” is not something that orthodox medicine alone can provide them. In doing so, she constructs the “wellness” that patients can forge through engaging in IM as better than healthy or as an alternative type of health that patients' can attain:

Chinese medicine still changes imbalance and it gives people back a sense of wellness that nothing I ever did in orthodoxy ever does to the same extent. Which is why I'm still in the Chinese model, nearly thirty years after I started doing Chinese medicine, because it works. So why would I choose to step out of it? I'd step out of medicine if I stepped out of Chinese medicine, because I'm not clear that I would simply want to work exclusively in the orthodox model again. I like having both, I like being able to use both

A sense of “wellness” or “optimal health” becomes constructed as the norm patients *should* strive for. In contrast, deviating from the script of thriving for “wellness” or “optimal health” that is implicitly proposed by the practitioners, by not looking after oneself, renders patients as potentially deviant. This is echoed by McPherson and Armstrong (2009) who examined GPs' talk about their experience of managing patients with depression. Patients' non-adherence to the prescribed treatment of anti-depressants led practitioners to reconstruct patients' problems as “non-medical social deviance” (p. 1141). For example, they attributed unpleasant character traits, such as manipulative tendencies and an inability to relate to other people, to patients. In conjunction, GPs were seen to respond to patients in “non-medical ways”, such as showing less sympathy and breaking patient confidentiality (p. 1137).

In the present study, it would appear that patients are encouraged to understand themselves in line with the holistic healthcare model and the philosophy employed by the IM practitioners. If patients fail to adopt the learning offered they are liable to become at an increased risk of illness. The patient is also constructed as at risk if their emotional state is out of kilter. Patients' unhappiness becomes conflated with ill-health and designated as a risk factor, whilst happiness becomes constructed as the emotion that should be sought by patients in order to feel healthy, as alluded to here by Jenny:

We see an awful lot of what I call unhappiness in practice which is ill-health and I don't wish my patients good health, I wish them happiness, because if they're happy they've got the other. You know so many of the people I see are neither happy with their lives, themselves or what goes on around them and that's expressed as their disease

The conflation of happiness with health and unhappiness with illness works to construct emotions as either good or bad, and may thus pathologise patients who express 'negative' emotions as these are maligned. In contrast, practitioners construct patients' expression of the 'correct' emotions as precipitating wellbeing. Furthermore, patients' expression of 'positive' emotions is constructed as a means by which they can attain "optimal health" or "wellness"; psycho-physiological states that appear to go beyond 'healthy' and which are framed as something patients *should* strive for. This reinforces the construction of health as a moral imperative, and positions patients as potentially deviant if they deviate from engaging in health-promoting behaviour.

Other research has noted how discourses of wellbeing transcend physiological health to encompass emotional and spiritual states and are taken up by practitioners to legitimate emotion management. This is a practice which is utilised by CAM practitioners to assist patients in terms of producing appropriate emotions. Sointu (2006c) suggests these emotional scripts are linked to ideas of self-fulfilment, unique and self-responsible subjectivity, personal freedom and agency. This in turn allows for patients' unease to be interpreted as a "possibility for wellbeing", going beyond the corporeal body to incorporate understandings of how the "self feels about itself" (p. 345). Thus emotion management is understood as a form of governance in that CAM practitioners are able to extend their therapeutic reach into the embodied and lived experiences of patients (Sointu, 2006c). However, this discursive account of wellbeing is also said to offer patients a means to negotiate disempowering subjectivities, such as the passive patient, as it enables the production of a subjecthood and body that is "more mobile, aware and well" (Sointu,

2006c, p. 345). This reveals the contradictory positioning that is opened up to patients through a discourse of wellbeing; on the one hand affording them agency, but on the other giving rise to a subject who is 'flexible' – a construction which fits with wider neoliberal discourses that understand personal flexibility as a highly valued commodity (Sointu, 2006b). In the current study, IM practitioners espouse an understanding that feeling the 'correct' emotions is a sign of health. This understanding moves the focus of IM healthcare away from a consideration of the patients' body to patients' psycho-spiritual state. In constructing the patients psyche as malleable, whereby changes to patients' thinking and emotional expression become an implicit part of IM treatment, patients' adaptability becomes constructed as inherently beneficial. This works to reproduce a notion of the good patient as flexible. Such a patient is able to reap the benefits of the wellbeing and "optimal health" on offer through IM by taking on the learning espoused by the practitioners. If patients do not, they become positioned as potentially deviant and immoral individuals. This suggests that the 'active' patient position that becomes opened up to the IM patient does not necessarily offer more agency than that afforded other patients. Further, it problematises the notion that the IM practitioner-patient relationship fosters empowerment.

However, constructing patients' wellbeing as bound up with healing does operate to offer an alternative position to patients. In contrast to offering patients' a cure, which limits the positioning of patients who cannot be cured, the notion of wellbeing opens up alternative understandings of health and illness to patients around what constitutes effective treatment. This may be particularly beneficial for those patients with chronic and contested illness. However, the philosophical difference between healing and cure has also been shown to prove problematic to patients. Baarts and Pedersen (2009), who interviewed patients about their experiences of alternative therapies, found that patients who engaged in this realm of medicine did not expect to be cured. Further, patients attributed any pain they experienced, during or after treatment, as potentially beneficial because it was considered an aspect of the healing process or as symbolising to them that their body needed help. Promoting healing over cure could minimise the importance of curing patients and, moreover, could lessen the emphasis placed on the therapeutic efficacy of care, whilst increasing the emphasis on helping patients' to find meaning in their symptoms. In the current study, the wellbeing and empowerment that is constructed by these practitioners may also subvert the possibility of patients' constructing wellbeing and

empowerment in alternative ways. This in turn may problematise patients' ability to resist the confines of the individualised self-sufficiency that becomes warranted and perpetuated.

Illness as transformative

The discourse of holism is also evident in practitioners' talk about illness, whereby illness becomes constructed as a deeper malaise that conventional medicine cannot treat or understand adequately, and a manifestation of multiple causes which combine to create a malady whose origin is complex and difficult to discern. In conjunction, discourses of empowerment and spirituality are taken up to construct illness as transformative and a means by which patients can become educated about what the symptoms of illness symbolise or signify. In the following excerpt, Carole talks of there being another layer to consider in her practice. This is not only about eradicating illness but also about what patients can learn from it:

And so there's another whole layer to illness. And people with cancer particularly, I'll see, will describe this as being a real transformative process. Having a serious diagnosis or an illness - that's really motivated them to look at their lives differently with their priorities, make quite major shifts. So some of them would say, "yeah it's been really hard, but it's been the best thing that happened to me". So I think there's a whole, another layer. My approach would be not just getting rid of the illness or the symptoms but what's this about? What's the sort of gems in this? Or the learnings from it?

Illness is therefore understood as being more than just an absence of health. Other research has noted how people with serious illness seek to find meaning in their illness (Kleinman, 1988; Frank, 1995.; Badone; 2008). However, in the current study finding meaning in illness becomes an implicit part of IM treatment in general and is constructed by practitioners as the means by which patients can understand something more about their life that they have failed to understand previously. In constructing illness in this way, practitioners create a fissure through which a joint exploration of the patients' subjectivity becomes possible and reasonable. This not only allows practitioners to deconstruct patients' understandings and beliefs but also grants them the space to reshape the understandings patients have around the aetiology and manifestation of their illness.

Illness becomes personalised to the individual and understood as having a multitude of possible causes. Further, through constructing illness as potentially stemming from dysfunction at the non-corporeal level, ill-health becomes decoupled from organic disease

and thus allows the practitioner to move away from the specific diagnosis of disease states. Instead, the “root cause” of illness shifts to being understood as more likely located within the psyche or spiritual realm of the patient to a greater degree, rather than being attributed to a diseased organ or body part. In the context of CAM, Sered and Agigan (2008) found that deeming the patient “in total as unwell rather than as essentially well with one diseased organ” (p. 617) resulted in the patient being held accountable for their illness or for failing to get well. This suggests that the body’s objectification in the realm of biomedicine could actually be beneficial to patients in some respects as it allows them to separate and disengage from the disease, thus liberating the patient from any blame or wrong-doing.

Within IM the practitioners construct patients as having a spiritual dimension, and it is within the spiritual realm that “ultimate healing” becomes a possibility. However, the patients’ ability to achieve “ultimate healing” is bound up with the practitioners’ correct interpretation of the causation of illness. Thus in order to find the “root cause” the practitioners’ exploration of the complex combination of environmental toxins, patients’ (incorrect) lifestyle choices, unhealthy behaviours and faulty thinking (along with a possible misunderstanding of what their illness signifies) becomes construed as necessary. However, “ultimate healing” is bound up with patients’ belief system and their purpose in life, rather than being evident in the body of the patient. This is exemplified in the following comment from James who suggests that healing is possible even when the material body no longer exists:

Well all the ultimate healing is in the spiritual realm at the end of the day. What the hell are we here for? What’s the purpose of this life? What are we really? Are we one life and we die and that’s the end of it? Or are we reincarnated? Are we coming back? Are we meant to be evolving higher and higher each life? Maybe not meant to come back one day? That’s what I believe. I mean having that belief system means that you operate as a therapist, as a doctor differently anyway, because you see what’s really going on at that level. There is nothing to really be scared of.... Even if you are dying, you know you’re not really dying. I believe we’re here for infinity. There’s no death really. It’s just a physical death. You live on. Very much as we’re thinking now, when you leave your body you’ve got all this going on. You’ve probably got more going on, presumably

Healing therefore becomes decoupled from returning patients to a state of physical health. Furthermore, notions of “ultimate healing” and “optimal health” become bound up together and each understanding reinforces and perpetuates a quest for the other. This further legitimates the practitioners’ use of the wider toolkit that is provided to them

through the practice of IM which, as discussed previously, is framed as “real medicine”. “Real medicine” is required to get at the complexity of the problems that patients present with; medicine with the ability to look at the deeper and hidden layers of patients. The practitioners couch this idea in incontestable terms, constructing the patient as having a body that has a *natural* movement towards healing and wholeness. However, if the body is not moving in this direction the patient potentially becomes held accountable for not behaving or thinking in the right way in order to achieve this natural bodily state of healing and wholeness. Synonymously, because it is in the patients’ best interests, it becomes necessary for the patient to understand what could be obstructing this seemingly natural process. If not, they may inhibit the process of attaining ‘wellbeing’ or “optimal health” or, of even more concern, fail to discern a possible explanatory factor in terms of what gave rise to the manifestation of illness.

However, this right to understand is only possible in conjunction with the practitioner who, as healer and educator, takes up a central position in supporting and guiding patients to understand the possible obstructions to achieving “optimal health”. And because IM is regarded as a practice that takes account of the multiple layers of patients, the level of knowledge required to understand ill-health is construed as difficult for patients to grasp. Instead, such knowledge is constructed as complex and challenging. This complexity is alluded to by Jenny who, drawing on a discourse of holism to describe Chinese medical theory, works to construct the patient’s body as an interconnected system that requires a wider perspective in order to fully understand it:

So in Chinese medical theory, the way the body works, the physical way the body works, the physiological way the body works, the emotional way the body works, our personal input and our spiritual requirements are all part of the general health of the organs and the relationships between the organs and how things work and our relationship with the real world. So it’s a much bigger picture in some ways

Jenny alludes to the “bigger picture” perspective that is required of the practitioner to understand the complexity of the multi-layered individual that the IM patient becomes. In doing so, she points to the degree of expertise required in order to understand health properly. Such talk serves to perpetuate a power imbalance in the practitioner-patient relationship in that the practice of helping patients “to recognise the reality of their situation” contradicts the empowerment that they also suggest is afforded IM patients.

Conclusion

In contemporary Western society the patient has been recast, rhetorically at least, as an active participant in, rather than as a passive recipient of, healthcare and has moved from occupying the position of 'sick role' to that of an 'informed' patient and 'active' consumer. This reflects a wider societal neoliberal ethic and suggests that patients are actually engaging in 'deliberative democracy' (Klijn & Koppenjon, 2000) which, in theory, grants them speaking rights and empowerment in the healthcare they receive. The current research reveals that in the realm of IM, discourses of empowerment and human liberalism are drawn on by the practitioners to engender the notion of the IM practitioner-patient relationship as a partnership. However, the equitable alliance that practitioners' suggest is fostered in the IM practitioner-patient relationship is questionable. The discursive framework drawn on by practitioners, and central to their reprofessionalisation, serves to enhance their agency in constructing patients within IM as a certain type of subject. In effect, the position afforded the practitioner provides them a platform from which to reconstruct patients subjectivity in terms of how patients *should* think and behave.

Within the IM practitioner-patient relationship, patients become positioned as essentially uneducated and in need of guidance and support. Further they are urged to strive for "optimal health" in order to become responsible, empowered citizens. However, the practitioners' expertise and the extensive 'toolkit' they have at their disposal, which offers a wider array of healthcare and treatment options beyond allopathy or alternative medicine alone, also becomes necessitated in order for patients to achieve optimal health. Consequently, this provides the IM practitioner with legitimacy to become agentic in shaping patient understandings.

In combination, the construction of illness as a transformative process and the patient as having a body which naturally moves towards healing and wholeness is problematic for patients on three counts. First, a deeper level of complexity is brought to the notion of health. In constructing health as more complex, and derived in large part through bringing the spiritual, psychological, emotional and physical aspects of patients into balance, an esoteric form of expertise becomes required by patients to discern such complexity. Second, a space is opened up in which patients' beliefs and emotions become understood as possible contributory factors to their ill health, particularly 'negative' emotions such as unhappiness. Thus everyday emotional states that patients are apt to experience become a

potential source of pathology which may function to problematise patients' emotional expression. Third, the practitioner is granted license to work with patients in order to understand what their illness means. This may usurp patients' agency as, in effect, patients' understandings become intertwined with those of the practitioner. And because the practitioners' exploration of the mind-body-spirit of the patient becomes legitimated within IM, the practitioner becomes granted the right to interpret patients' experience. These three factors operate to problematise the empowerment this is said to be granted to patients because patients' understandings come to incorporate aspects of themselves that they may not have understood as problematic prior to engaging in IM. In combination, the positioning and construction of patients that IM practitioners' talk gives rise to may problematise patients' ability to restory their lives and identity in the face of the challenges that illness brings. This is because in patients' illness narratives being opened up to interpretation by another, patients' ability to reconstruct their own biographical identity in the face of illness could be undermined. Furthermore, patients, prior to their engagement in IM treatment, may not have understood health as "optimal", illness as "transformative" or themselves as such complex beings prior to their engagement in IM treatment. Therefore, due to being granted an uneducated, relatively passive position in relation to the expert practitioner, patients become placed in a vulnerable position in which they are more likely to open up to and take on board the philosophy espoused by the practitioner.

McDonald et al. (2007) argue that the state has a vested interest in extending the realm of its influence in terms of governance and that "from a governmentality perspective the state's desire to empower patients and the public may be conceived as an attempt to reduce insubordination and resistance by influencing individual identity" (p. 434). In the present study, although patients have access to "optimal health" and "wellness", which potentially provides them with an increased ability to achieve wellbeing, when exploring this critically it would appear that the wellbeing on offer also serves to reinforce the hegemony of empowerment and healthism discourses. This is because patients are impelled to become suitably empowered through taking more ownership over their health; there is a moral imperative for them to do so. Further, in addition to producing wellbeing, IM may produce a form of recognition that potentially comforts and sustains patients because it dovetails nicely with the practitioners' philosophy of practice and fits neatly with what becomes acceptable personhood in the wider neoliberal society in which the patient resides.

Chapter 6

Patients' talk: Recognition, trust and responsibility

This chapter discusses how IM patients construct themselves and the IM practitioners they consult. It also explores how patients construct the IM practitioner-patient relationship, IM treatment and health and illness. First, the chapter discusses how patients' position themselves as collaborators within the IM practitioner-patient relationship. In this position they claim an equitable relationship with practitioners. As collaborators they construct treatment as offered to them rather than prescribed. They also claim to be knowledgeable about the underlying philosophy of IM, and claim that the multiple treatments offered "make sense" which legitimates their engagement in non-scientific forms of treatment. This section also explores how, through their engagement in IM, patients with chronic and contested illness claim to gain emotional and psychological recognition which the realm of allopathic medicine has failed to provide them. In doing so, they are able to resist the position of a pathologised patient. Second, the chapter shows how patients construct the IM practitioners as trusted professionals by drawing on the practitioners' extensive knowledge-base of both allopathic and alternative medicine, the practitioners' openness to multiple modes of medicine and their on-going commitment during the patients' treatment journey. Next, the chapter discusses how patients construct the IM practitioner-patient relationship as one in which trust, openness and commitment are fostered. Fourth, the

chapter explores the ways in which patients construct IM treatment as holistic. Framing IM treatment as holistic legitimates patients' engagement in experimental treatment practices and warrants the bricolage they undertake as health consumers. However, patients also become positioned as largely responsible for their own healthcare. Finally, the chapter discusses how patients draw on discourses of healthism and science to construct health and illness as moral choices and as biologically determined. Through doing so they are able to resist being positioned as immoral.

The integrative medicine patient: A collaborator and a 'normal' citizen

The collaborator

Within the realm of IM, patients work to construct themselves quite differently to the patient in the allopathic sphere. Within IM, patients position themselves as in 'collaboration' with practitioners. Patients talk of working *with* their practitioner within the IM relationship rather than being directed by their practitioner to take a prescriptive course of treatment. Patients also talk of how the practitioners' knowledge is shared with them, and how they are able to select treatment options themselves. They refer to how the IM practitioner provides them with explanations about the underlying philosophy and principles of the various treatment options available, and how they have the opportunity to learn about the IM toolkit in order to take up elements of this themselves.

Patients construct practitioners' ability to talk in a way that "makes sense" as key to effective collaboration, claiming that this enables them to grasp and understand the information conveyed. Previous studies have noted how "sense-making" is constitutive of producing a sustainable and mutually reinforcing relationship between patient and practitioner in which mutual understandings and interpretations are reached through dialectical interaction (Heldal & Tjora, 2009). In the current study, sense-making is a means by which patients come to understand both the practitioners' philosophical framework and the rationale for them engaging in specific treatment practices.

In the following, Cath, a woman in her 70s with rheumatoid arthritis, describes her understanding of the rationale behind Jenny's suggestion that Cath "shouldn't do so much". Cath implies that prior to understanding the philosophical and theoretical framework of the alternative side of Jenny's practice, she did not understand what Jenny

was talking about. However, through taking up the knowledge conveyed by Jenny, Cath is now able to “make sense” of what Jenny tells her:

Helen So I suppose that chi as you understand it, like Jenny said to you initially “oh I don’t think you should be doing so much, you’ve got to slow down”. Did she explain what her kind of reasoning behind all of that was to you when you first went in?

Cath: She might’ve but I didn’t really take it in, because I didn’t know what she was talking about. But you see I’ve since and it did, everything she says makes sense. And that’s what the acupuncture science, if you like to call it is – it makes sense

For Cath, sense-making constitutes a process through which she is able to organise her world and the illness she experiences in an intelligible way. In the above excerpt, Cath draws on a discourse of science to make sense of the acupuncture treatment she receives. However, Cath’s way of “making sense” also positions her as needing to be open to the understandings Jenny espouses. Further, although Cath claims that the “acupuncture science makes sense” to her, she also demonstrates uncertainty around what to actually name the treatment Jenny provides.

Another way in which patients construct themselves as being in collaboration with practitioners is through claiming to have “good bodily awareness” and thus knowledge about what the practitioner is doing during treatment. This is exemplified in the following excerpt from Gloria, a 72 year old with diabetes:

Well I know what she’s doing. I think I’m fortunate that I have pretty good body awareness. I know where everything is and what she’s doing

Through drawing on a discourse of holism Gloria claims to have good body awareness, and more understanding over other (allopathic) patients who ‘didn’t have a clue’:

Helen So that’s about having more awareness of your body?

Gloria Absolutely, total holistic. You know the wonderful expression which I think tells us more than we need to know “I’m under the doctor for such and such” which is a wonderful, old fashioned expression. Well they were under the doctor for such and such, because they didn’t know what the hell was happening. They were under him in every sense of the word. Didn’t have a clue

Through such rhetoric Gloria positions herself as more ‘expert’ than other patients’, and in doing so constructs herself as occupying a more equitable position within the IM practitioner-patient relationship.

Patients also position themselves as collaborators through constructing the treatment they engage in with IM practitioners' as non-prescriptive. They refer to their ability to choose whether to accept the treatment offered by the practitioner, rather than it being prescribed. Claiming their engagement in such practices reinforces the notion of collaboration. For example in the following Jo, a woman in her late 20s with spondylitis (curvature of the spine), refers to the relationship she experiences with Clive. Although Jo alludes to Clive being the "holder of knowledge" about treatment options, she positions Clive as offering these options to her rather than insisting upon her taking these up:

He does hold a lot of knowledge, but there's that collaboration where he's asking you a lot more about what your experiences are. The power structure seemed to be less so in this relationship, but it was still there because he still was that holder of knowledge and suggesting things. But I would have known that it would be OK if I choose not to accept what he was offering. You know it was more of an offering than a "you must do this, you must take these pills three times a day and off you go". Offers. I think 'offer' is a good word for what he was doing

Therefore although Clive is deemed the "holder of knowledge", Jo claims a certain level of power in the relationship through having the ability to decide whether she accepts the treatment Clive offers. Jo appears to be given choice in regard to treatment options within the IM practitioner-patient relationship, and thus able to take up the position of an 'active' health consumer. The collaborative relationship that Jo claims she experiences with Clive therefore suggests the possibility of empowerment. However Jo's choice is constrained in that it is limited to either accepting or rejecting the treatment options offered. Jo's lack of knowledge in comparison to Clive's is indicated in her reference to not knowing why he gives her specific treatment:

I don't know how he works out. I know there was a specific set that he did for relaxation but he also did some for pain relief as well, where he was sticking them in the pain

Therefore, the degree of power and collaboration Jo is afforded within the IM practitioner-patient relationship remains doubtful, particularly when she is placed in a position of wanting to overcome ill-health and pain. Further, Jo's ability to work in collaboration with the practitioner is limited because treatment talk is located within the confines of the practitioners' medicocentric language which, although diluted, still grants the practitioners' voice greater legitimacy. Therefore although patients claim collaboration with practitioners through an enhanced ability to make decisions about treatment options, which indicates a more equitable practitioner-patient relationship, the extent of this equity in terms of patient choice and collaboration remains questionable.

Recognition and constructing the ‘normal’ citizen

It is through discourses of science and biomedicine, and the diagnostic and therapeutic techniques that become warranted, that those people with mental or physical illness come to be positioned as ‘abnormal’. For patients with contested illness being positioned as abnormal can be especially problematic as the pathologisation attributed them shifts from the physical realm to the psychological realm due to the patients’ illness not being medically recognised. Such patients not only experience a lack of recognition in the allopathic realm but are faced with a double bind. This is because, in addition to being positioned as ‘abnormal’ by science and biomedicine, they are also apt to experience biographical disruption through the enforced changes to lifestyle and an inability to live life normally that illness brings. And it is through engaging in IM that such patients are able to claim the status of a ‘normal’ citizen because IM fosters a sense of recognition.

In the present study, patients construct this recognition as largely derived through the validation granted them in consulting a practitioner who takes their whole being into account and whose biomedical credentials and medical professionalism are certified, and thus deemed bona fide, in comparison to alternative medicine practitioners who they are apt to stigmatise. Therefore, through drawing on a biomedical discourse, patients are able to confer the IM practitioners a legitimate status in comparison to other CAM practitioners. Consequently, those patients with chronic and contested illnesses are granted a means to reposition themselves from the ‘abnormal’ location they occupy within biomedical discourse, to become ‘normal’ citizens. This is a position that neither the allopathic or alternative medicine sphere can offer.

That the allopathic realm is a problematic space for patients is apparent throughout the patients’ talk. For example, Jan constructs the allopathic system as having no place for her and refers to being at a loss to know how to make life worthwhile:

I mean you have to find some way of making your life worthwhile because looked at in the basic, in the normal way, it’s not worth living, it’s just not

Jan’s reference to living outside the “normal way” reflects the constraints and limits imposed by being positioned as ‘abnormal’. In addition to seeking treatment to relieve symptoms Jan refers to having sought multiple alternative treatments in a quest to be recognised as ‘normal’. Jan talks of the need to find another way to frame her life through which she can forge meaning.

Similarly, in the following excerpt, Sarah, a woman in her 30s with the skin disease Lichen Planus, constructs the lack of understanding conveyed by either allopathic or alternative medicine practitioners as central to the lack of recognition she has experienced. She constructs such practitioners' inability to understand as necessitating a heightened responsibility to manage her own healthcare or as she says "do that all on your own". However, Sarah draws on Carole's biomedical training and knowledge-base to construct Carole as a bona fide medical professional and through doing so legitimates her position as deserving of ongoing healthcare. Since meeting Carole, Sarah talks of no longer needing to manage everything herself and instead is able to "have what I experience":

Sarah But if you're a person who needs to take drugs, having to do that all on your own as it were, coz I guess in the past I did have a little bit with Deidre, my GP, not understanding. Coz I had naturopaths on one side going "all drugs are terrible" as opposed to graded between "there are these drugs that aren't really that terrible at all" and "there are these drugs over here that are really serious". So if I was talking with Deidre about the drugs she wouldn't understand why I was concerned about it. So now, I mean I don't have to do all of that myself. I can trust Deidre and Carole and Jack and also it means that I don't have to think about the side-effects and stuff like that. I have what I experience and I go and talk about that with them and they say "do this, try that, whatever" but I don't have to manage it all

Helen Which would be a huge amount of responsibility it sounds like, to have to try to manage all of that stuff

Sarah It was when I tried to do it. I mean seeing Carole is massively more expensive than the naturopath/herbalist I worked with previously who was a wonderful person and who I love, but for me it's better to save up and go and see Carole because she understands the drugs. I mean I went onto a drug this week to help get me through the crisis of Monday, but I can't take too much because it will precipitate a greater pre-menstrual crisis and that just wouldn't mean anything to my naturopath apart from "ugh it's a drug". Whereas Carole, she will be "OK well why don't you tail back over the next two days and use such and such?"

Sarah constructs Carole's knowledge of both the allopathic and alternative medicine realms as essential to her wellbeing. She claims that a lack of such would position her as being at risk of further health crises. Through drawing on Carole's integrative expertise and the possible risks to health that are likely without Carole's input, Sarah is able to legitimate her engagement in ongoing healthcare. Moreover, Sarah is able to confer herself a position of safety which she has not being able to achieve through either the allopathic or alternative medicine practitioners she has consulted in the past. Noble (2004) suggests that "recognition is fundamental to our quest for ontological security in the perseverance of our being and to our capacities for social action". The form of recognition patients claim in the

realm of IM thus offers them a subject position through which they can resist the ideology of the doctor as all powerful.

Patients construct the compassion and empathy that IM practitioners offer as central to their recognition. Jo constructs her relationship with her IM practitioner Clive, and the validation she receives, particularly on an emotional level, as providing her with reassurance that everything will be OK. Jo claims that it is through the recognition she receives from Clive that she is able to resist the pathologisation previously attributed her. This is achieved through her experience of pain being legitimated as ‘real’ rather than as “all in my head”. In doing so, Jo is able to position herself as ‘normal’, and is thus released from doubting the reality of her situation:

I was still in that situation where I was still experiencing a lot of pain and waiting for the surgery but I think it gave me maybe more of a sense of calm and sense of “it will be ok and I’m understood and this isn’t something that’s all in my head”. And you know having someone that you could talk to without having to protect them. Like talking to my family, I couldn’t talk to my family about it, even though I probably could have, but my family don’t really do the whole emotional thing. Friends didn’t really want to know, and really what friend in their twenties really understands any of this anyway? And my partner was pretty good about it, but he was living with it, so he knew, he could see. So it was good to have just that outsider perspective that was saying “yes this is really hard and we’ll see how we can help you”

Jo constructs Clive’s full acknowledgement and understanding of her feelings as an important part of treatment, alongside the acupuncture that she also engages in, as can be seen in the excerpt below:

It was that “how are you?” and “what’s happening?” and really, really understanding. And he did some acupuncture there at the clinic as well, which was useful. Yeah, huge empathy and huge kind of acknowledgement of everything that I was going through at that time

Nettleton, O’Malley, Watt and Duffey (2004), who explored undiagnosed neurology outpatients’ narratives, found that when symptoms were attributed to psychological causes, the patients struggled to make sense of their illness, talking about their illness as “fake” or “imagined”, as they could not ground their narrative within a medicalised discourse (p. 47). Nettleton et al. (2004) concluded that patients straddled a precarious void between illness and disease, remaining uncertain about whom to seek help from. Thus the absence of clinical categorisation is suggested to impact on patient’s process of narrative reconstruction in that the patient is not able to ground their illness narrative in a

meaningful way (Nettleton et al., 2004). In general, IM patients emphasise “experiencing” the treatment rather than “being treated”. In doing so they differentiate their positioning in IM with that within allopathic medicine, a realm within which, through a lack of emotional validation and recognition, they become objectified and biomedicalised. In contrast, the IM treatment they receive is constructed as experiential due to the relational aspect of the healthcare. And it is through such experiential engagement that they claim to be subjectively acknowledged and to gain recognition and thus deserving of ongoing care.

Patients’ resistance to being positioned by biomedical discourse as “abnormal” is also evident in their critique of the biomedical and scientific practices in which GPs engage. For example, Jan ridicules the way diagnosis of chronic fatigue is made and in doing so implicates GPs as incompetent. Here she mimics what the GP would say:

We don’t know what any of this is. You’re very tired, you’re run down, it’s probably chronic fatigue and if you can tick ten boxes out of the next twenty-five then you’ve probably got it.

Every instance in which Jan discredits medicine and its practices as untrustworthy and unreliable the GP becomes implicated. She points to science as not to be trusted, by using anecdotal evidence of a situation where the medical system got the lab tests of her blood samples wrong. Here the GP is also positioned as untrustworthy:

So now my actual results went out of the spectrum, but they’re actually good results based on the best knowledge that’s coming out from all over the world, but they’re way out of the range that the doctors, the doctors would normally give you

And biomedical experts are deemed unreliable in their ability to assay tests correctly or indeed get laboratory tests right:

So that’s another whole, you can’t even rely on the tests that they do and then add into that, you can’t rely on the laboratories actually doing the assay right, so even if you do get the results, you can’t rely on that being right

Jan actually points to the limitations of biomedicine and its failure to provide a diagnosis. Through the use of such rhetoric she is able to resist the precarious position that her medically unrecognised illness brings. Other research has noted that when diagnosis is absent patients’ physical suffering is invalidated through patients’ symptoms being understood as psychogenic and access to medical services being denied (Dumit, 2006; Nettleton, 2006; Jutel, 2009). Diagnosis therefore validates and legitimates the patients’ condition as something which should be considered by medicine (Jutel, 2010).

In a similar vein, Sarah talks of the lack of emotional validation she has experienced in the allopathic realm, reciting an episode where a specialist refused to take her “traumatic history” into account when treating Sarah’s physical condition. Sarah constructs her practitioners’ acknowledgement of her emotional state as central to keeping well. In conjunction, she constructs IM as a means through which she is fully recognised and supported:

- Sarah I remember a dermatologist who I subsequently refuse to see. I can’t remember what she’d asked me, but I remember saying to her that I thought that a traumatic history was involved in my condition and she basically said “how could that possibly be true?”. She knew two other women in New Zealand who had a similar situation, much less so than mine and “they hadn’t any traumatic history”. And I was kind of like “yeah you know this how?” I mean, I do think I over-react emotionally, but I do also feel that there was also a force behind her words. She just said that she felt that I’d let my physical situation take over my life and that I should just take the drugs and just basically shut up. Which was an odd thing to say given the drugs that I’d tried and what had already happened
- Helen And it doesn’t sound like there’s any form of validation of how you’re feeling?
- Sarah The opposite
- Helen Whereas you’re obviously given, well it sounds like, you’re recognised at a different level in somewhere like the “X” Health Centre
- Sarah Oh absolutely. And it makes a huge difference to me. I mean I was quite concerned as to how I’d get through the Christmas period having less access to my support system

In this excerpt, Sarah construes the neglect and abuse she suffered as a child as central to her physical condition. However, constructing emotions as being central to illness, and viewing one’s emotional self as causing physical ailments can be problematic. In constructing emotional crises as a predisposing factor in her illness, based on past emotional trauma or circumstances over which she has no control, Sarah engages with the notion that her physical problem is extremely deep-rooted. This understanding functions to perpetuate the need for her practitioner to explore Sarah’s psyche, spirit and emotions to a greater degree. However, within the realm of IM, it is through patients’ subjective states being acknowledged, and through on-going attempts to locate the “root cause” of illness that patients’ conditions become legitimated as ‘real’.

Patients’ incorporation of the environment in which the IM practice is located is also an important part of claiming the position of a ‘normal’ citizen. For example, Jo constructs Clive’s practice as a place of healing rather than a place of sickness. The books on Zen and

other material objects in Clive's consulting rooms that Jo refers to reinforce her understanding of Clive's practice as a place of healing. Bill, a man in his 70s with arthritis, also talks about the feelings of calmness and relaxation that the atmosphere of Clive's practice invokes:

- Bill It's very relaxing. I think the whole place is laid out to soothe. You go into his driveway and he's got a little fountain bubbling, a little Buddha in the corner and that sort of thing. It's quite relaxing. And the room is not unlike this, nothing sort of jumping out at you
- Helen So you feel kind of relaxed
- Bill Classical music, just in a low register

Constructing the IM environment as a place of healing and relaxation enables the patient to claim an alternative identity to that of the biomedicalised patient in orthodox medicine; the person who visits such a place is connoted a subjectivity that is distinct from the patient who visits a GPs surgery. Bringing space or place to the foreground, along with the material objects that add to the social and cultural inscription on that space or place, and thus imbuing it with meaning, is another dimension of how "being is accumulated" (Noble, 2004). As McCreanor et al. (2006, p. 198) suggest "feelings for and about places are connected with identity because places potentially symbolize aspects of how we define ourselves".

It has been argued that doctors' interpretation of patients' health and illness journey, via clinical notes and the patients' medical history, creates a patient who becomes a product of the medical gaze. However, even though the patient is, in part, constructed by medical discourse, the patient is an agentic being (Porter, 1985). Patients in the current study demonstrate agency through the discursive work they engage in. Through patients constructing the IM practitioner-patient relationship as collaborative they are able to move away from the position of the biomedicalised patient. And, in constructing themselves as unlike the typical allopathic patient, they are able to position themselves as 'normal' and deserving of ongoing healthcare. Thus even in the face of continual tests and treatment, patients with chronic and contested illness are able to resist the pathologisation that becomes attributed them due to their illness not being medically recognised or their pain being considered other than 'real'.

The integrative medicine practitioner: A professional to trust

Patients construct the IM practitioners they consult as different from allopathic and alternative medicine practitioners and contrast IM practitioners with both these types of practitioner. As alluded to previously, patients talk of a lack of faith in biomedical practitioners and ridicule and stereotype alternative practitioners. Patients also display a distrust of allopathic medicine and display scepticism of alternative medicine through alluding to the lack of credentials held by many practitioners in this realm of healthcare. They also construct both allopathic and alternative practitioners as engaging in practices which have the ability to damage health. Through such discursive work they elevate the status of the IM practitioner who is constructed as open-minded and all knowing; knowledgeable of practices that have been refined over hundreds of years, but also knowledgeable in terms of having a scientific understanding of the body. The dual paradigmatic knowledge-base, and practices that stem from this, allow patients to hold IM practitioners aloft in terms of their professional status. Patients construct IM practice as based on treatment that is ‘offered’ rather than prescribed. They also construct the language employed by practitioners as accessible due to the practitioners’ ability to translate the knowledge-base of one paradigm of medicine into an understandable framework within the other. In doing so, patients construct IM practitioners knowledge as superior to GPs or alternative therapists. Concurrently, they legitimise their own engagement in this emerging form of healthcare as reasonable and necessary, as IM is constructed as healthcare that is less likely to damage health, and moreover, a means to gain better health.

However, these IM patients also face a contradiction that arises through their scepticism and distrust of allopathic and alternative medicine practices outside the sphere of IM, and in the case of allopathic medicine, the evidence-base that underlies it. In order to overcome this contradiction, patients tend to redirect their faith from the IM treatment they receive to the IM practitioner. Patients’ faith in the IM practitioner is indicated in multiple ways. Patients claim that trust in the practitioner is built over time and through a series of successful steps, transitions and outcomes in the treatment journey. The practitioner’s perseverance is construed as central to this. Ben, in his early 40s, who suffered a severe physical injury some years ago, refers to Jenny’s perseverance when stating: “when everybody else gave up, she continued...she doesn’t give up”.

Patients construct the practitioner's integrity as central to the development of a trusting practitioner-patient relationship. For example, in the following excerpt Jo refers to "knowing that it's OK", in this case to open up emotionally to her practitioner. However, Jo also constructs her role in the relationship as bound up with revealing a lot of personal information about herself:

Yeah, which is kind of a disarming thing as well because you feel like you've got nowhere to hide coz you've got these big walls up and someone's coming in who's like "right what else is going on?" And that is quite alarming, but in a good way though, you know that it's OK

It is the scientific underpinning of the IM practitioners' knowledge and their Western medical training that appears to form the bedrock from which patients' trust and faith in the practitioner is established and maintained. This reflects the hegemony of biomedical and scientific discourse and the truth status granted to such knowledge. For example, to Kim, a woman in her 50s who regularly visits Sandra, a practitioner of nutritional and anti-aging medicine, it is by drawing on Sandra's training and qualification as a "scientist-practitioner" and having a professional membership that Kim legitimates her faith in Sandra's ability:

Helen How do you understand complementary and alternative medicine?
Kim Oh I just feel it's got a role in helping people to become well or stay well. It has to. But it would be best that that health intervention is done by a suitably qualified person
Helen Right yeah
Kim Who actually knows? I mean I'm not sure about dieticians and nutritionists, how they're trained and I don't know whether they've got a professional body, I've never sort of needed to look into that
Helen Yeah, but you are reassured that the person has that training?
Kim Yeah, I'd want any holistic health person to be qualified as a scientist-practitioner. Because science is so vitally important and science is not disputing anything that the holistic doctors say. Science is right where they're practicing, right at the hub of scientific development isn't it?

Similarly, Bill constructs alternative practitioners without medical credentials as unprofessional and as lacking integrity as they are held to engage in dubious treatments which are potentially unsafe and thus may pose a risk to health. In contrast, when talking of Clive and practitioners like him, Bill claims to feel "comfortable that they know what they were doing", unlike other alternative practitioners who he paints in a derogatory light:

If I simply drove along the street and I saw an acupuncturist sign, Chinese, I don't think I'd go in. I have got no idea who this person

might be. I've got no idea what they've been doing with their needles

Bill, constructs Clive's "grounding" in allopathic medicine as the means by which he gains an assurance about Clive's capability as a practitioner:

Well it was more reassuring to know that this was not just somebody who would stick needles in you. He also had a grounding in traditional medicine [allopathic medicine], so I was quite, quite comfortable to do that, to go and see him

Patients construct the IM practitioners' training in conventional medicine as providing a reassurance to patients that their practitioner will not do anything "silly". Moreover, they construct the IM practitioners' biomedical expertise as a safeguard to prevent patients themselves from being "silly with things". Beverly, a 41 year old, mother of two, with ulcerative colitis encapsulates this in the following:

Well you know, some people won't go to GPs at all. They're "oh no". But no, we're not silly about it. And Jenny's the same. She'll even say "oh we're not going to be silly about this, if you need to take the medication"

Patients also construct practitioners' expertise as bound up with combining both allopathic and alternative medicine paradigms within their practice and as having the ability to translate the language of one paradigm of medicine into an understandable form within the other. However, interestingly it is the practitioners' biomedical training that is held as fundamental to their ability to do this effectively.

The practitioners' openness to both sides of medicine is a further means by which patients construct their IM practitioner as trustworthy. In the following excerpt Cath, who has been diagnosed with rheumatoid arthritis by her GP, talks of how her IM practitioner, Jenny, is open to both sides of medicine:

Oh heavens yes, she knows. "What drugs are you on Cath?" And "ah yes, that's for that and that's for that" and she said "oh I don't know about that one, so she gets out her book and she looks up and she says "oh yes and the side effects are yes, yes, yes, yes and yes". Oh no, she's very interested, she wants to know what you're on and she knows all about them. She's certainly not one-eyed and that's a huge thing in her favour as far as I'm concerned. She's very open

Cath constructs Jenny as open-minded and as actively interested in the medications she takes. Cath draws on Jenny's ability to explain the reasons for such treatment being prescribed, how the treatment actually works and the possible side-effects that it could

bring as pivotal to demonstrating competence. Cath constructs Jenny's knowledge of, and openness to, both spheres of medicine as essential as it is through Jenny demonstrating such competence that risks to Cath's health can be suitably identified. The practitioners' extensive knowledge-base and open-mindedness, and the assurance of safety this provides, which is held as lacking in other healthcare professionals, warrants patients' pursuit of ongoing IM healthcare.

Similarly, Sarah constructs her practitioner, Carole, as "all-knowing" which acts to legitimate the faith Sarah claims to have in Carole's ability. Further, Sarah claims that it is proper integrative help that saved her from becoming further entrenched in the conventional medical system which she constructs as a potential risk to health:

I wouldn't have gotten through the last year without proper integrative help. That's what I've had the last year and I had to have it. If I'd not had that proper integrative help then the degree to which I had to go into conventional medicine would have just been a disaster

By constructing conventional medicine as precipitating "a disaster" Sarah constructs the integrative help offered by Carole as the means by which she averted such. This works to legitimate Sarah's engagement in IM and functions to reinforce Carole's status as a superior kind of healthcare professional - one who, implicitly, can be trusted.

In contrast to IM practitioners, allopathic and alternative medicine practitioners are constructed as narrow-minded and as lacking expertise in terms of their ability to provide a detailed picture of health and because they do not understand both sides of medicine. Di, who has visited numerous allopathic and alternative medicine practitioners over the years, for multiple ailments, compares her experience of visiting a non-medically trained naturopath to that of the IM practitioner she currently sees:

I like the fact that they have both sides of it. One naturopath I went to I felt like I was seeing like the local witch (laughter). I mean she didn't look like it, but she had this really strange manner and I just thought (laughter), um, yeah

Here Di alludes to her scepticism of the naturopath. Later in the interview, Di constructs the IM practitioners' rigorous medical training as comforting and suggests that integrating two forms of medicine not only lessens the constraints imposed by conventional medical thought, but also enables her to engage in alternative medicine as it "makes it seem less kooky".

Patients also construct orthodox practitioners as narrow-minded by pointing to how they appear to have an aversion to alternative modes of medical practice. Bill describes some of the GPs he has visited as those who “steer away from acupuncture” and who have a “mental blockage about alternative healthcare practices”. This understanding is also conveyed by Jan. She refers to conventional practitioners as conservative and narrow-minded and as “not much interested in whether you get well or not”. In comparison, she constructs those practitioners who think “more laterally”, who are “more inquisitive” and “wanting more” as those who can be trusted. In using this rhetoric Jan constructs IM practitioners, or “alternative doctors”, as being more knowledgeable and open-minded than allopathic doctors:

So that’s another issue that you face. That most doctors interpret the results that they get in a very conservative way and the alternative doctors try to interpret that in a much more interesting way and a much more knowledgeable way

Patients construct knowledge steeped in history and practices embedded in the past and honed down over hundreds of years as constitutive proof of effectiveness. Such talk functions to lessen the importance attributed to EBM and works to legitimate patients’ claims to having faith in some of the non-biomedical practices in which their IM practitioners engage. This is exemplified in the following excerpt from Jo:

You actually want someone that has an understanding of physiology. Because they’ve had to go through med school and all those exams and there is a lot to be said for that. Even though I’m completely willing to go, you know I’ve talked about going to Tohunga and things where it’s really ancestral knowledge that’s passed on. But for some reason, I’ve got more faith in that than someone who goes and does a diploma in naturopathy or something.....And actually one of the things, linking back to that Tohunga and how their knowledge is passed on, Clive’s knowledge was of Eastern medicine and that’s passed on and that’s got much longer history than Western medicine. I remember thinking that it’s embedded in the past and it’s been honed down over, I think probably hundreds and hundreds of years, compared to our Western medicine which is actually relatively new. So that gave me more faith. Even though it’s crossed over into the medical world now, if I was Chinese I would probably be getting that as my standard of care

Jo talks of how important it is for practitioners to have a full understanding of the body and Western medical training, referring to the rigorous medical training that doctors engage in as a valid means by which practitioners gain a full understanding of physiology. Jo also talks of engaging in Rongoa, a Māori healing system in which knowledge about practice is verbally imparted by the practitioner to successive generations of healers. Jo attributes

more credibility to knowledge that has been gained over generations, and in doing so, constructs this as more trustworthy than Western medicine. In comparing practices that are based on knowledge accumulated and refined over years, Jo elevates Clive's status as he is someone who practices both, and minimises the credibility of naturopaths, who merely "do a diploma". However, such rhetoric also acts to undermine or destabilise the hegemony of scientific evidence, and GPs' status.

Not only do patients discredit conventional medicine, but in pointing to the limitations inherent in this realm, biomedicine and biomedical science are held as untrustworthy and limited in their ability to test, diagnose and treat illness effectively. In parallel, allopathic doctors are held as closed-minded. The patients' discreditation of orthodoxy indicates a resistance to the medicocentrism within biomedicine. Medicoentrism is held to be an implicit feature of biomedicine which fails to recognise the moral life of patients (Frank, 1997) and the meanings patients ascribe to illness, giving rise to a patient who is "a medical construct rather than an entity in its own right" (Condrau, 2007, p. 529).

Within the IM practitioner-patient relationship the IM practitioner is constructed as more credible than allopathic or alternative medicine practitioners. Patients construct IM practitioners' knowledge of both allopathic and alternative medicine, and their dissemination of such to patients in ways they can understand, as a credible display of professionalism in which patients can trust. In contrast, patients' construct allopathic and alternative medicine practices outside the sphere of IM as potentially risky to health. This acts to legitimate the patients' engagement in IM and the non-biomedical treatments in which they engage.

The integrative medicine practitioner-patient relationship

Patients construct the IM practitioners' exploration of the mind, body and spirit, through which they attend to the 'whole person', as signifying a more in-depth relationship. The practitioners' focus on the underlying reasons for ill-health and investigating the origins of ill-health or the "root-cause" is talked of as being especially important. In contrast, patients construct their relationship with GPs as superficial, with the GP constructed as merely wanting to relieve symptoms. Through taking up the holistic discourse the patients' accord importance to the practitioners' ability to understand who you are as a person in addition

to how you are physically. Patients talk of this as crucial to the efficacy of the treatment offered. This is exemplified by Jo:

When I went to see him the thing that struck me was how he sat down and just talked to you and tried to find out who you were as a person, what was going on for you, where you've come from. And now I would understand it as kind of a psychologically orientated approach where you are thinking about how the person is spiritually and physically and mentally as well, instead of just looking at that one aspect. So it was really good. And when I went there, just having that connection with the doctor I just, I honestly just cried and it was really good coz he actually listens to you and understands you

IM patients construct the practitioner-patient relationship as consisting of good rapport. Furthermore, patients' construct the trust engendered through the relationship they have with their practitioner as essential to them taking up the alternative types of treatment offered. Ben exemplifies this in the following:

I have a really good rapport and relationship with Dr Barker [Jenny]. I have to trust somebody, before I will allow that type of impact

Patients claim that their engagement in rapport building with the practitioner ensures that a trusting and "really honest relationship" is established. Not being "afraid to hold things back" is held as an important means by which this connection is established. Thus patients draw on a holistic discourse to construct "being open" with the practitioner as a key aspect of their role within the IM patient-practitioner encounter. Patients refer to treatment as involving "talking things through" and "exploring options". An important part of this is referred to as the practitioner taking the patients' emotional and psychological states into account which are apt to get distorted:

Someone like that that will listen and actually explore options with you and will actually not just see the physical symptom, but there's also an emotional side. Like when you're really crook [ill] you don't see things that you do when you're one hundred per cent fit, right? Things can get distorted. You're thinking "why is this happening?" "Is it related to the condition?" And sometimes it is and sometimes it's not

As discussed previously, public trust in general medical practice has eroded somewhat and notions of medical professional identity have been challenged. In parallel, professional competence has become associated with abstracted knowledge rather than being understood as a tactile craft (Nettleton, Burrows & Watt, 2008; Brown, Alaszewski, Swift & Nordin, 2011). However, patients' trust not only stems from practitioners' display of

competence in terms of exhibiting expertise in the form of medical knowledge or by performing accurate diagnosis, but also through embodied interactions. In the current study, IM patients construct practitioners' non-verbal communication and actions, especially the empathy and compassion they demonstrate, as vital aspects toward building or undermining trust. This was similarly noted by Brown et al. (2008), who in drawing on data from interviews with cervical cancer patients, found that practitioners' verbal communication and non-verbal presentation enhanced patients' trust in the practitioner's competence and assured them of practitioners' ability to provide continuity in terms of delivering a future agenda which placed patients' interests at the forefront. Similarly, Sinding et al. (2010) who interviewed women with breast cancer found that women held physicians' intuition more highly than their ability to offer statistical probabilities in relation to treatment options' effectiveness. Reflecting the findings of Sinding et al.'s study, patients within the current study construct their healthcare needs as relationally-based. To these patients efficacious care is constructed as being demonstrated through practitioners' empathy and compassion towards patients, by taking the time to listen and encouraging patients to express themselves fully. This suggests that "authority resides not only in knowledge but in the trust engendered by compassion" (Tauber, 2002, p. 188).

It is through the patients' trust in the practitioner that a deeper level of engagement becomes enabled within the practitioner-patient relationship. Patients refer to the depth of their engagement with their practitioners as fostering emotional resonance between the two. It is also apparent that patients draw on a spiritual discourse when talking about the treatment they receive as they refer to treatment bringing about emotional and spiritual changes. For example, in the following excerpt, Ben describes how the acupuncture treatment he receives works to "lift the spirit":

I've been in there depressed because I've been so sick, feeling so sick and feeling rock bottom and she's put some needles in at different points that actually lift, she says to lift the spirit. So it's the treatment there as well that does that

The emotional resonance fostered within the practitioner-patient relationship also functions to encourage patients' to reveal personal information to the practitioner about any emotional difficulties they are facing. Thus the exploration of patients' emotions, which are held as a possible factor in the manifestation of their illness, become an integral aspect of IM practice. That patients' hold illness as psycho-spiritual in origin is apparent in their talk. For example in the following, Jan links her current ill-health to her emotions,

particularly the frustration she has had to endure over the years because of her matrimonial separation:

I can't do anything about the fact that I had to spend thirteen years fighting to get my money out of my ex-husband. You know, I can't do anything about that. All I can do is deal with the results, the end result

Here, Jan alludes to “the end result” in reference to her poor state of health. Jan constructs the emotional turmoil she experienced over this time as contributing to her physical ailments.

Patients' claim that understandings of this psycho-spiritual-physiological link arise from the ideas promoted by the IM practitioners. In the following excerpt, Ben states explicitly that his practitioner's view is “you make yourself ill”:

She's quite often said you can make yourself ill. That's why she stops the chattering, and the writing of the stories, because I've done it, and I suppose most of us have done it. You know you've just wound yourself up for no reason. You know “what ifs”, as soon as I say that she comes down on me like a ton of bricks (laughter), really does. Not, just “we'll stop that” or “we'll change that”, you know, really not forcefully said, but pointedly said “we won't have that”. Sometimes she's said to me “we won't have that”

Ben has come to hold his mindset and thought processes as central to his malaise. He constructs ‘thinking in the right’ way as essential to overcoming illness and keeping well. For example, Ben claims that it is through engaging in the rational work of controlling his “mind-chatter”, that he can enhance his physical wellbeing:

I've had to change my behaviour and I don't mean that in a negative context, I just mean that in a literal context. And how I think about things. One thing is stopping the mind-chattering, especially when you're crook because that takes up a lot of time and space. It's just one skill, one tip she's given me help to do. So that has been really, really important

Furthermore, it is Ben's “mind-chattering” or mis-thinking that is implicated in the development of illness. This understanding makes the practice of the practitioner exploring Ben's psyche, in order to ascertain the deeper meaning behind his illness, seem reasonable.

That patients' come to understand their thoughts and emotions as linked to the manifestation of illness can be detrimental to patients because the reason for illness developing becomes embedded within the individual, thus detracting from social structural factors being implicated in illness. Further, exhibiting ill-health becomes potentially

problematic to patients as it can be held to reflect emotional dysfunction. And in contrast, having the ‘correct’ emotions predisposes one the power to heal. This understanding may have negative connotations, especially for those patients whose biographical narrative may have been fractured by the advent of chronic illness or through not having had their illness medically recognised. Further, rendering such “mind-chatter” or unruly emotions, such as anxiety, as problematic has further repercussions. That is, talk of the mind affecting the body works to grant the mind, and rational thought in particular, a superior status.

Hughes (2004) suggests that within the realm of CAM, health and illness become connected to “individuals’ ability in areas such as emotions and mental balance, interpretations of physical state and physical pain, and the somatisation of emotional distress” (p. 38). This is reflected in the findings of the present study. However, this understanding is paradoxical to the philosophical underpinning of holistic medicine and suggests that instead of taking the whole person into account, the practice implicitly breaks the person down into the separate parts of mind and body, granting the rational mind supremacy over emotions.

Consequently, because there is so much focus on the psychological, spiritual and emotional dimensions of the patient in the practitioners’ quest to find the “root cause”, the body remains relatively absent. This suggests that a mind-body dualism is continuously invoked within IM and lends credence to the view that the holistic model of medicine merely shifts the location of mind-body dualism rather than replacing it (Scott, 1999). Further, although the practitioners claim the use of a holistic healthcare model, in order to find the “root cause” of illness so as to treat the (whole) person effectively, this accentuates the possibility of the patient being pathologised. Thus IM patient-centred care and the heightened attention on patients that comes with it, inadvertently positions the patient as potentially culpable for illness. Paradoxically, although patients’ construct the deeper level of engagement in the IM practitioner-patient relationship as beneficial because such a relationship engenders trust and openness, the opening up and exploration that becomes a key part of treatment may not ultimately be in patients’ best interests. Moreover, it detracts from an emphasis being placed on the efficacy of a particular mode of treatment or the competency of the practitioner. This suggests that modes of medicine with a clear evidence-base, and whose efficacy has been ‘proven’, may work in the interests of patients in that they nullify the blame that may be attributed to patients.

Integrative medicine treatment: Holistic medicine and responsibility for health

Patients talk of holism as implicit in IM practice and draw on it to differentiate the treatment they receive in the IM sphere to that in allopathic medicine. In general, IM patients construct holism as beneficial to achieving a greater understanding of their health issues, but some are also critical of the implicit individualism that underlies holism. Patients' draw on the discourse of holism to differentiate the IM practitioner from allopathic practitioners and suggest holistic medicine allows the practitioner to take account of their whole being. Patients also refer to the holistic model as granting them more responsibility in terms of control over their healthcare.

When patients were asked to describe the practice they experienced and the treatment they received, holism was frequently mentioned:

Well, a more holistic practice I suppose - although I don't really know what that word means. But I guess just, yeah looking at the whole person, looking at the whole picture, looking at you on all your different levels, not just your physical level, but your emotional level as well

Patients talk of holistic medicine as something that “doesn't separate you from your body” and as “treating the whole body”, “the full body, not just treating parts of the body”. However, the holism discourse is also drawn on by patients to construct their whole lifestyle as potentially implicated in health and illness, making illness a nebulous concept with a difficult-to-define aetiology. This also works to construct risks to health as hard to define, yet potentially ever-present.

Patients' talk of the wider perspective offered by their IM practitioners and how the practitioners' holistic orientation to practice affords them more treatment options. For example in the following, Di, a woman in her 30s, talks of how James frames the contraceptive pill in a holistic rather than a medicalised way and in doing so constructs James as unlike her GP who Di suggests provides her with only one option:

Di When I went to see about contraceptive options I was really intrigued that he was really recommending the IUD with the hormone in it. So the hormone is being released just at a very localised point, rather than taking the pill which is putting hormones all over the place. And so the IUD to me is a really medical kind of thing, but he seemed to be a great fan of it, so I found that really interesting

Helen Yeah

Di But at the same time, he was sort of talking about contraception in a more holistic way than just my doctor who says “here's the pill, why don't you try it and see how you like it?”

The holism that underlies IM healthcare, and the philosophy the IM practitioners consequentially espouse - that allopathic medicine is superficial in comparison to IM and thus cannot offer the in-depth exploration necessary to find the “root cause” – reinforces the importance of more extensive testing and assessment.

For example, in the following excerpt, Di constructs her practitioner’s ability to provide a whole picture of health as important, something she suggests is lacking in orthodox medicine:

Di And if something’s wrong then they’ll tell you this, but it’s not like a whole picture of your health. So it was cholesterol and hormones and everything

However, ironically, framing the provision of “a whole picture” of health as important actually perpetuates a need for more tests to be carried out, thus increasing the number of medicalising practices that patients’ may themselves deem it necessary to engage in. It is in this way that patients are held to contribute to the construction of their own medicalised identities (Rosenfeld & Faircloth, 2006). Moreover, the need for patients to obtain a whole picture of health is a practice which becomes reproduced through IM.

However, some patients demonstrate resistance to taking up the position afforded them through a discourse of holism. Such resistance is indicated in this excerpt from Jill in her response to a comment I make about compassion in the CAM or IM realm:

Helen Yeah, because one would imagine there would be more compassion in that kind of realm
Jill That’s what you would expect and there is, but it’s often at a very abstract, universal level for humanity, and it doesn’t necessarily translate to the individuals
Helen Do you think that’s bound up with this notion of holism?
Jill Yeah in some ways. Maybe it’s something to do with the individualism of that model or the implicit individualism of that model in that practitioners seem to be so kind of bound up in their own personal journeys, as individuals, that even though they’re ostensibly helping others with their journeys, at the end of the day what they’re doing is actually very self-centred, and it’s all about them in a way, yeah. Yeah, you just get that those people have this real hands-off thing, unless you’re a person that shares the exact same beliefs as they do. If there’s any differences they keep you at arms’ length

Jill talks of the implicit individualism of the holistic model and indicates an awareness of how holistic treatment is founded on a set of beliefs which patients are encouraged to share. Jill’s talk highlights how *not* taking on the philosophy of the practitioner can

problematise the collaborative relationship. In drawing on this understanding she constructs patients' acceptance of the underlying philosophy espoused by CAM and IM practitioners as necessary in order to ensure the practitioners' full engagement in the patient-practitioner relationship.

Within IM, a move away from EBM to an holistic orientation to treatment enables an exploration of a multiplicity of treatment options. Also, because treatment goals are not always specified and the efficacy of the treatments offered by practitioners are not considered, in part due to the individualised nature of alternative medicine practice, treatment experimentation becomes accepted and legitimated (Sered & Agigan, 2008). Thus personalised treatment, a primary reason people engage in alternative medicine, and the 'trying what works' approach that is thought to afford patients agency and feelings of control (McLean, 2005; Sered & Agigan, 2008) may in fact lead them to pursue a raft of different treatments in order to find out which, if any, work for them.

Within IM, patients indicate a willingness to engage in experimental practises and treatments they construct as "spacey", "weird" or "not an exact science":

Jo We did a lot of acupuncture and some other things. Like he gave me some injections of magnesium, which were a bit weird, but he was very much like "OK I've heard this can be helpful for some people, let's see if it works"

Jan Everybody's different and what works for you, won't work for me. So if you think about it in those terms, muscle testing makes absolute sense. You know that you can determine things in different ways. There's an awful lot to it and understanding how it works and against what, is a major area. I don't understand how it works. I mean I sort of follow it, but I don't really know. But using that tool, Tony was able to tell me that there were lots of things, bugs, toxins, whatever, in my system that we needed to remove and we'd do that homeopathically

In the latter excerpt, even though Jan, a woman in her late 50s who suffers depression and chronic fatigue, indicates an understanding of homeopathy, her understanding appears to be limited. Jan negotiates this contradiction by using a circular rhetoric to justify Tony's practice (Tony is another IM practitioner that Jan visits). Jan suggests that it is only through the use of such a tool that an assessment of the amount of "bugs" and "toxins" in her "system" could be made. Through this discursive work she avoids being positioned as a person who engages in risky, scientifically unsubstantiated treatment which sounds

“spacey”, and instead positions herself as engaging in a valid treatment with which to eliminate the toxins that pose a risk to health. However, despite Jan’s claims to a degree of knowledge in this area, she becomes positioned as relatively uneducated in comparison to her practitioner, regardless of all the information sharing that she claims to occur between herself and her practitioners:

All these unknown factors and you just never, you know, you just never really know. I mean all my doctors share results. And I tell them, I mean they all know each other and I share everything with everybody. There’s no “we don’t go in for that, this is my area and you’re not going to do that”. And so that’s the way that you do it. But it’s almost a full time job, I mean, to deal with all of those sorts of things

Jan refers to “all these unknown factors” and “never really knowing” which suggests she has no clear understanding of whether the treatment she receives is effective. Jan also positions herself as responsible for managing her healthcare. She alludes to how she ensures all the healthcare providers she engages with are informed about the multiple treatments she engages in. Further, she refers to the healthcare management role she takes on as “almost a full-time job”. Such talk indicates Jan’s preoccupation with monitoring her health. Jan’s lack of knowledge, in combination with her sense of responsibility to manage her healthcare, works to create a precarious subjectivity. This suggests that the discourse of empowerment that is taken up within IM creates a conflictual space for patients. The responsibility that becomes granted patients produces an increased preoccupation with health, but leaves them in a space where they have no certainty about how to safeguard and maintain health effectively.

However, even though patients claim a lack of understanding around how treatment works, the experimental practices the practitioners engage in are deemed appropriate. This is exemplified in the following excerpt from Jo:

Yeah, like at one point he was putting needles in my ear and left them there. Like these little wee ones that were like a couple of mil long. And he put them in my ear and taped them on because the ear connected somehow to the back, and left them in. And again it was like “we’ll see how this works, this may give you some relief or it may not and we’ll see how it goes”. So it wasn’t really that whole setting you up with really high expectations. And yeah, I was reasonably open to that as well, coz I thought “well let’s give it a go, see what happens”. Yeah. But that’s probably been the one thing that has really helped heaps is the acupuncture, but probably the more direct ones where they’re putting them into your back where it’s sore

Jo talks of being “open” to the experimentation that Clive engages in even though such treatments are not underpinned by biomedical science. Experimentation and the “see how it goes” approach to treatment become legitimated because the emphasis of such treatment ties in neatly with liberal humanism and empowerment discourses. These work to construct the patient as a unique individual, deserving of a personalised healthcare approach in which multiple treatment options are available for them to choose from. Furthermore, treatment efficacy within IM is constructed as bound up with patients’ finding meaning in their symptoms and feeling a sense of subjective wellbeing. It is because treatment efficacy within IM is constructed differently from that of EBM within biomedical discourse, which is bound up with the eradication of symptoms and curing disease, that the practitioners’ exploratory approach becomes warranted.

Such experimental practice is arguably validating to patients, particularly to those like Jo, who have a chronic or contested illness and who visit multiple healthcare providers in their quest for diagnosis or cure. For such patients, the ‘trying what works’ approach demonstrates practitioners’ belief in the patients illness as ‘real’, rather than psychogenic. This is because their continued attempts to rectify patients’ maladies also work to substantiate the maladies as ‘real’. An emphasis on the ‘trying what works’ approach also lessens the importance of diagnosis because it is largely bound up with the patient feeling better. Clive’s dominant position within the IM practitioner-patient relationship is also enhanced through being afforded a vantage point in which his holistically-oriented interpretation of Jo’s underlying malaise becomes legitimised.

Patients talk of the IM practitioners’ orientation towards a more extensive assessment in positive terms. They construct the extended toolkit they have at their disposal as enabling them to weigh up treatment options themselves. Patients also claim enhanced knowledge about treatment and a greater understanding of what mode of treatment is needed in which circumstances. This is exemplified in the following excerpts:

Sarah I’ve got a whole toolkit now

Helen Yeah, yeah. So do you see the toolkit, that’s a nice idea, that that’s part of what you feel you’ve got now?

Sarah Yes

Helen And you’ve got various tools that you can use?

Sarah I do. I mean as I say, the various things, the various herbal medicines that Carole has given me that I use at various times. Various nutritional support and stuff. Most of the toolkit has come from Carole. I mean I do think of what she’s given me as a

them as a certain type of patient can be problematic for patients. Sarah alludes to this in the following:

I see illness as coming about through a toppling over of those systems. You know you've got emotional, physical, psychological, and when the stresses build up to a critical mass, either in one, or, I mean it's never just one you know, there's a mix, at some point you topple. And I think if you want to reverse that topple you're gonna have to get involved with all of those things. And so to me, that's where the recipe comes in. I mean even though there's recipes in individual areas, like physical recipes, but for me, it all comes together. What am I strong enough to do emotionally? What time of day do I have to do it according to my psychological health and according to physical health, fatigue and things like that? It's all working together to allow my body to get back through that bottleneck situation and get to the place where all the different physical symptoms can start to function better and support each other so the overall health level goes up

In drawing on a holism discourse, Sarah conveys an understanding of her body as multifaceted, a highly complex system and alongside this, a notion of health comprising multiple elements which if not balanced correctly can topple over at any moment. Sarah claims that Carole, her practitioner, takes on responsibility for her healthcare. However, Sarah's talk suggests that she herself has to monitor her health closely as she is aware of the fragility of the 'system', and how it is ultimately down to her to get the recipe right.

Patients allude explicitly to the increased sense of responsibility they experience in the realm of holistic healthcare. For example, when Kim was asked where she believes responsibility for health lies, she explicitly stated that in allopathy "the doctor's got the responsibility" whereas "in holistic healthcare you have the responsibility". The level of self-responsibility for health is also referred to by Jan:

You know, I mean I go to a physiotherapist sometimes because I have this pain in here (touches back of neck), and he was saying, he said "I can't understand why your muscles are so tight unless there's a toxic load in them". So that is another little bit of information. What is a toxic load? Where do you? How does that? What could we look for in here that could be a toxin that could be in the muscles which means that they don't relax properly? They're always really tight or they're really inflamed or they're really something else? So it's a massive jigsaw puzzle of reading and talking to people and following up any little lead, anything that anyone can suggest and then doing, you know what you can with it

Jan's talk conveys that she juggles a multitude of understandings about what factors could be contributing to her ill-health and appears confused about which treatments might be

beneficial to her health and the reasons as to why. She refers to an array of treatments that could help alleviate pain and the troublesome bodily symptoms she experiences. However, Jan's understanding indicates that her body remains fragmented. Therefore the holism that is taken up within IM does not appear to repair the fragmentation that occurs within the biomedical sphere in any coherent way. Furthermore, finding the correct treatment for each aspect of the 'whole person' becomes a complex, time-consuming and anxiety-provoking task for the patient themselves.

Therefore being positioned within a discourse of holism opens up many possibilities to patients around what could be causing illness but also runs the risk of reifying these at the individual level if situational or structural change is not taken into account. This predisposes patients to experience a heightened degree of responsibility for safeguarding their health. Further, in understanding the 'whole' as operating at different levels (mind-body-spirit) which interact with each other, one's 'self' becomes constructed as comprising a highly complex system. Moreover, the factors that contribute to the onset of illness, and how to remedy it effectively, remain ambiguous, particularly hard to treat illnesses like chronic fatigue, as the patient never really knows which aspect of their mind-body-spirit is contributing to the manifestation or continued presence of illness. The patient therefore remains in a state of confusion as is demonstrated in the excerpts above.

This highlights how individualism is inherent in holism. The subject that holistic discourse constructs is a *whole individual*, which assumes a view of the self as an autonomous being and fails to account for the relational nature of people's emotions and life experiences. However, it is important to take the relational nature of people's experiences into account as wider relationships have an impact on how illness is experienced and understood by patients. For example, CAM cancer patients who maintain a positive approach to their treatment trajectory talk of how performing positivity feeds into the needs of family and friends, but also speak of these as "illusory performances" that the patients said they could not "continue to enact in an unrelenting manner" (Broom, 2009, p. 81). Relationships have also been shown to be influential on adjusting to living with illness (Radley, 1989) and are central to health promotion strategies that have used peer support to promote people's engagement in health practices (Lhussier & Carr, 2008). As Dahlberg, Todres and Galvin (2009) suggest:

“We are not separate from our concrete engagements with the world or with others and this announces limitations and vulnerabilities about what we come up against: the facticity of our finitude or death, the fragilities of our bodies, the vicissitudes of existing (or, living) in a particular time, place, culture and language” (p. 267)

Thus the disciplinary effects that individuals’ engagement in IM produces, such as self-responsibility and self-actualisation, are not achieved autonomously with only the self in mind but are bound up with what individuals are working to achieve in relationship with others.

Health, illness and wellbeing

It is through a healthism discourse that individuals become positioned as morally obliged to take responsibility for health and illness. Within this discursive framework health and illness become moral choices and it is through engaging in unhealthy practices that a person becomes positioned as at risk of, and culpable for, illness. Having too much stress, or not dealing with stress well, or not eating properly are constructed as risk factors and become insidious daily concerns which people come to understand through a morally-laden health-framed lens.

That patients are positioned as culpable for illness is evident in the present study. Patients construct illness as something “we cause”, as being “in your head”, as “dis-ease” and as being the result of “a lack of balance and a lack of ease”. This implicates one’s thinking as bringing about illness, and is a construction that IM arguably reproduces. Furthermore, that the patients’ lifestyle is held as problematic can precipitate them feeling compelled to enact change. Ben stated this explicitly: “I had to change”. This ties in with Sered and Agigan’s (2008) view that “holistic sickening is a necessary precursor that gives holistic healing its meaning” and how “the very holism of its etiological narratives means that corresponding narratives of efficacy tend to be vague and open-ended, leaving patients (perhaps) in a chronically holistically sickened state” (p. 628).

For patients in the current study, health also appears to become conflated with healthcare and they allude to having a greater means by which to take responsibility for health and healthcare. This is apparent in their construction of health as a moral choice, in which they talk of health as being “something that’s achieved”, and as about “looking after yourself”.

Patients also claim that one's ability to achieve health is linked to having the right temperament and emotions and "keeping your immune system up high". However, previous research has noted how individuals work to resist such moral positioning. For example, Bolam, et al. (2003) revealed how claims to positive thinking in tandem with acknowledging limited control over health due to structural factors, enabled low SES individuals to negotiate "the moral imperative of responsibility for health" when placed in adverse circumstances (Bolam, Hodgetts, Chamberlain, Murphy & Gleeson, 2003, p. 15). Similarly, Hodgetts, Bolam and Stephens (2005) noted how individuals drew on notions of 'living for the moment' and 'health as balance' to negotiate the immorality that becomes ascribed them through engaging in unfavourable practices according to a wider healthism discourse.

In the current study, patients demonstrate resistance to healthism discourses and to being positioned as immoral or personally culpable for illness. Patients are shown to negotiate the immorality ascribed them in numerous ways. First, they draw on biomedical discourse to construct health and illness as biologically determined. Patients claim to have an "inbuilt resilience to illness" and claim that health and illness is bound up with one's genetic inheritance: "it's your genes too, what you were born with". This is evident in the following excerpt in which Jan draws on a notion of biological determinism and natural selection to suggest that chronic ill health is a result of the "stock of human beings" being "less robust than it used to be":

Now, you know, some people will have a strong constitution. They will roar through life, be able to smoke, drink, take drugs, whatever and will still go out with a hiss and a roar at 94 or something. Some people barely get, you know, they crawl into life and struggle all the way through. And so we all come with a different constitution. I think one of the reasons why we're seeing so much chronic ill health now is because basically the stock of human beings is nowhere near as robust as it used to be

In drawing on a discourse of biological determinism, Jan resists being culpable for her own illness and thus works to negate responsibility for the "problem" of her depression:

And that's because of the psychological factors. And I know that when I'm feeling depressed, it can't be the clinical depression, because the drugs are the same. It's my reaction or how I deal with the life events. So that was just in my case. I came, if you like, with that little problem

However, although Jan alludes to being at the mercy of certain psychological factors that may precipitate feelings of depression, she also frames it being as a result of her "reaction"

and how she “deals with life events”. This indicates that Jan finds it difficult to move out of a position of blame.

Second, patients resist being positioned as immoral by constructing health and illness as having a spiritual origin that lies beyond their control. For example, they draw on understandings such as “life is karmic”, and life as being “about taking chances”. They also point to environmental conditions as contributing to illness. Ideas around “the environment having worked on us” and the change of seasons contributing to illness are evident in the talk. Furthermore, patients construct people as being “pre-disposed to certain things”. However, because one’s philosophy of life is constituted as bound up with health and illness, resisting the position of being culpable for illness is problematic. For example, in the following excerpt, Gloria constructs physical health or illness as bound up with one’s philosophical orientation and refers to the importance of using the accumulated knowledge gained from previous disease experiences in order to maintain health:

It’s all in your body, in your thoughts, in your feelings and the reaction of your muscles in the past and in your attitudes made up in the first few years of life. It all adds up to dis-ease, the way you use the philosophies that you’ve learnt...It was time for me to pick up my diabetes gene, I’m sorry, it was, I don’t know exactly why – I’m truly trying to work on that. My brother picked up his in his mid 40s, our son picked up his in his mid 40s – he’s just passed his mid 40s. Um my aunts picked them up in their 80s so it’s a matter of when you’re ready to pick them up, does that make sense? When you choose in your mind unconsciously to take them up

Gloria constructs health as biologically determined and in doing so, discursively works to separate the disease aetiology she can control from disease aetiology that she cannot. The phrase “it was time for me to pick up my diabetes gene” indicates that she construes the onset of diabetes as a pre-determined event rather than one that she is personally implicated in bringing about. However, Gloria also constructs the individual as being required to implement what has been learnt, and in doing so grants primacy to the mind, which is deemed to operate at an unconscious level, to bring about illness. Moreover, even though she frames the onset of the disease as beyond her control, self-blame is apparent when she goes on to say:

I don’t know what causes it, but I know that we cause it ourselves,
in our weakest spot

That illness is constructed as located in the mind or at a spiritual level is also evidenced in a comment by Jo around how she understands illness since she started to see Clive:

Because I think it was helping me to connect that spiritual understanding of it to myself which I hadn't really thought about or experienced until I had that initial consultation, where I started to actually let go of a lot of the painful things that I had gone through, and that was really useful. Coz before then if you'd asked me I probably would've really looked at it as just being a physical thing coz I just was soldiering on and not really acknowledging how hard it was, which I guess you do to protect yourself. But it was quite good to be able to think about it in a different way

In constructing her illness as spiritual in origin, Jo is able to claim better health through “letting go of a lot of the painful things”. Through this construction Jo locates her pain outside the physical realm and instead it becomes bound up with her emotions.

The third way in which patients negotiate being positioned as immoral is by resisting an understanding of health and illness as a binary opposite. Instead, IM patients construct illness as something which does not necessarily indicate an absence of health. Through this discursive work they are able to resist the immorality ascribed them through making unhealthy lifestyle choices. This is exemplified in the following excerpt from Kim who has a hypo-thyroid condition. She refers to being well even when she exhibits symptoms that can be attributed to her illness, such as a lack of energy and tiredness, and talks of illness as being “where you're really sick and can't come to work”:

Helen So how do you understand health and illness?

Kim Illness is where you're really sick, yeah then you can't come to work, but wellness is where you come to work but you might struggle. You might not have energy to do exercise...Because everyone does get tired, everyone does have times when they can't sleep or overslept. And that's fine, but it's where it goes over and beyond a normal fluctuating pattern. I'm talking weeks or even months. Then you'd look. But other than that you just tolerate. I mean people are more and more looking for a level of functioning that is quite even, but that's unrealistic, mood-wise and physically-wise

Through this understanding patients are able to construct themselves as well even whilst having a chronic illness diagnosis. Or similarly, they can claim to have a chronic illness, but not label themselves as ill. This discursive work serves two further purposes. First, constructing health and illness in this way allows patients to resist the pathologisation attributed the biomedicalised patient, particularly those with contested illness where it's “all in their head”. Second, it allows them to negotiate the (biographical) disruption to identity which their illness brings. Such understandings may reproduce the idea that health does not reside in the body but is a communicative medium within an interactive system, neither a property of body or environment but something that flows between them (Frank, 1991).

Such a construction may thus serve to counter the hegemony of healthism discourse which holds the individual as culpable and morally reprehensible for the manifestation of illness, if they do not make the correct lifestyle choices.

However, in the current study patients' ability to resist pathologisation remains problematic. This is because although being 'unhealthy' does not necessarily reflect the presence of illness, one's engagement in what are deemed 'unhealthy behaviours' become understood as predisposing one to be more susceptible to illness. Further, health is constructed as unstable. That health is unstable was signified by Sarah, as discussed previously. Sarah talked of her health as a "balance of all these factors which can topple over" and how she feels a responsibility to keep her mind's-eye on her healthcare recipe, tweaking it as she sees fit so as to "reverse that topple". This consists of a constant monitoring of her emotions, her psychological self and her physical self. If Sarah manages to do this well then "all the different physical systems can start to function better together and support each other so the overall health level goes up". This fits with Cartright and Torr's (2005) study in which CAM patients understood treatment to have a long term impact on multiple levels (physical, psychological and social) which not only reduced primary and secondary symptoms, but accentuated general feelings of wellbeing. In the present study, it appears that if patients take an adequate level of responsibility by monitoring and working to enhance the physical, psychological and spiritual aspects of the 'whole person' then wellbeing becomes a possibility.

However, the health these patients are offered through IM extends beyond 'healthy' to 'better than healthy' or to "optimal health". Thus, in order to ensure a greater buffer against the risk of becoming diseased, patients are urged to strive for wellness or wellbeing that is constructed as "more than healthy". IM provides them with a means to become so. This is because treatment within IM focuses on finding the "root cause" of illness which involves exploring all facets of patients in order to ascertain what combination could be contributing to the illness. Previous research has illustrated how through validating patients' emotional and spiritual lives, practitioners can actually help patients to negotiate contradictory positions. However, it may also bring the body to the forefront of patients' attention and thus perpetuate practices of bodily surveillance (Sointu & Woodhead, 2008).

In the present study, constructing wellness as not necessarily equating to health has further implications. First, it opens up the possibility for “ultimate healing” to occur (as discussed in Chapter 5, p. 100). Second, medications that are used to ‘feel right’ are constructed as separate from those used to treat a ‘real illness’. Alternative medications tend to be bound up with one’s subjective wellbeing whereas allopathic medicines are used for ‘real illnesses’. This may act to perpetuate the lack of recognition that patients can experience when illness is not medically recognised, and operates to continue to give alternative medications a ‘less than real’ status. Through this understanding the placebo effect becomes acceptable. Likewise, it becomes acceptable for conventional medicine to be administered when there’s a real need, thus accentuating a mind-body separation, as is exemplified in this excerpt from Beverly:

- Beverly If I ever turned up at Jenny’s and was sick with something. It did happen once. I had the ‘flu and ended up with a chest infection and I happened to be going for acupuncture. Turned up there and she said “you need antibiotics, here’s the prescription” as well as the needling so you get them both, so there’s no mucking around
- Helen No
- Beverly There’s no “oh well we’re going to try this first”. This is the most appropriate road
- Helen Based on the realm of all the different types she has available to her. Oh gosh, that’s interesting because if you go to a lot of alternative practitioners I suppose they don’t offer that Western side of things do they?
- Beverly No she understands everything and sometimes you know it’s like “oh wow” (laughter) what’s in that little head is like just amazing

IM patients’ talk conveys that there is a moral responsibility associated with illness. However, patients demonstrate resistance to healthism discourses and to being positioned as immoral individuals, in which they become potentially culpable for illness. The patients negotiate this immoral positioning by drawing on notions of biological determinism and by claiming limited understanding of how spiritual and emotional dimensions could be implicated in illness, prior to IM treatment. Other research has noted how constructing illness as representative of an imbalance in lifestyle or within the wider network of relationships in which they are embedded rather than as individual bodily pathology that needs to be cured can be beneficial to patients (Frank, 1997). Such illness narratives are held to allow people with illness to redraw the moral maps of their worlds in various ways within the context of their relationships. Through this process it is suggested that people come to understand more about themselves and find it easier to live with illness if they understand it as morally meaningful in some way (Frank, 1997).

However, even though patients in the current study engage in such discursive work to reposition themselves from being held culpable for illness, their talk reflects an element of self-blame. It has been noted previously that incorporating CAM in one's healthcare practises plays a contradictory role in patients' therapeutic trajectories. On one hand, CAM increases patients' feelings of power, control and autonomy, supporting and meeting patients' therapeutic needs and, on the other hand, it engenders notions of self-healing and extreme positivity for health, thus precluding patients from grieving and masking the fear of dying (Broom, 2009). Patients experiencing chronic pain have also been found to be taught by their practitioners to separate mind from matter through repeated incantations of "before pain controlled me, now I control my pain" (Jackson, 1994, p. 208). Such practices not only perpetuate Cartesian dualism but potentially problematise biographical flow in that acceptance of illness, and the associated pain, may be necessary aspects of forging an ongoing coherent subjecthood, and thus a means to counter any biographical disruption (Bury, 1982) that illness brings.

Conclusion

Patients position themselves as collaborators within the IM practitioner-patient relationship, where they become open to exploring treatment options and to forging new understandings about themselves. Through the education they receive from practitioners, in the form of the IM toolkit, and the treatments it encompasses, patients claim an enhanced ability to make decisions about treatment options beyond their consultations and become responsibilised to manage their own health to a larger degree. IM also provides patients with chronic and contested illness a means by which to avert the pathologisation they are likely to be attributed in the biomedical realm, particularly those patients with contested illness, who claim that in allopathic healthcare their illness has been rendered "not real" or "all in your head". Through their engagement in IM, instead of being pathologised as 'abnormal' within a biomedical discourse, such patients are able to claim the status of a 'normal' citizen. Rather than a 'sick' person they become a person with medical problems.

Within IM, patients position themselves as individuals with spiritual and emotional dimensions in addition to physical bodies. The patient constructed in IM aligns with that constituted by wider 'psy' discourses; that is, a subject with an 'inner self' that also requires recognition. IM is also a site in which patients' previously misunderstood conditions and

symptoms become understood and deemed authentic and therefore one in which they can lay claim to and become validated as ‘normal’, rather than ‘abnormal’ citizens. The validation granted them is largely derived through their consultation with a practitioner who not only takes their whole being into account, but whose biomedical credentials and medical professionalism are certified, and thus deemed bona fide, in comparison to alternative medicine practitioners whose practises and knowledge are held as questionable.

Within IM, patients draw on the IM practitioners’ knowledge and professionalism, their biomedical training and its scientific underpinning, to construct the IM practitioner as having more credibility than other types of healthcare practitioner. This credibility is also bound up with the practitioners’ open-mindedness and their more extensive knowledge-base. Unlike allopathic practitioners, whose practices are held as limited or risky to health, and alternative medicine practitioners, who patients stereotype and ridicule, the attributes granted to IM practitioners work to construct them as a professional who can be trusted. Patients construct the IM practitioner as a trusted expert who works with an extensive therapeutic toolkit, wider than that afforded by either allopathic or alternative medicine practitioners. Moreover, the IM practitioner is understood to effectively translate understandings from one type of medicine into another, which patients’ claim to “make sense”. The discursive work the patients engage in works to construct IM as a sensible and necessary healthcare option as it provides a means to safeguard health, in contrast to other forms of healthcare which potentially pose a risk to health.

Patients talk of trust as being essential to the maintenance of their ongoing relationship with practitioners. They claim that trust is upheld through the practitioner demonstrating tenacity in terms of their desire to find the “root cause” of patients’ illnesses and through their commitment to patients’ ongoing treatment journeys. Trust is also constructed as being built through patients ‘opening up’ to the IM practitioner who can then explore their emotional, psychological and spiritual dimensions and assist them to alter any faulty thinking and ‘incorrect’ behaviours in which they might be engaging. Within this practitioner-patient relationship patients’ faith resides with the practitioner rather than with the IM practice they engage in. Through their talk, patients demonstrate commitment to their relationship with IM practitioners and ongoing faith in the practitioner, even in those instances where practitioners are held to engage in “out there” treatment practices.

In the realm of IM, health and illness become moral choices. Furthermore, striving for “optimal health” becomes an implicit requirement and a sensible pursuit as it serves as a more effective buffer against the multitude of risks to health, and a means to maintain moral citizenship. However, using the knowledge gained from practitioners about what they need to do to gain “optimal health”, or to remain healthy, becomes a complicated process which can lead to confusion and anxiety. This is because “optimal health” remains an ambiguous concept which appears to be bound up with patients finding meaning in their illness. However, patients ability to find meaning in their illness may be problematised because their’ illness narratives, which are held to allow people with illness to redraw the moral maps of their worlds (Frank, 1997), become open to interpretation by the practitioner. This arguably undermines patients’ ability to understand themselves and their illness in a self-derived way, thus potentially obfuscating their ability to understand it as morally meaningful.

IM also becomes a means by which patients are able to maintain a sense of health or wellbeing, even whilst their body is held by conventional medicine as faulty. This is because IM enables patients to claim a sense of wellness or healing on an emotional or spiritual level, even though diagnosed with a physical disease. Therefore ‘wellness’ and ‘wellbeing’ are not necessarily predicated on cure and instead become bound up with quality of life. The dichotomy of wellbeing at a mind-spirit level, whilst pathology remains at the physical level, can also operate to reinforce a dualism which appears to perpetuate bodily disappearance. Thus although IM practitioners take up a discourse of holism and a healthcare model that incorporates mind, body and spirit, through which patients are offered a potential means to seek immanence or transcendence, the body remains an object. The body in IM fades into the background whilst a focus is placed on the emotional, spiritual and psychological dimensions of patients. In that embodied experience forms the foundation on which lay knowledge and beliefs of health and illness are based, the fact that the body remains largely absent within IM acts to suppress patient’s claims to an experiential level of expertise within this realm of medicine, and thus further problematises the notion of patient empowerment.

IM practitioners’ focus on the complex mind-spirit-emotions of patients is problematic. Through such a focus patients’ gain a heightened awareness and hyper-vigilance of their mental and emotional states, particularly around how their mind, spirit and emotions are

implicated in health and illness. Patients' attentiveness to how their mind and emotions are affecting their bodily health could lead patients to have increased bodily awareness. Thus engaging in IM may encourage patients to partake in practices beyond the consulting room that act "toward the body rather than from the body" (Baarts & Pedersen, 2009, p. 724). As a result the body does indeed become "a project" (Shilling, 2003) through which individuals are able to express their identity and lifestyle choices. Shilling (2003) suggests that the body is being shaped or altered by the social, in terms of biomedical and scientific classification, and through the emphasis on the individual engaging in healthy lifestyle pursuits. She suggests that the scientific classification of the biological body in conjunction with understanding it as open to change through social factors, perpetuates a dualism between biology and society (Shilling, 2003). This is held to problematise patients' actual experience of their bodies which leaves them vulnerable to having their experience defined for them (Shilling, 2003). It could therefore be argued that the IM practitioners' emphasis on patients' making the appropriate lifestyle changes works to produce a certain type of body. However, the relative absence of the body within IM practice, along with the concomitant prescription for patients to perpetually work on health outside the consulting room, arguably increases patients' subjective surveillance of the mind, spirit and body. Therefore, rather than producing an active and empowered patient, paradoxically the patients' voice becomes stifled as their increased 'self' understanding becomes embedded within a proto-professional language.

Chapter 7

Discussion

In New Zealand IM is emerging as a new form of healthcare practice and is located at the crossroads of two paradigms that are philosophically diverse. Little consensus has been reached as to how IM is defined and understood or as to what IM represents. However, IM is imbued with political and cultural meaning (Fries, 2008), with contestation around whether its emergence constitutes a process of ‘mainstreaming’ (Coulter, 2004) rather than a partnership or merger between the two paradigms.

This thesis has provided insights into three key issues that are central to the emergence of IM. First, it has shown the complex ways that practitioners and patients are positioned within and by IM. In particular, the thesis demonstrates how the reprofessionalisation in which practitioners engage, in order to reconstruct their own professional identity, has implications for patient subjectivities. Second, the thesis has identified how practitioners resolve the paradoxical position in which they are placed. This resolution entails practitioners resisting the position of biomedical expert and incorporating techniques to extend the healthcare they offer patients. Third, the thesis has revealed whether IM is integrative and sheds light on the degree to which the inherent paradigms of IM converge. This chapter discusses these issues and their implications in more detail.

The positioning of practitioners and patients within and by integrative medicine

The first major finding of this thesis reveals that IM provides an avenue through which practitioners can reconstruct their professional identity and make themselves into a new kind of healthcare professional. This constitutes a form of re-professionalisation that is different from that discussed in previous research. Previous research refers to re-professionalisation as

“a new definition of (organizational) professionalization...taking the place of the old (occupational) one, comprising the substitution of organizational for professional values, bureaucratic accountabilities for collegial relationships and an emphasis on financial rationalization, performance targets and increased political control” (Pickard, 2009, p. 252).

In contrast, the re-professionalisation demonstrated by IM practitioners in the current study consists of the reintegration of old occupational values into a new form of healthcare. The practitioners achieve this by discursively constructing IM as imbued with values and practices that are being eroded through healthcare reforms, such as autonomy and continuity of care (Saulz & Lochner, 2005; Pickard, 2009). For example, the practitioners are able to forge a reconceptualised continuity of care by constructing IM treatment as a healing journey which continues over time and by positioning themselves as facilitators of healing and educators. Through doing so, they become granted the right to accompany IM patients on their on-going healing journeys. The practitioners also construct the ‘expertise’ they offer to patients as being more than that offered by either GPs or alternative medicine practitioners. This positions them as a new type of healthcare expert. Such discursive work enables the practitioners to negotiate the challenges that healthcare reforms have brought to their professional identity. In doing so, they are invoking a new form of re-professionalisation.

This thesis also shows that IM legitimates patients’ engagement in self-reflexivity practices. IM offers patients a means to engage in a discursive reconstruction. For some patients this consists of repairing the ‘self’ that has become fragmented through non-recognition in biomedicine. A quest for recognition is particularly understandable for those who have suffered a lack of recognition previously, such as people with contested illnesses. In the wider literature, ‘recognition’ is understood to enable individuals to construct a more coherent self (Fisher, 2008) which is held to emerge from the empathy, validation and

acceptance of the self by another (Sointu, 2006a). Through the IM encounter patients engage in a reconstruction of self and the possibility of forging a coherent biographical interpretation (Williams, 1984) and a means by which to repair the biographical fractures that may have resulted from illness (Bury, 1982), or from a lack of recognition. This may explain why the IM practitioners' language and philosophy is taken up by patients. It is because the patients are offered a location through which they can meaningfully reconstruct their illness experience. For example, through understanding themselves as spiritual they become able to "let go of a lot of the painful things" experienced in the past. Thus in effect IM offers patients recognition and a new discursive space; one that is legitimated through patients' claims to an equitable position within their relationship with a biomedically trained practitioner.

The participants' talk constructs IM practice as bound up with a quest to find the "root cause" of patients' illnesses. This quest implicates patients' mind, body, spirit and emotions. Thus IM practice legitimates patients' desire to work on themselves which acts to reproduce and reinforce reflexive subjecthood. However, the reflexive 'self' that is perpetuated may problematise patients' ontological security, especially the chronically ill and those with contested illness, as the reflexive work that becomes legitimated may also create disruption to biographical coherence. Patients, in effect, become urged to engage in a discursive reconstruction of the self. And IM offers a space in which a deeper understanding of one's 'self' becomes possible, and moreover, is legitimated. Thus an endless cycle is created. The practice of IM fosters a requirement for patients' self-reflection *whilst at the same time* providing recognition for patients and thus a possible solution for any biographical fractures that occur. This acts to reproduce the reflexive and flexible self that has become so highly prized within contemporary neoliberal society (Giddens, 1991; Sointu, 2006b).

IM also problematises the notion that a more pluralised healthcare landscape offers the health consumer greater choice. In the current study, the reflexive self that the IM patient can become is constructed as a patient who has more 'choice'. The IM practitioners construct IM as different to other forms of healthcare and as a further choice that is opened up to the healthcare consumer outside allopathic medicine or alternative medicine. And, because of the extended toolkit that comprises IM, patients are constructed as being offered more choice *within* IM itself. However, the choice offered to patients is restricted.

Although the practitioners take up the concept of ‘information for choice’ (Henwood et al., 2003) which they construct as a means to grant patients empowerment, the choice that is offered to patients within the patient-practitioner encounter is limited to patients accepting or rejecting the treatment options recommended by the practitioners. Patient choice is also undermined by the prescriptive role that the patient is expected to perform. This problematises the notion of the ‘informed’ patient or ‘active’ health consumer.

This research also shows that IM lessens patients’ corporeality and reinforces a therapeutic focus on the mind-body link. Further, although the holistic healthcare in which the IM practitioners engage is held to treat the ‘whole person’, a fragmentation of the body-mind remains apparent. The holistic model in which the practitioners claim to work appears to reproduce rather than subvert some of the inherent features of the biomedical model, such as Cartesian dualism and individualism. This can result in more responsibility for health being granted to the patient and alongside this, self-blame for illness occurring (Sontag, 1991; McClean, 2005; Sered & Agigan, 2008; Baarts & Pedersen, 2009) Through the IM practitioners taking up a discourse of holism it becomes taken-for-granted that patients’ minds and emotions should be a focus of attention. Other constructions taken up by the practitioners also work in a similar way: Constructing “the body as a system” and “as energy” detracts from the patient’s body being understood as a corporeal object. Within IM the psyche of the patient also becomes implicated in maintaining health in the body. This demonstrates how a holistic model of medicine may merely shift the location of mind-body dualism rather than overcoming it (Scott, 1999). Other researchers have also noted how an emphasis on bodily control and ownership is paradoxical to the interconnectedness of mind-body-spirit that is emphasised in holism (McDonald & Slavin, 2010). IM practitioners do not seem able to escape from this limitation.

This research shows that within IM, patients become subjects with psychological, spiritual and emotional dimensions, in addition to physical bodies, which are taken into account and considered. The subjecthood that is afforded ties in neatly with the subject that wider ‘psy’ discourses have functioned to construct. Paradoxically, within IM, wellbeing appears to be valued *because* it promotes “‘discovery’ and ‘getting in touch with a core self’, the ‘real me’” (Sointu & Woodhead, 2008, p. 263), a replication of projects of the self that wider hegemonic ‘psy’ discourses give rise to. It is argued that ‘psy’ discourses construct objects, and in this case IM patients, in ways that work to normalize certain identities. In the

current study it is the discourses of holism, empowerment, liberal humanism and spirituality drawn on by these practitioners that frame the norms and values to which patients aspire, through self-regulation. This constitutes a process of subjectification through which patient-hood is represented in such a way as to “infuse and shape the personal investments of individuals” (Rose, 1990, p. 129).

How do integrative medicine practitioners resolve the paradoxical position they are shown to occupy?

As noted earlier, a number of paradoxes are also evident within IM. These revolve around the incommensurability of the paradigms, the contestability of the terms holism and empowerment and whether IM fosters professionalisation and standardisation of practice, which is antithetic to the alternative medicine paradigm. These paradoxes have implications for how IM treatment is given and received and for patients’ and practitioners’ positioning with the IM practitioner-patient relationship. This thesis has explored these paradoxes. It reveals whether the two paradigms within IM integrate and what this gives rise to in terms of challenges to either of the paradigms, along with the positioning and subjectivities of the individuals involved.

Consequently, the second major finding to emerge from this thesis is that practitioners are able to discursively negotiate the contradictory positions in which they are placed. The discursive work in which the practitioners engage to construct IM practice and to position themselves and patients within the IM patient-practitioner encounter enables them to resolve the contradictory position of working within two incommensurate paradigms.

Practitioners dichotomise medicine into ‘good’ and ‘bad’ categories to construct IM as better healthcare than allopathic or alternative medicine. They also claim to offer patients the ‘best of both worlds’ which indicates that the provision of these two forms of healthcare are combined rather than polarised. It would therefore appear that the IM practitioners in this study, who have knowledge of more than one mode of medicine, are able to overcome the paradox of being located at the crossroads of two paradigms that are philosophically diverse, largely because they are able to claim expertise in both. Practitioners also resist being positioned solely within the biomedical model by discrediting EBM and by denigrating allopathic practice. Further, they draw on notions of ‘best

practice' and 'good doctoring' to construct IM practice as offering a more extensive toolkit to patients which makes biomedicine appear narrow in comparison.

Practitioners also construct IM as 'patient centred' medicine. This type of practice is constructed as compassionate and more humane, and treatment becomes constructed as a journey. Further, the practitioners claim a diffused expertise, positioning themselves as facilitators of healing and educators. Through this positioning the practitioners become granted the right to accompany patients on their healing journeys and to assist patients to find meaning in their illness. Thus 'best practice' for these practitioners is constructed as largely about responsabilising and empowering patients rather than being a form of 'best practice' that rests on the standardisation of treatments. By grounding themselves in a new form of practice the practitioners also resist the process of scientisation and the increasing use of biomedical language and concepts (Evans, 2008). This is aided by the fact that they are already conversant with these understandings and can draw on them in a self-defined way.

The IM practitioners' talk may convey a notion that 'best practice' is largely about empowering patients, but the empowerment they claim to afford patients is shown to give rise to conflictual subjectivities. In the wider literature empowerment has been critiqued for being defined too narrowly. A focus is placed on helping patients to become more knowledgeable and to "take control over their bodies, disease and treatment" (Aujoulat et al. 2008, p. 1229). It tends to overlook patients' inability to understand illness with the same medical acuity as practitioners and fails to take account of patients' lack of skills and decreased bodily control which precipitate feelings of powerlessness, particularly for those with chronic conditions (Aujoulat et al., 2008). The current research expands this idea to suggest that the 'empowerment' offered patients is a form of proto-professionalisation. In this sense patients internalise the "fundamental stances and the basic concepts of the particular profession with which they are closely interacting" (de Swaan, 1990, p. 100). This has repercussions for patients' subjectivities in that through taking up the philosophy the practitioners espouse their own understanding of themselves may be altered.

Such proto-professionalisation has been identified in CAM. In a study by Smithson et al. (2012), which took account of people's experience of using CAM following cancer diagnosis, participants frequently referred to treatment as having a spiritual element, and

talked of their engagement in “psychosocial and spiritual activities” as integral to treatment and recuperation. They also identified commonly-held constructions of such therapies as transformative and a means by which patients experience spiritual or personal growth. However, that patients’ construct this “transformation” as beneficial is arguably because of the wider transformational discourse which the likes of self-help literature and consumer culture perpetuate.

The discursive work in which the practitioners engage to construct practice and to position themselves and patients operates to produce a patient-‘self’ that patients may not have understood themselves as having or being prior to their “treatment journey”. Further, through constructing the body and mind as separate, but also as complexly connected, patients are positioned as being in need of re-education and guidance (from the practitioner) which problematises the notion of patient empowerment.

Is integrative medicine integrative?

The third major finding this thesis shows is that IM is not truly integrative. This research documents how the IM practitioners lay claim to specific credentials, in the form of medical training and qualifications, and expertise, through having a scientific and biomedical understanding of the body, to confer greater legitimacy. In addition, they demonstrate knowledge of the alternative medicine they practice through engaging in a wider range of tests and through endorsing the practice of holistic medicine. This is the basis on which patients’ trust is established. The training, certification and subsequent prestige that the dual knowledge-base of biomedicine and alternative medicine bestows upon these practitioners also enables them to claim a level of expertise over and above GPs and those who practice alternative medicine solely. IM is also a site of contestation whereby the hegemony of biomedicine is actually challenged. The medical training that the practitioners possess provides them a warrant, a position from which to make this challenge.

Further, the IM practitioners’ philosophy, which is largely based on finding the “root cause”, does the same work as diagnosis; it acts to organise chaotic complaints that patients may have endured for years, but outside of the typical diagnostic framework. However, seeking the “root cause” is bound up with the holism which underpins CAM. And, it is through taking up a holism discourse that these IM practitioners are provided with a

discursive space which allows patients to convey the essence of their illness more meaningfully.

However, I would also argue that these practitioners, by appropriating and using aspects of alternative medicine healing systems outside of their original context, imbue them with values that serve to legitimate practices inherent to IM and, in doing so, are able to reconstruct their own professional identity. This arguably constitutes a form of boundary expansion and epitomizes how the appropriation of alternative medicine can be effected (Hollenberg & Muzzin, 2010) It also constitutes another means by which alternative healthcare practices become co-opted (Singer & Fisher, 2007) thus representing a further challenge to the self-definition of alternative therapies; albeit in a different form to the externally imposed regulatory measures and standardisation of practice that wider processes of professionalisation have brought about (Cant, 2009). Such appropriation of alternative medicine is also evident in other forms. For example Shroff (2011) suggests that holistic health concepts have become imbued with patriarchal, upper class and heterosexist values which have corrupted traditional notions. He also points to how the Taoist understanding of yin and yang have come to mean “good” and “bad” because oppressive structures have made incursions into such concepts.

In the wider literature, IM practitioners’ claims to ‘best practice’ and the ‘right way’ to practice have been shown to represent a form of IM which takes up aspects of alternative medicine but in a decontextualised way, through appropriating knowledge and techniques and using them to fit within the practice in which they engage (Benjamin et al., 2007). This is held to represent a colonization of alternative medicine rather than a merger (Benjamin et al., 2007). The wider ramification of such processes is that evidence based knowledge, in its appropriation of traditional knowledge, actually undermines and devalues traditional knowledge (Singer & Fisher, 2007). This constitutes a threat to the integrity of traditional knowledge because practices can become decontextualised and manipulated to fit scientific methodology (Baer 2004; Coulter 2004; Singer & Fisher, 2007). This is evident in herbalists training in the UK and Australia where students are being taught scientific and reductionist principles which thwart the development of holistic understandings of health and illness. However this awareness has added an impetus on the part of alternative practitioners to resist co-optation and may actually work to promote greater pluralism in the healthcare arena (Singer & Fisher, 2007).

An understanding of the emergence of IM as symbolising a colonisation has been noted elsewhere. Some researchers have suggested that it represents an appropriation and economic marginalisation of CAM and conclude that “IM is simply a historical repeat, albeit in new forms, of the biomedical takeover of CAM in the 19th and early 20th Centuries” (Hollenberg & Muzzin, 2010, p. 37). Other researchers have pointed to how IM is promoted erroneously as the ‘brave new world’ of a ‘new’ medicine, a ‘moral economy of hope’ that will reinvigorate patients’ faith and overcome ongoing fiscal challenges within the wider healthcare arena (Fries, 2008, p. 363). However, findings from the current thesis show how through constructing IM as encompassing a “whole different philosophy” and through claims to a different type of expertise the practitioners are reprofessionalising their practice. This enables them to enhance their status and to forge a self-defined and autonomous medical identity.

However, this thesis shows that although these IM practitioners adopt CAM, largely through taking up the notion of holism and through appropriating CAM techniques, the IM they practice also bears a close resemblance to CAM. This revelation allows a conclusion to be drawn: IM is not truly integrative.

My reflexive engagement with the research

I acknowledge that the findings presented in this thesis are interpreted and constitute a constructive account of the participants’ talk based partly on my own positioning. However, through engaging in this research my understandings have continually shifted as and I have become increasingly aware of the plurality and complexity of the positioning afforded both IM patients and practitioners, which I hope the findings reflect. Moreover, I have gained the impression that IM practitioners, through claims to medical professionalism, occupy a relatively static position in comparison to IM patients, one which affords the practitioners power in the IM relationship regardless of their espousal of patient empowerment and equality within the practitioner-patient relationship.

Another point of interest for me is around how the body is understood as far more than a biological entity, with understandings of the health of the body being inextricably linked to the mind and spirit. It seems that the IM practitioners philosophy of taking account of the ‘whole person’, dovetails neatly with patients’ quest for recognition as a person whose

feelings and cognitions, in addition to their bodies, are valued and considered within healthcare consultations. These understandings therefore work in a mutually-reinforcing way. They also produce a rhetoric which resonates with me personally: that emotional health is inseparable from physical health. However, through my position as researcher within IM, what also became apparent was how, paradoxically, the very thoughts and emotions that practitioners take into account can also be a source of pathologisation and thus far from salutogenic, which in turn, may problematise patients' claims to health and wellbeing.

The research findings also suggest to me that as a result of engaging in IM, women in particular are likely to experience an ongoing preoccupation with health and bodily awareness, perhaps because IM, and healthcare in general, is taken up by women to a larger degree. This is problematic in two respects. First, women are urged to strive for the feminine beauty ideal which consists of engaging in healthy practices, such as healthy eating and regular exercise, and displaying a slim and feminine body. Second, through healthism discourse women become placed under increased pressure to take greater responsibility for their own, and their families, health. Thus, not only are women required to display health through the fit, slim and healthy body, but they are also required to attain knowledge about the interconnected mind-body-spirit so as to more effectively monitor their own and others' health and wellbeing. In doing so, they are able to avoid the risk factors that, through healthism discourse, they become increasingly aware. However, in comparison to the experts they consult, women have a limited understanding of how alternative medicine works, particularly because within CAM and IM, health and illness are constructed as having a psycho-spiritual origin. Further, the myriad ways in which this idea of 'dis-ease', and its link with illness, is understood may perpetuate an individualised quest to find out what precipitates illness, but may not necessarily lend to locating a coherent answer. Instead, the ambiguity that surrounds the mind-body-spirit link may foster women's increased preoccupation with their bodies and their 'selves', in order to effectively safeguard health. Such positioning shapes how women live their lives and infiltrates the everyday practices in which they engage. In light of this increasing onus on us to be hypervigilant about our bodily and psychological states, we, as women, become even more preoccupied with health and health related aspects of life.

However, is an increasing awareness of our bodies and our physiological and emotional states necessarily detrimental? A preoccupation with one's psycho-physiological state could also be construed as beneficial. Noticing subtle psycho-physiological symptoms in conjunction with an awareness of the wider range of healthcare options now available, enables individuals to self-treat, which potentially gives them a greater sense of control over their lives. Therefore although seeking health is constructed as a moral imperative within healthism discourses, it is also a strategy which enables the individual to maintain a certain level of productivity for one's own sake, allowing one to take control and to alleviate the anxiety that a dissatisfactory level of productivity may bring. Thus although such personal productivity allows an individual to claim the status of a worthy, productive neo-liberal citizen within the wider society, it also enables one to attain goals that are personally meaningful.

Engaging in this research also resulted in my awareness of the implicit individualism of IM, whereby patients' social context, including their gender, social class and ethnicity, were largely disregarded whilst, in contrast, the notion that IM enabled patients to *choose* health was largely taken up. The individualism within IM became particularly salient in instances where practitioners constructed health as something that is "owned" by people. Such an understanding arguably contradicts the notion of choice as it implies that *all* people are able to, and moreover *should*, take control of their own health. Those who fail, or who choose not to live a 'healthy lifestyle', which human liberalism and empowerment discourses construct as a right, become ascribed the attribution of immorality.

Placing an inordinately high value on health is arguably problematic. First, if health becomes the key objective to maintaining a fulfilling life, then aging becomes an issue because one's health tends to be compromised as one ages (Verweij, 1999). Thus older people in society are more prone to be stigmatized because they are more vulnerable to ill-health. Second, solidarity, which is considered a "morally valuable" feature of society, becomes undermined because a victim blaming mentality, which individualism brings, detracts from those who are "better off" bearing "the burdens of those who are worse-off" (Verweij, 1999, p. 99). This suggests to me that this endless pursuit of health may be anti-collectivist and thus detrimental to the values of indigenous cultures and the bicultural society that constitutes New Zealand. This negates the possibility of opening up a

discursive space in which marginalized groups' voices and values can become accepted and legitimated.

Future directions

The current research was conducted within the socio-cultural context of New Zealand. The specific healthcare arena and social processes that are unique to New Zealand will undoubtedly have an impact on how IM emerges in this context. Thus, although the research provides insights into how IM is emerging in this context, these may not hold in other social contexts, with different healthcare systems and socio-cultural processes. It would therefore be beneficial for a similar study to be conducted in a different country or socio-cultural context. The discursive constructions offered through such an investigation are likely to vary from those identified in the present study because of the differing healthcare landscape and social processes that provide the wider context in which IM emerges.

As discussed in the Methodology Chapter (p. 42), the method of recruiting patients was through the IM practitioners who participated. This was deemed important for the research because it ensured that patients' references to the practitioner-patient relationship, the treatment they engaged in, and so on, were pertaining to the same understandings of IM as the practitioners interviewed, rather than to practice which had a more allopathic orientation, or which featured alternative medicine solely. The practitioners who participated were a reasonably heterogeneous group encompassing a number of different treatment modalities. However, future research could extend this study to recruit patients and practitioners whose CAM modalities differ from those featured in this study, incorporating such practices as Ayurvedic medicine, Reiki, and so on. This may also give rise to the participation of an ethnically heterogeneous group, which would produce a more diverse set of understandings.

However, although the findings reflect a nuanced set of understandings, within the context of IM in New Zealand, they also point to the benefits of conducting a micro-level investigation. This research has demonstrated how such an investigation into IM, which takes account of the discursive work in which the IM practitioners and their patients engage, has extended existing understandings of this emerging social phenomenon. In particular it reveals how discourses such as holism and empowerment, that are held to

represent the fundamental difference between allopathic medicine and alternative medicine, are drawn by practitioners to construct themselves as a new type of medical professional and as other than a GP or biomedical expert. It also warrants the practitioners a deeper level of engagement in patients' lifeworlds which may not actually translate into wholly beneficial outcomes for patients.

In conclusion, challenges to healthcare professionals' autonomy and credibility, brought about by healthcare reforms and wider social processes, such as medicalization and pharmaceuticalisation, make the act of reconstructing professional identity a viable means by which these IM practitioners maintain vocational fulfillment and professional integrity. However, the professional identity that IM gives rise to enables IM practitioners to become more entrepreneurial (Hollenberg & Muzzin, 2010). This suggests that the fragmentation and pluralisation of the healthcare landscape may present a double-edged sword. Although the liberated identity that is granted to healthcare practitioners may benefit wider ideals of neoliberalism, it may not necessarily serve the best interests of the patient or health consumer.

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Appendix A: Practitioners' information sheet



Understanding healthcare practices that combine conventional medicine with complementary and alternative medicine

Researcher: Helen Madden, Ph: 09 414 0800 Ext. 41220, email: h.madden@massey.ac.nz

Supervisor: Kerry Chamberlain, Ph: 09 414 0800 Ext. 41226, email: k.chamberlain@massey.ac.nz

PARTICIPANT INFORMATION SHEET

What is the research about?

You are invited to take part in a research project I am conducting for my PhD at Massey University on healthcare practices that combine conventional medicine with complementary and alternative medicine. The aim of the project is to explore how integrative medicine practitioners and patients understand treatment, the body, and the practitioner-patient relationship in integrative medicine practice. This will increase knowledge around how this form of healthcare is practiced and understood and its implications for the wider healthcare system. Participating in the study will also be beneficial to you in terms of providing a deeper level of understanding around the practices you offer to patients.

What is required if you decide to participate?

I would be interested in interviewing you about your role and your understandings of the healthcare practices you engage in with patients. The interview will take up to an hour. Please note that your participation in the study is entirely voluntary. If you choose to participate, the interview could be held in your consulting room or at the Centre for Psychology, Massey University, Albany. Alternatively, if it's more convenient, I can come and visit you at your home at a time that is convenient to you.

If you would like to take part in the study, I will ask you to sign a consent form prior to the interview, which grants your permission for the interview to be audiotaped. The audiotaped recording of the interview will be transcribed and analysed by myself. All of the data will be stored securely and only my supervisors, Professor Kerry Chamberlain and Associate Professor Darrin Hodgetts, and I will have access to it. Additionally, all information received from you during the study will remain confidential and your name and any identifying features will be altered if excerpts of the transcript are used in the written findings. No material which could personally identify you will be used in any reports on this study. Finally, at the conclusion of the study, the audio tapes will be disposed of, and transcripts, with identifying information removed, will remain at Massey University for ten years, thereafter being destroyed. If you are interested in receiving a summary of the main

findings of the study, I will ask you to provide details of your name and address so that the research summary can be sent to you.

If you do agree to take part in the research project you are free to:

- ask for the audiotape to be turned off at any time during the interview
- decline to discuss any topics you are not comfortable with
- withdraw from the study at any time up to 2 weeks following the interview without having to give a reason ask questions about the study at any time during participation
- ask questions about the study at any time during participation
- provide information on the understanding that your name will not be used
- ask for a summary of the research findings on conclusion of the project

What will happen to the research findings?

The research findings will be used for completion of my PhD, for publication in peer reviewed social science journals and as part of presentations I give at academic conferences.

Any questions about the study?

If you have any questions about the study please contact myself, Helen Madden, on 09 414 0800, Ext. 41220 (email: h.madden@massey.ac.nz) or Professor Kerry Chamberlain on 09 414 0800, Ext. 41226 (email: k.chamberlain@massey.ac.nz).

Any questions or concerns about your rights as a participant?

If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act. Telephone: (NZ wide) 0800 555 050; Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT); Email (NZ wide): advocacy@hdc.org.nz.

This study has received ethical approval from the Northern X Regional Ethics Committee.

Thank you for your time

Appendix B: Patients' information sheet



Understanding healthcare practices that combine conventional medicine with complementary and alternative medicine

Researcher: Helen Madden, Ph: 09 414 0800 Ext. 41220, email: h.madden@massey.ac.nz
Supervisor: Kerry Chamberlain, Ph: 09 414 0800 Ext. 41226, email: k.chamberlain@massey.ac.nz

PARTICIPANT INFORMATION SHEET

What is the research about?

You are invited to take part in a research project I am conducting for my PhD at Massey University on healthcare practices that combine conventional medicine with complementary and alternative medicine. The aim of the project is to explore how integrative medicine practitioners and patients understand treatment, the body, and the practitioner/patient relationship in integrative medicine practice. This will increase knowledge around how this form of healthcare is practiced and understood and its implications for the wider healthcare system. Participating in the study will also be beneficial, in that it will allow you a forum from which to reflect on the healthcare you receive, the processes involved, and the benefits you derive from your treatment.

What is required if you decide to participate?

If you are 18 years or over I would be interested in interviewing you about your understandings of the healthcare you receive. The interview will take approximately one hour.

If you are interested in taking part in the research, please contact me by telephone or email as per the contact details below. Please note that your participation in the study is entirely voluntary and that taking part in this research will not affect your future healthcare at the centre. If you choose to participate, the interview could be held at the Centre for Psychology, Massey University, Albany. Alternatively, if it's more convenient, I can come and visit you at your home at a time that is convenient to you.

If you would like to take part in the study, I will ask you to sign a consent form prior to the interview, which grants your permission for the interview to be audiotaped. The audiotaped recording of the interview will be transcribed and analysed by myself. All of the data will be stored securely and only my supervisors, Professor Kerry Chamberlain and Associate Professor Darrin Hodgetts, and I will have access to it. Additionally, all information received from you during the study will remain confidential and your name and any identifying features will be altered if excerpts of the transcript are used in the written findings. No material which could personally identify you will be used in any reports on this study.

Finally, at the conclusion of the study, the audio tapes will be disposed of, and transcripts, with identifying information removed, will remain at Massey University for ten years, thereafter being destroyed. If you are interested in receiving a summary of the main findings of the study, I will ask you to provide details of your name and address so that the research summary can be sent to you.

If you do agree to take part in the research project you are free to:

- ask for the audiotape to be turned off at any time during the interview
- decline to discuss any topics you are not comfortable with
- withdraw from the study at any time up to 2 weeks following the interview without having to give a reason ask questions about the study at any time during participation
- ask questions about the study at any time during participation
- provide information on the understanding that your name will not be used
- ask for a summary of the research findings on conclusion of the project

Safety concerns

If you express concern about any untreated serious health issues during the interview, I will suggest that you mention such concerns to your practitioner.

If you express concern about the practice or conduct of your practitioner, I will advise you to contact the Health and Disability Commissioner's Office to discuss the matter further.

What will happen to the research findings?

The research findings will be used for completion of my PhD, for publication in peer reviewed social science journals and as part of presentations I give at academic conferences.

Any questions about the study?

If you have any questions about the study please contact myself, Helen Madden, on 09 414 0800, Ext. 41220 (email: h.madden@massey.ac.nz) or Professor Kerry Chamberlain on 09 414 0800, Ext. 41226 (email: k.chamberlain@massey.ac.nz).

Any questions or concerns about your rights as a participant?

If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act. Telephone: (NZ wide) 0800 555 050; Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT); Email (NZ wide): advocacy@hdc.org.nz.

This study has received ethical approval from the Northern X Regional Ethics Committee.

Thank you for your time

Appendix C: Locality assessment form

LOCALITY ASSESSMENT – by Locality Organisation

Refer to pp10-12 of the Guidelines for Completion of the National Application Form for Ethical Approval of a Research Project

Full Project Title : **The practice and understandings of integrative medicine in New Zealand**

Short Project Title : **Understanding healthcare practices that combine conventional medicine with complementary and alternative medicine**

Brief outline of study:

The primary objective of this project is to gain a greater understanding of how integrative medicine is emerging in contemporary New Zealand society. Specifically, the research aims to explore how this emergent form of healthcare may be changing treatment practices and the understandings of both practitioners and patients in terms of treatment, the body and the practitioner/patient encounter.

Principal Investigator: **Helen Madden**

Contact details: Helen Madden
School of Psychology
Massey University Albany
Private Bag 102 904
North Shore Mail Centre
Telephone: 09 414 0800 ext 41220

Local investigators: **N/A**

Contact details: **N/A**

Locality Organisation signoff

Ethics committees review whether investigators have ensured their studies would meet established ethical standards, if conducted at appropriate localities; each locality organisation is asked to use the locality assessment form to check that the investigator has also made the appropriate local study arrangements.

Ethics approval for study conduct at each site is conditional on favourable locality assessment at that locality.

Locality issues: (see guidelines for more information and examples)
Identify any local issues and specify how they will be addressed.

1. Suitability of local researcher

For example, are all roles for the investigator(s) at the local site appropriate (eg has any conflict the investigator might have between her or his local roles in research and in patient care been adequately resolved)?

Answer:

2. Suitability of the local research environment

For example, have the resources (other than funding which is conditional on ethical approval) and/or facilities that the study requires locally been identified? Are they appropriate and available?

Answer:

3. What are the specific issues relating to the local community?

For example, are there any cultural or other issues *specific* to this locality, or to participants for whom study recruitment or participation is primarily at this locality? If so, how have they been addressed?

Answer:

4. Information sheet/consent form contact details:

Contact details for Health & Disability Consumer Advocates:

Telephone (NZ wide): 0800 555 050, free fax (NZ wide): 0800 27877678 (0800 2 SUPPORT), email (NZ wide): advocacy@hdc.org.nz.

Contact details for any other important local services:

I understand that I may withdraw locality approval if any significant local concerns arise. I agree to advise the Principal Investigator and then the relevant ethics committee should this occur.

Signature:

Date:

Name:

Position:

Contact details: _____

Appendix D: Interview guide for practitioners

Questions for practitioners

1. How would you describe your practice?
2. What does the term integrative medicine mean to you?
3. What sort of treatment do you provide?
4. It appears that the practitioner/patient relationship in the integrative medicine realm differs from the relationship in the biomedical and CAM realm. Could you comment on that?
5. Is the patient treated differently in the IM, CAM and biomedical realms? If so, how?
6. Where do you think responsibility for healthcare lies in IM practice?
7. How do you understand health?
8. How do you understand illness?
9. How do you understand the body?
10. What are your thoughts around how health and illness are understood within the context of the healthcare system in NZ?
11. How do you understand CAM?
12. How do you understand biomedicine?
13. Where do you consider IM practitioners (and practice) to be located in the context of the NZ healthcare system?
14. What does professionalisation and increased regulation, particularly in regard to CAM, mean to IM in NZ? What does this mean to your practice?

Appendix E: Interview guide for patients

Questions for patients

1. What sort of treatment do you receive? Could you describe it
2. It appears that the practitioner/patient relationship in the integrative medicine realm differs from the relationship in the biomedical and CAM realm. Could you comment on that?
3. How would you describe your relationship with [name of practitioner]?
4. Where do you think responsibility for health and healthcare lies in the healthcare you receive from [name of practitioner]?
5. How do you understand health?
6. How do you understand illness?
7. How do you understand the body?
8. What are your thoughts around how health and illness are understood within the context of the healthcare system in NZ?
9. How do you understand CAM?
10. How do you understand biomedicine?
11. What does the term integrative medicine mean to you?

Appendix F: Ethics approval



Pat_chaine@mo.govt.nz

Northern X Regional Ethics Committee

Ministry of Health
3rd Floor, Unisys Building
650 Great South Road, Penrose
Private Bag 92 522
Wellesley Street, Auckland
Phone (09) 580 9105
Fax (09) 580 9001

Please note postal address: Administrator, Northern X Regional Ethics Committee, PB 92 522 Wellesley St, Auckland 1141

Phone: 09 580 9105

12 May 2009

Ms Helen Madden
School of Psychology
Massey University Albany
Private Bag 102 904
North Shore Mail Centre
Auckland.

Dear Helen

NTX/09/04/036 The practice and understandings of integrative medicine in New Zealand: PIS/Cons V#2, 27/04/09

Principal Investigator: Ms Helen Madden

We are in receipt of the changes requested by the Committee. The above study has now been given ethical approval by the **Northern X Regional Ethics Committee**.

Approved Documents

- Participant Information Sheet/Consent Form for Patients, V#2 dated 27 April 2009
- Participant Information Sheet/Consent Form for Practitioners, V#2 dated 27 April 2009

Accreditation

The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Final Report

The study is approved until **12 May 2010**. A final report is required at the end of the study and a form to assist with this is available at <http://www.ethicscommittees.health.govt.nz> (forms – progress reports). If the study will not be completed as advised, please forward a progress report and a letter of application for extension of ethical approval one month before the above date.

Amendments

It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Pat Chainey', with a horizontal line extending to the right.

Pat Chainey
Administrator
Northern X Regional Ethics Committee

Cc: Massey University – Merle Turner